



State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

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1.4 Overview of the State

Title V in Context of the State Health Care System

Louisiana is unique because of its history of a comprehensive publicly financed health care system to serve its large proportion of poor citizens. Louisiana relies heavily on its regional, State-supported hospital system and large network of Maternal and Child Health (MCH) Block Grant and other federal and state funded public health clinics to directly provide preventive and primary health care for pregnant women, infants, children, and adolescents, as well as services for children with special health care needs, for its large medically indigent population. The MCH Adolescent School Health Initiative began in the early 1990's and provides funding for primary and preventive physical and mental health services in 40 school-based health centers across the state.

Since the Omnibus Reconciliation Act of 1990, Medicaid reimbursement for obstetric and pediatric care has increased, resulting in a growing participation of private physicians and hospitals to serve Louisiana's low-income pregnant women and children. Although the State hospitals and the MCH funded parish health units continue to serve a large portion of women and children living below the poverty level, the private sector involvement has assumed a significant role in providing health care to poor women and children. Since the early 1990's, the proportion of women delivering at the State hospitals has decreased from one-third to less than one-fifth.

There are areas, however, where the Title V services are the only resources for prenatal care and preventive pediatric services. Statewide, women and children receive benefits from the Supplemental Food Program for Women, Infants, and Children (WIC) through 105 parish health units. Title V funds provide the wrap-around services for these families, including immunizations, prenatal and parenting education, case management, and referral for other health and social services. These services are provided to over 150,000 women and children, comprising a large percentage of the state's population of pregnant women (70%) and children under age five in poverty (66%).

The MCH clinics are managed through nine Regional Offices which in turn report to a Central Office of the Office of Public Health (OPH). The MCH Adolescent School Health Initiative provides technical assistance to all contract school-based health centers. The MCH and Children's Special Health Services (CSHS) Programs are housed within OPH's Division of Health Services, which also includes the Family Planning, Nutrition (including WIC), Social Services, and Genetics Programs. Formal staff meetings of the Division and Program Managers are held 1-3 times per month, and informal coordination is done regularly. The Children's Special Health Services Program has nine Regional Offices through which the CSHS services are delivered.

The New Orleans Health Department is responsible for public health services in Orleans Parish. Title V provides funding for an MCH Medical Director. There are seven health centers located throughout the parish. Each clinic provides child health services including EPSDT, WIC and Commodity Supplemental Foods program, and immunizations. Maternity patients in Orleans Parish are followed at the Medical Center of Louisiana at New Orleans' OB Clinic, as well as in four community-based prenatal care sites funded by Title V, including sites in three New Orleans low-income housing projects. In addition to its general child health program, the New Orleans Health

Department also administers the New Orleans Lead Poisoning Control Program, funded by Title V.

Health Care Needs of the State's Population

A 1999 national report by ReliaStar Financial ranks Louisiana last in overall health, making Louisiana the “least healthy state in the nation”. Louisiana’s ranking is similar to its ranking of 48th and 49th the last two years. The report is based on 17 criteria, including disease rate, access to health care, occupational safety and disability, crime rate, motor vehicle death rate, and other mortality rates and data from 1998. Louisiana’s ranking as the most unhealthy state stems from its high violent crime rate, high unemployment, poor access to primary care, physical inactivity, high rate of heart disease, and high rate of premature death. Support for public health care has improved from 35% to 12% below the national average, but still lags behind other states. Since 1990, Louisiana has failed to match national improvements in prevalence of smoking and has seen an increased risk of heart disease (Louisiana Health Report Card, 2000).

According to the 1998 Census estimate, the total population of Louisiana was 4,368,967, indicating a 3.5% increase from the 1990 estimate. In terms of racial groups, 66.1% were white, 32.1% were black, (more than twice the national figure of 12.7%), and 1.7% were reported as Other. A comparison of Louisiana and National race distribution is provided in Figure 1, Appendix A. The total number of women of childbearing age went from 1,001,270 in 1990 or 27.3% to 1,002,566 or 23% in 1998. Teenagers 15-19 numbered 370,600 and included 186,742 male teenagers and 183,858 female teenagers (1998). Male and females aged 0-14 totaled 971,995, making up approximately 22% of Louisiana’s 1998 population. A table of 1998 parish population estimates is provided in Table 1, Appendix B.

Although Louisiana live births declined 7% from 1990 to 1998, there has been little change in the number of reported live births over the past several years. In 1997 and 1998 there were 65,947 and 66,773 births respectively. These numbers indicate a 1% increase from 1996 to 1997 as well as a 1% increase from 1997 to 1998. While the infant mortality rate in Louisiana has had an overall downward trend, the black infant mortality rate remains approximately twice that of white infants. (See Figures 5 & 6, Appendix A.) See Section 2.5 for more discussion of racial disparities in infant mortality.

Louisiana is a predominantly rural state. Only 13% of the 64 parishes have over 70% of their population considered urban. Seven of those parishes are located in the greater New Orleans metropolitan area.

According to the Bureau of Economic Analysis (May 2000), there have been several changes in Louisiana’s economic development. In 1998, total personal income grew at a rate of 4.7%, lower than the national rate of 5.9%, ranking Louisiana 24th nationally. Louisiana’s 1998 preliminary per capita personal income was \$22,206, or 82% of the national average at \$27,203. This reflected an increase of 4.5% from 1997, ranking Louisiana 42nd in the nation for per capita income. The Louisiana Department of Labor reports that in 1999, the overall unemployment rate was 5.1% for the state compared with a national rate of 4.2%.

The 1990 census data shows that Louisiana has an overall poverty rate of 23.6%. Louisiana continues to have one of the highest poverty rates in the United States. In 1996, 21.2% of Louisianans, approximately 912,513 people, lived in poverty. Louisiana has the fifth highest poverty rate of all the states (Louisiana State of the State Report 1997). The *2000 National Kids Count Data Book* reports Louisiana as having the 48th highest child poverty rate among the 50 states. Thirty percent of the children in Louisiana lived in poverty in 1997 as compared to 21% nationally. According to census data, 31.3% of children 18 and under (56.5% of blacks; 15.4% of whites) live in poverty. Approximately thirty-seven percent (36.6%) of children under five years old live in poverty (60.5% of blacks; 15.4% of whites).

During the state 1998/1999 fiscal year, 717,813 Louisianians were recipients of Medicaid services. This represents roughly 17% of the population (*Louisiana Medicaid Program Report, State Fiscal Year 1998/1999*). This percentage is slightly (2%) higher than the percentage of the population on Medicaid nationwide. Among the southern states, only Mississippi has a higher percentage of its population on Medicaid. The percentage of Louisiana's population on Medicaid has decreased slightly from a high of 18% in 1993. Private sector involvement in the health care of low-income women and children has increased during the past few years due to increases in reimbursement by the Medicaid program. From 1988 to 1998, the percentage of total deliveries in the state that occurred in state operated hospitals decreased from 32% to 18.3%. Some physicians accepting Medicaid place a limit on the number of Medicaid patients they will serve. There are also discrepancies among specialties, i.e. more private obstetrical providers accept Medicaid than private pediatricians. Pediatric sub-specialists providing care to children with special health care needs are concentrated in the teaching medical centers in New Orleans and to a lesser degree, Shreveport. There are very few located in the more rural areas of the state. This is demonstrated by a chart depicting pediatric sub-specialists reported by the Louisiana Medical Society. (See Table 4, Appendix B.)

According to the U.S. Census Bureau (1990), Louisiana has the 6th highest prevalence in the nation (29.08%) of disabilities among persons less than 18 years of age. The number of children receiving SSI benefits decreased from 1996 to 1999, with 38,590 children receiving SSI benefits in 1996 and 23,360 children in 1999. Since persons with disabilities use significantly more medical services than those without disabilities, the high prevalence of disabilities among children in the state, coupled with the fact that the percent of uninsured children in Louisiana is approximately 20%, indicates a tremendous need for health care services and resources for children with special health care needs.

Current OPH Priorities and Initiatives and Title V's Role

Louisiana, as one of the poorest and unhealthiest states in the nation, has the challenge of using its limited resources for the highest priority activities. Prevention services are underfunded as compared to other health care services. The Office of Public Health, through a strategic planning process, has defined its mission as follows:

- C To promote health through education that emphasizes the importance of individual responsibility for health and wellness.
- C To enforce regulations that protect the environment and to investigate health hazards in the community.
- C To collect and distribute information vital to informed decision-making on matters related to individual, community, and environmental health.
- C To provide leadership for the prevention and control of disease, injury, and disability in the state.
- C To assure universal access to essential health services.

Operating within the context of the Office of Public Health and the changing health care environment, the Title V Program maintains its commitment to decreasing mortality and morbidity and assuring access to primary and preventive health care services for Louisiana's maternal and child health population. The Title V Program addresses each aspect of the OPH mission for the maternal and child population, including children with special health care needs, in the following ways:

- C Health promotion is a major priority of the Title V Program, and includes public information and media campaigns on domestic violence, child abuse, prenatal care, HIV, SIDS, and injury prevention. Public health staff provide health education and counseling to over 150,000 pregnant women and children each year in individual patient counseling or group sessions.
- C Some of the health hazards addressed by the Title V Program include lead poisoning, car safety and other injury prevention, and child care health and safety.
- C The Title V Program shares vital statistics information widely and is completing its third year of implementing the Pregnancy Risk Assessment Monitoring System (PRAMS). The Child Death Review process informs legislators and policymakers on the needs of children and families in the state.
- C The Title V staff lead and participate in various task forces related to the health of women and children, including child abuse prevention, domestic violence, perinatal care, child death review, oral health, and injury prevention. Title V works with professional and advocacy organizations to promote legislation and regulations to protect and promote the health of women and children.
- C Through its system of parish health units and school-based health centers, Title V is able to provide a statewide safety net of direct health services for women, children, and adolescents who are uninsured or have no access to other health care providers. With the largest number of poor children of any state, Title V resources continue to be dedicated to direct health care services. Children with special health care needs have access to a comprehensive, family-centered, community-based network of pediatric specialists, including physicians, nurses, social workers, and other health care providers throughout the state through the CSHS regional clinics and community-based services.

Impact of Welfare Reform, Children's Health Insurance Program (LaCHIP), and Managed Care

Welfare Reform: Louisiana's cash assistance program is operated by the State's Department of Social Services (DSS), a separate agency from the Department of Health and Hospitals, which houses both the Office of Public Health and the State Medicaid Program. In December 1996, before the implementation of Welfare Reform, there were 213,551 AFDC recipients in Louisiana. By March 1998, the number of recipients of cash assistance, now called Temporary Aid to Needy Families (TANF), had decreased by 42% to 124,031. In September 1999, there were 86,470 TANF recipients in the state, representing 32,077 families. This is a decrease in enrollment of approximately 65% from January 1993.

As in other states, Welfare Reform brought about many changes to Louisiana's cash assistance program. As of January 1, 1997, Louisiana limited welfare benefits to two years in any five years; capped benefits at five years in a lifetime; and required twenty hours per week of work or work training, unless exempt. The first families in Louisiana felt the impact of the two year time limits on January 1, 1999; 2,171 families lost their benefits on that date due to time limits. An additional 895 individuals were exempted from losing their benefits because they were either actively seeking work, in a training program that would be completed within the year, had unfavorable job factors, or suffered some form of hardship. There is also an exemption for victims of domestic violence.

The decline in TANF caseload has resulted in a surplus of funds available for expenditure by the state. DSS transferred 30% of the TANF Block Grant to its Child Care Assistance Program, which will add child care slots and increase child care subsidies. Currently, the Child Care Assistance Program serves about 40,000 children. Other support services provided by DSS to those finding employment include transportation, job search services, and counseling and training. DSS has proposed other programs to be funded with unspent TANF dollars; all are slated to begin sometime in the year 2000. These programs include a kinship care subsidy program, an expansion of the existing teen pregnancy prevention program, and mentoring programs. In 1999, MCH proposed additional support services for families that could be funded with unspent TANF dollars, including home visiting services for needy families, as well as an enhancement to the existing child care system. The OPH Social Services Medical Director assisted with implementation of the domestic violence exception.

TANF severs the automatic link to Medicaid eligibility for those receiving cash assistance. Although there is an on-line mechanism to transfer information on those who are losing cash assistance from the Department of Social Services to Medicaid, individuals must follow up with the additional verification requirements that Medicaid requires. Medicaid estimates the welfare losses to be somewhere between 20,000 and 30,000 children - these are children whose families lost cash assistance and who failed to enroll their children in LaCHIP/Medicaid. MCH has acted as a liaison between the State Medicaid Agency within the Department of Health and Hospitals and the State TANF Program within the Department of Social Services to improve the link between the two programs. Both Medicaid and DSS participate on a coalition for CHIP outreach, directed and convened by MCH, and are attempting to work through the process as part of Louisiana's Covering Kids Initiative Project to ensure that children have health coverage.

Specifically, MCH formed a TANF/Medicaid Workgroup in 1999-2000 comprised of eligibility workers from both agencies, administrators from both agencies, and community agencies that assist families in applying for these government programs. The workgroup reviewed various application scenarios in order to identify weak points in the systems where children may be falling through the cracks. The meeting resulted in a collaboration between the agencies on the promotion of LaCHIP/Medicaid to all welfare case workers, and included distribution of promotional materials to welfare offices and plans for a “buddy system” between eligibility workers.

For families of children with special health care needs, welfare reform has created unique problems for parents entering the workforce and attempting to take care of their children’s complex medical needs. Increasing problems of families not being able to obtain time off from work to keep medical appointments has presented the CSHS Program with challenges in providing comprehensive care. The problem of finding appropriate and willing child care services for children with special needs has also intensified for these families. In addition, families affected by welfare reform have also expressed an increased need for additional respite services brought on by the demands of working and caring for a child with special needs.

The changing eligibility requirements for SSI have not had a negative impact on the CSHS Program because the children eligible for CSHS have more severe disabilities than those whose SSI benefits were terminated. CSHS did take a leadership role in the state by convening a statewide committee for awareness of the changing eligibility requirements for SSI. This involved a cooperative effort between many state agencies, such as the Developmental Disabilities Unit of the Department of Social Services, and private agencies, such as the New Orleans Legal Aid Corporation. In addition to providing awareness to recipients, this collaboration fostered better working relationships among the agencies involved.

The Welfare Reform Act created a new Section 510 of Title V, establishing funding for abstinence education. In Louisiana, control of this funding falls under the Governor’s Office, and an abstinence education program has been implemented.

CHIP: Louisiana’s Child Health Insurance Program (LaCHIP) began on November 1, 1998, as a Medicaid expansion to 133% of Federal Poverty Level (FPL) to age 19. On November 1, 1999, the State began a second phase of LaCHIP implementation, with a further expansion of the Medicaid program to 150% FPL. A third phase was slated for implementation in the Fall of 2000, and would have either further expanded Medicaid or created a private insurance plan for children from 150% to 200% FPL. Plans for this expansion were delayed due to a severe state budgetary crisis; however, the third phase was approved in a Special Legislative Session in June 2000 as another expansion of the Medicaid Program. This final phase will go into effect by January 2001.

The state’s goals for year one of LaCHIP implementation were to enroll 28,350 children in LaCHIP, and approximately the same number of previously eligible and unenrolled children in Medicaid. By the end of year one, October 31st, 1999, the state had enrolled 27,725 children in LaCHIP, and had experienced a net gain of 32,500

children in the regular Medicaid program. Louisiana's uninsured rate is slowly falling. The rate of uninsured children in 1998 is estimated to be 18.3%. In 1996, the American Academy of Pediatrics ranked Louisiana 49th in the nation for number of uninsured children; the AAP projects that in the year 2000, Louisiana will fall to 40th.

In preparation for LaCHIP, the state took many critical steps to streamline the eligibility process - a simple, one page application form was created for both LaCHIP and Medicaid for children; 12 month continuous eligibility was initiated; the need for a face to face interview was removed and mail in applications are now accepted; and a Central Processing Office was established to handle all child applications for Medicaid/LaCHIP. Medicaid has relied on regional outreach teams of existing Medicaid field staff to spearhead community-based outreach strategies statewide. Last Fall, the state also streamlined the LaCHIP/Medicaid recertification form, which is sent out to families after 12 months to re-apply for their children. This form is now the same length and format as the LaCHIP/Medicaid application form. Still, Medicaid has estimated that approximately 7,000 children were lost from November 1999 to January 2000 due to a failure to re-enroll. The state budget crisis forced reduction in reimbursement rates to Medicaid providers, which have recently been reversed. Fluctuations in reimbursement rates may result in reduced access to care, leaving providers reluctant to participate in the Medicaid Program or to accept new patients. There are already areas of the state with few or no options for Medicaid/LaCHIP enrollees.

MCH Program staff works closely with Medicaid staff on LaCHIP outreach, and on operation of the Louisiana Covering Kids Initiative, a Robert Wood Johnson Foundation project for which MCH is the Lead Agency. Covering Kids outreach efforts in year one included a school-based outreach campaign reaching 760,000 public schoolchildren statewide; translation of the LaCHIP application into Spanish and Vietnamese; creation of a Hispanic workgroup to conduct outreach and advise Medicaid on barriers unique to Hispanic families; creation of a student volunteer network at Tulane University; delivery of community trainings and presentations on LaCHIP; creation of a TANF/Medicaid Workgroup; and intense community-based outreach in two pilot areas. The drop off due to a failure to reenroll in the program has emerged as a major barrier, and MCH works with Medicaid to increase the number of families who recertify their children. MCH tailors outreach messages to reinforce the message that families must reenroll after 12 months, and MCH staff facilitated a discussion with Medicaid and all entities conducting outreach in Louisiana to brainstorm on solutions. Suggestions are in Medicaid's hands for consideration, and include an expiration sticker on the Medicaid/LaCHIP card, as well as colorful mailings to certified families.

MCH has also led the Office of Public Health's participation in LaCHIP, by training parish health unit staff statewide on LaCHIP; communicating regular LaCHIP updates to clinic staff; and negotiating to establish the school-based health centers as official LaCHIP application centers. Parish health units are consistently one of the top origination points of LaCHIP applications.

The impact of LaCHIP on the CSHS Program is a complex issue and is unknown at this time. Expanded Medicaid coverage has brought more eligible families into the program, increasing revenues. It was hoped that this may allow Title V funds to be spent to expand either eligibility or covered services. However, state budget cuts have

curtailed any expansion of services. On the other hand, as more children are eligible for Medicaid, a recent trend toward accessing the private sector may increase. Unfortunately, some families whose children have more complex medical problems are finding it very difficult to appropriately utilize the private system and have returned to the CSHS Program with additional, more serious problems. CSHS plans to collaborate with the LaCHIP program, providing leadership in the unique issues faced by families with children who have special health care needs. The level of reimbursement rates for Medicaid Providers are critical to health care access. The more recent state budget crisis reduced payments to physicians and other Medicaid providers. Although this was overturned, any fluctuations may reduce access, as providers begin to no longer accept Medicaid and patients have fewer health care choices.

Health Care Reform: Medicaid initiatives implementing primary care case management in 20 rural parishes, as well as the increase of privatization of EPSDT services, have decreased the delivery of preventive pediatric and maternity services among local health departments and increased these services in the private sector. In 1997, Louisiana applied for a Medicaid Waiver to the Health Care Financing Administration to create a system-wide provision of managed care beginning with one regional pilot project. Plans for this pilot were abandoned, and replaced by plans for an enhanced primary care case management program that would encompass two regions of the state. Plans for this project have also been tabled.

For children with special health care needs, a move to a managed care environment presents many concerns. CSHS will continue to emphasize the care coordination services that the CSHS Program provides and that are critical to families. CSHS has begun to work with Medicaid's KIDMED (EPSDT) Program to increase communication with primary care providers in Community Care parishes. This includes assistance from KIDMED in obtaining needed referrals from primary care physicians for CSHS services.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

At the time that this Block Grant Application was written, the state was experiencing a severe budget crisis. In January 1999, Governor Foster issued an Executive Order mandating a hiring and spending freeze for all government agencies. The Department of Health and Hospitals' Secretary has extended this freeze indefinitely due to extreme budget shortfalls, and at this time, all DHH agencies are operating under a spending freeze. This includes restrictions on purchases, contracting, out of state travel, and hiring. Programs were required to cut 10% from contract expenditures, and DHH staff will be reduced by 1,800 employees this year. This has hampered the operations of the MCH and CSHS Programs in several ways. First, staff have not been allowed to travel out of state for conferences or meetings. Second, vacant positions have not been able to be filled. Third, any new contracts, grants, or activities are extremely difficult to get approved. And fourth, existing contracts have suffered cuts. Some examples include a disapproval of the plan to expand eligibility criteria for the CSHS Program, and a failure to replace the Women's

Health and CSHS Medical Director positions.

1.5.1.1 Organizational Structure

The Department of Health and Hospitals is one of twenty departments under the direct control of the Governor. The Office of Public Health is one of the five major agencies within the Department of Health and Hospitals (DHH). The State Medicaid Agency, Bureau of Health Services Financing, is also located in this Department. The Title V programs, the Maternal and Child Health Program and Children's Special Health Services, are located in the Division of Health Services in the Office of Public Health. The organizational charts in Figure 4, Appendix A, illustrate the structure of the Division of Health Services Programs, DHH, and the departments under the Governor.

The following State statutes are relevant to the Title V program:

1. LSA-R.S. 46:971-973
Administration of MCH Services in State of Louisiana - Health Department Responsible
2. LSA-R.S. 17:2111-2112
Vision and hearing screening - Health Department and Department of Education Responsible
3. LSA-R.S. 33:1563
SIDS autopsy; reporting to Health Department Required
4. LSA-R.S. 40:1299
Mandated Genetics- Newborn screening - Health Department Responsible
5. LSA-R.S. 40:1299.111-.120
Children's Special Health Services - Health Department Responsible
6. LSA-R.S. 40:5
State Board of Health authority to create MCH & CC Agency
7. LSA-R.S. 40:31.3
Adolescent School Health - School Based Clinics - Health Department Responsible
8. LSA-R.S. 46:2261
The Identification of Hearing Impairment in Infants Law- Health Department Responsible

1.5.1.2 Program Capacity

Personal health services and local public health functions are provided by 105 OPH parish health units distributed throughout the state, except in New Orleans and Plaquemines Parish, which have their own independent health departments. OPH has nine Regional Administrators who supervise the health units, regional CSHS clinics, and regional health staff in their respective regions. CSHS has nine Regional Offices which serve as clinic sites. The

MCH Adolescent School Health Initiative provides funding and technical assistance to 40 contract school-based health centers.

Pregnant women and children ages 0-21 who have no access to prenatal or preventive health care in the private sector are served in MCH funded clinics whose services are linked with WIC, Family Planning, and Sexually Transmitted Disease services. Program directors at the state level meet monthly to coordinate these programs so the services will be "seamless" at the local level. MCH services are available in every parish in Louisiana. Orleans Parish operates an independent health department and receives support from the Title V Program. MCH services are also provided through other medical and social services entities. Plaquemines Parish operates a clinic which provides EPSDT, immunization, and WIC services.

CSHS provides family-centered, community-based, coordinated care for children with special health care needs and their families, including rehabilitation services for children receiving SSI benefits, through its network of 300 pediatric subspecialty providers and facilities at the regional and local levels. Parents acting as family liaisons enhance the care coordination provided by the CSHS regional team and provide needed support. As CSHS strives to facilitate the development of systems of care for families, services are being merged with existing facilities or moved to local sites to complement the already existing service network established by the staff.

1.5.1.3 Other Capacity

In addition to the Regional Administrator, each region has a Medical Director, Regional Nurse Manager, Administrative Manager, Social Worker, Nutritionist, MCH/Family Planning Nurse, and Regional CSHS Staff. Although policy development and programmatic direction are provided by the State MCH Program staff, input is provided by regional and local staff. The State MCH/CSHS Program staff include a separate Medical Director and Administrator for each program (Women's Health, Child Health, and CSHS). Staffing also includes a Statewide Maternity Nursing Consultant, Pediatric Nursing Consultant, CSHS Nursing Consultant, CSHS Social Work Consultant, CSHS Statewide Parent Coordinator, Hearing, Speech, and Vision Program Director, Hearing, Speech, and Vision Statewide Parent Coordinator, MCH Assistant Administrator, Child Health Manager, Child Health Program Assistant, MCH Nutritionist, Covering Kids Initiative Project Director, SIDS Program Coordinator, Mental Health Specialist, two CSHS accounting and contract monitoring staff, an Oral Health Director, a part-time dental hygienist, two PRAMS staff, a Birth Defects Registry Coordinator, a Division of Health Services Epidemiologist, two SSDI funded epidemiologists, a CDC assignee MCH epidemiologist, MCH Health Education Coordinator, Adolescent Health Initiative Coordinator, Adolescent Health Medical Director, four Adolescent Health Initiative staff, and nine clerical staff. The State Director of Medical Social Services serves as a consultant to both the MCH and CSHS Programs.

Of the State positions mentioned above, there are four vacant positions: the Women's Health Medical Director, the CSHS Medical Director, the CSHS Social Work Consultant, and the Hearing, Speech, and Vision Program Director.

The number of OPH field staff resources (FTEs) funded by the MCH and CSHS Programs is approximately 223 and 75, respectively. As the number of staff decreases in the direct health care portions of the program, staff are being hired to initiate nurse home visiting programs across the state. In Central Office, staff have been hired to expand the epidemiologic and evaluation capacity in the program, including two epidemiologists funded with the SSDI grant from MCHB. A contract has been written for a family representative to be hired by the MCH Program. The goal of the contract is to develop a statewide system of gaining parent input into MCH services and activities and to provide input into MCH policy, needs assessment, and customer satisfaction issues. The parent has been selected, and the contract is pending approval.

CSHS employs parents as Family Liaisons in all 9 Regional Offices. In addition to providing one to one family support and information, the Family Liaisons promote the issues critical to families with children with special needs in local communities and at a state level. The CSHS Statewide Parent Coordinator has been instrumental in providing input to policy and establishing links with other consumer organizations at the state and national level.

1.5.2 State Agency Organization

The organizational relationships among state human services agencies and Title V are numerous and range from formal interagency agreements to participation on task forces to regular meetings and phone calls to inform or educate each other on the areas of common interest. The following gives an overview of the relationships among the various state human services agencies and Title V. For a detailed discussion of Title V collaboration, see Section 2.4.

Written Agreements	Interagency Task Forces/Commissions	Collaboration (including joint funding of projects)
Medicaid	Office of Mental Health	Department of Education
Office of Alcohol and Substance Abuse	Department of Social Services	Tulane School of Public Health
Schools of Medicine and Public Health (Tulane and LSU)	Medicaid	Tertiary Care Facilities
Primary Care Cooperative Agreement(FQHCs)	American Academy of Pediatrics, LA Chapter	City of New Orleans Health Department
Office of Community Services (Child Protection)	Perinatal Care Commission	Children’s Trust Fund
University Affiliated Program	Family Voices	Agenda for Children

Families Helping Families, Inc.	Louisiana Council on Child Abuse	Easter Seals Society
LSU Dental School	Child Death Review	Toy R Us, Corp.
Shriner's Hospital	ChildNet (Part C)	MCH Coalition

II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

See Supporting Documents, Section 5.8 for Forms 3, 4, and 5. The large discrepancy between fiscal year 1997 budgeted and expended figures is because the budgeted figures were derived from the State budget request submitted to the State Legislature before the final approved appropriation for the state fiscal year 1997 was actually received. In addition, there was a difference in program income related to a decrease in Medicaid reimbursement. In contrast, the budgeted totals for fiscal years 1999 and 2000 are based on actual expenses. Budget requests were used only for those items for which the budgeted requests represent a realistic picture of actual expenditures. Otherwise, budgeted figures for 1999 and 2000 represent a slight increase over the previous year's actual expenditures.

2.2 Annual Number of Individuals Served

See Supporting Documents, Section 5.8 for Forms 6, 7, 8, and 9.

2.3 State Summary Profile

See Supporting Documents, Section 5.8 for Form 10.

2.4 Progress on Annual Performance Measures

See Supporting Documents, Section 5.8 for Form 11.

The following is a discussion of the accomplishments of the Title V program, by each level of the pyramid and by required population groups, for the time period 10/1/98 to 9/30/99.

Direct Health Care Services

Pregnant Women, Mothers, and Infants

There were 124,605 visits to parish health units for maternity related services including pregnancy tests, comprehensive prenatal care, health education, case management, and WIC benefits. There is an increasing number of private sector providers for the Medicaid population and Title V initiates prenatal care for women who often end up seeking private care once they are Medicaid eligible. Approximately one quarter of the maternity patients seen

in parish health units were adolescents between age 10 and 19.

Nutritional status assessment and counseling were provided to 10,000 women in the parish health units, and 6,000 nutritionist visits to prenatal patients were provided. This is a considerable decrease from last year. The Office of Public Health employs a limited number of nutritionists, and as nutritionist positions become vacant, they often can not be filled because of the hiring freeze in effect since January 1999. Nutritionist positions are monitored closely by the MCH Nutritionist and the Nutrition Services Section.

HIV screening, education, and counseling for all pregnant women continue to be an MCH priority. All patients choosing to initiate their prenatal care within one of the parish health units are educated and counseled about HIV during pregnancy, and offered an HIV test.

Many areas in the state continue to lack prenatal care services for women in need. MCH provides comprehensive prenatal care in most parish health units across the state and pregnancy testing, and prenatal counseling and education in all parish health units. Region one has three contract maternity clinics in high risk New Orleans neighborhoods. In all the remaining regions, staff work closely and collaboratively with local private providers and regional hospitals that provide prenatal care to furnish extensive prenatal education and WIC services.

Title V funding provided prenatal and postpartal care to 1,438 women living in three low income housing projects in New Orleans. These services were provided by the New Orleans Health Department near the Fisher Housing Project; St. Thomas Health Services, Inc. near the St. Thomas Housing Project; and LSU Medical Center at the Desire Housing Project. Prenatal, postpartum, family planning, and pediatric care were provided to 610 adolescents and their children through the Tots and Teens Clinic in Shreveport. Title V continued to fund and monitor prenatal clinic sites utilized by Great Expectations, the New Orleans Healthy Start Program.

Women of Reproductive Age

Family planning medical services, education, and contraception were provided to 67,009 low income women. Periconceptual education is given to all women utilizing the parish health unit Family Planning Clinics during their initial and annual visits. Emphasis is placed on safe spacing and planning of children; nutrition, with an emphasis on the need for a daily folic acid supplement (4mcg.); exercise; safety; and prevention of sexually transmitted infections.

Infants and Children

There were 221,303 child health visits to the parish health units. Comprehensive preventive child health services included nutritional assessments and services, immunizations, health education, and laboratory and other physical,

psychosocial, and developmental screening procedures.

Title V funds support primary care services in the St. Thomas Housing Project in New Orleans. Last year, 1,205 pediatric visits were provided to indigent children living in that area. Other community-based child health care services funded by Title V included the Tots and Teens Program in Shreveport (see above) and the Teen Advocacy Program in Baton Rouge (see below).

Parish health unit nurses worked closely with the Child Protection Agency, the Office of Community Services (OCS). In some parishes, a designated public health nurse attended OCS staffings and routinely took part in investigations of alleged child abuse or neglect. Other parishes mainly interacted with OCS as a referral source when they suspected abuse or neglect had taken place.

Family-centered clinical speech/language pathology and audiology services were provided by licensed audiologists and speech/language pathologists to children in parish health units statewide and in regional infant-toddler assessment clinics. Services were provided to 1,116 infants, toddlers and children in FY 1998-1999. Due to increased emphasis on training and reductions of staff, services have decreased.

The Genetics Program provided tracking services to 516 patients suspect for a disease detected through newborn screening. Patients confirmed to have disease totaled 6 for classical phenylketonuria, 15 for congenital hypothyroidism and 85 for sickle cell diseases.

Children and Adolescents

During the 1998-1999 school year, 20,949 student patients made a total of 101,762 visits to 36 Louisiana school-based health centers (SBHCs). SBHCs collaborated with the DHH Offices of Addictive Disorders and Mental Health to provide alcohol, drug, and tobacco use counseling and behavioral health counseling. Many centers offered conflict resolution, anger management, and other violence prevention strategies.

Children with Special Health Care Needs

There were 7,397 CSHS patients seen in regional CSHS clinics statewide in FY 1998-1999. The decrease in number of children enrolled in CSHS services is due to several factors. The income criteria for CSHS eligibility has remained static for approximately 12 years. During that time, federal poverty income levels and associated Medicaid income levels have risen to be equivalent to CSHS eligibility. With the advent of LaCHIP, income eligibility for Medicaid and CSHS are essentially the same. Families now eligible for Medicaid/LaCHIP have freedom of choice for private specialty providers and in many urban areas where these services are available, families have chosen to

seek private care. The CSHS Program attempted to address this trend by revising its income criteria above LaCHIP levels to 400% FPL. The State denied funding for this increase, due to a severe budgetary crisis. CSHS will continue to form partnerships with the private sector to provide wrap-around services where direct care is available and accessible and increase outreach to assure that all eligible families are aware of available services.

In New Orleans, the CSHS Program and the LSU Human Development Center operate a multi-disciplinary clinic for follow-up of newborns at high risk for developmental disabilities. The CSHS Program continued to support three other High Risk Clinics to identify and treat infants and children at greater risk for developing conditions that significantly limit major life activities. These are the Tulane University School of Medicine Department of Pediatrics, High Risk Follow-up Program at Huey P. Long Hospital in Alexandria; the LSU Medical Center's NICU Comprehensive Care Clinic in Shreveport; and the LSU Medical Center's High Risk Infant Follow-up Program at Earl K. Long Medical Center in Baton Rouge.

The CSHS Program maintained a dental care direct service program through the CSHS Children's Hospital Dental Clinic, contracted through the Louisiana State University School of Dentistry. This program accepts referrals for children with special health care needs from across the state and provides a scope of services, including basic restorative, preventive, and limited orthodontic and oral surgical dental services. The LSU Dental School, Department of Pediatrics faculty, staff the clinic and other school faculty are available as needed for consultation and services. The facility space is donated by Children's Hospital and the Alliance for the Louisiana Dental Association donates services. CSHS also provided assistance through DHH/OPH Regional Offices for eligible children to receive dental services through the private sector for children in need of dental services including cleft lip and palate team services.

Enabling Services

Case Management

Pregnant Women, Mothers, and Infants

The Teen Advocate Program in Baton Rouge provided outreach and case management services to teens and teen mothers and their children, focusing on assisting them to avoid unplanned pregnancies, access ongoing medical care, return to or stay in school, obtain job training or child care, and access other needed community resources. From October 1998 through September 1999, 163 pregnant teens received prenatal case management services and 132 teens received family planning services through the program. The Moms and Babies Program in Baton Rouge is an intensive outreach case management program that reaches medically high risk pregnant women, 18 and older, and their babies, with the focus on HIV positive or substance abusing clients. From October 1998 through September 1999, 34 clients were served.

Pregnant Women, Mothers, Infants, and Children

From 10/1/98 - 9/30/99, MCH provided funding to four home visiting programs using paraprofessional staff. Each of these programs adheres to the Healthy Families America model which provides standardized program protocols for regularly scheduled home visits. These programs coordinated with a wide range of community-based programs and services and facilitated referrals when needs were identified. The total number of families receiving services through these four programs was 338 with over 3,808 successful home visits.

In March 1999, MCH initiated the David Olds Nurse Home Visitation Model in two pilot regions. This is a program for first time mothers of low socio-economic status. Nurses follow a very strict program protocol which calls for regular visits to the family beginning before the twenty-eighth week of pregnancy until the infant is two years of age. This model was chosen by MCH because of its proven effectiveness as a preventive intervention. Clinical trials and longitudinal studies have shown that this model of prevention significantly reduced by 79% the verified reports of child abuse and neglect, reduced by 31% the number of subsequent births, and increased by 83% the rates of labor force participation. MCH worked closely with the Louisiana Children's Cabinet to promote this program for future statewide implementation and this program was chosen as one of the top program priorities recommended by the Children's Cabinet. From March 1999 - September 1999, the Nurse Home Visiting Program enrolled 149 families and completed 970 home visits.

Hospital Nurse Coordinators are stationed in each Region at the State-supported hospitals in Louisiana. Their job is to facilitate and coordinate referrals of parish health unit patients to these facilities. Coordinators meet regularly with Parish Health Unit Supervisors at their monthly or regularly scheduled staff meetings.

Parish health units are closely linked with Head Start Centers, and health unit staff accepted referrals from the Centers and provided well child services.

Children with Special Health Care Needs

During 1998 - 1999, case management services were provided by CSHS staff through follow up visits. The CSHS Program has been developing a standard and protocols for care coordination, and data collection for this service will be implemented.

Outreach

Pregnant Women, Mothers, Infants, and Children

Many parish health units continued to provide presumptive eligibility (PE) determination for Medicaid coverage of pregnant women statewide. The parish health units are a primary provider of PE determinations for pregnant

women in the state, and as of June 28th, 1999, there were 12,887 active PE cases in Louisiana. Whenever necessary and feasible, parish health unit nurses provided home visiting and other follow up for high risk families. The *Partners for Healthy Babies* campaign continued outreach to link women with prenatal care. The MCH hotline, advertised via the *Partners* campaign, received more than 5,650 calls during federal fiscal year 1999. Callers were linked with MCH services available throughout the state, many of which are Title V funded, as well as private providers who accept Medicaid.

Infants and Children

MCH staff trained parish health unit staff statewide on the intake form for Louisiana's Child Health Insurance Program (LaCHIP), and tracked their participation in enrolling children via application origination points. MCH staff communicated regularly to clinic staff about changes and updates to the program.

Children and Adolescents

MCH staff trained school-based health center staff on the intake form for LaCHIP and arranged with Medicaid for the centers to become official LaCHIP application centers. MCH staff trained school-based health center staff periodically throughout the year on outreach messages and methods, as well as enrollment barriers.

Children with Special Health Care Needs

CSHS clinic staff also received regular communication regarding changes and updates to LaCHIP, and all CSHS clinics promoted the program and distributed applications to their clients.

Health Education

Pregnant Women, Mothers, Infants, and Children

Nutrition education continued to be provided to women and children in the parish health units, via trained paraprofessional Nutrition Aides, classes, and nutrition cards.

Women of Reproductive Age

Eight educational cards were designed based on results of focus groups of parish health unit family planning clients conducted by staff nutritionists. These educational card topics include weight control and maintenance, healthy relationships, violence prevention (domestic and sexual), body image, skin care and basic hygiene, and nutrition and exercise. The cards are completed, and are used in every health unit statewide. In addition to the basic nutrition counseling provided to all women receiving family planning and/or maternity services, nutrition referrals to a staff nutritionist were made for patients with obesity, eating disorders, anemia, food fads, and others.

Infants and Children

Five parenting cards developed and introduced the previous year remain available for distribution to the public by all Louisiana parish health units. These cards were created from over 4,000 ideas generated from surveys completed by 786 parents in parish health unit waiting rooms across the state. The topics of the cards are: how to deal with baby's crying; getting your child to listen and cooperate; boosting your child's self-esteem; potty training ; and what works better than spanking. In October 1998, a second printing of the cards was needed to meet the overwhelming demand from the parish health units.

MCH conducted parenting education classes and provided materials to parents in the parish health units. A newsletter titled "Family Focus" was developed, focusing on issues relevant to the parents receiving services in the parish health units. This newsletter is made available to the public through distribution in the parish health units. The second and third editions of the newsletter were issued in October and November, 1998.

Pregnant Women, Mothers, Infants, and Children

Parish health units continued to provide domestic violence prevention materials to clients. Region specific emergency referral/safety cards continued to be displayed in all health unit female bathrooms. These cards were mailed to all physicians providing obstetric services statewide for use with their patients.

Coordination with Education

Children and Adolescents

The Perinatal Substance Abuse Coordinator collaborated with the Department of Education to provide resources for the Safe and Drug-Free Schools Program.

MCH's Adolescent School Health Initiative (ASHI) continued a collaborative agreement with the State Department of Education (DOE) to fund Southeastern Louisiana University's (SLU) Excellence in Health and Education Project (EHEP) in 1998-99. The goals of the collaboration include providing training for health educators, teachers, school social workers and nutritionists; advocating for coordinated school health (CSH); conducting research and evaluating services pertaining to CSH; and establishing a clearinghouse of resources on CSH. The infrastructure for training in-service and pre-service health education professionals throughout Louisiana gained strength. This infrastructure enables faculty and staff at SLU to develop and conduct workshops and seminars. Over the past year this collaboration has produced many successful workshops on nationally recognized health curricula. The Cadre of Trainers, identified by EHEP and made up of community and school health educators, continued to conduct quality, interactive professional development activities throughout the state. EHEP held its second Summer Institute for CSH in 1999. Attendance increased three-fold from the first Summer Institute. It offered training to health educators

on skills and research-based curricula with an emphasis on incorporating nutrition into CSH. EHEP conducted a survey of principals to determine need for and interest in school-based health centers (SBHCs). The findings were presented to the Louisiana Children's Cabinet to gain support for SBHCs. Lastly, EHEP received a grant from the Association of State and Territorial Health Officials to pilot test Coordinated School Health marketing materials.

MCH gained the support of Louisiana's Superintendent of Education with the implementation of a statewide school-based outreach campaign for LaCHIP. MCH negotiated with the Department of Education to send 760,000 promotional flyers home to all public school students statewide with applications for the Free and Reduced School Lunch Program. MCH staff also ran an outreach campaign targeted to school principals, sending 650 speaker's packets to principals, speaking at the annual principals' conference, and providing one-on-one support to principals in promoting LaCHIP at their schools.

Children with Special Health Care Needs

CSHS has a longstanding collaboration with the Part C Program in Louisiana, entitled ChildNet. Children who are eligible for CSHS services are routinely referred to local education agencies for early intervention and family service coordination, and ChildNet frequently refers children in need of diagnostic or medical treatment services to CSHS Regional Offices. In most regions, CSHS participates in the ChildNet system as a provider and regional staff attend linkage group meetings. Also, the CSHS Program links families with appropriate special education services in their local communities.

Coordination with WIC

Pregnant Women, Mothers, Infants, and Children

The State Supplemental Food Program for Women, Infants, and Children (WIC) and MCH Program continued to be closely linked, at both the state and local levels. Pregnant women and children received WIC benefits at the same time they received preventive/primary care at the parish health units.

Coordination with Medicaid

Pregnant Women, Mothers, Infants, and Children

As mentioned above, many parish health units continued to provide presumptive eligibility determination for Medicaid coverage of pregnant women statewide.

Infants and Children

EPSDT screenings continued to be provided in parish health units statewide. Approximately 46% of children seen in parish health units were Medicaid eligible.

Infants, Children, and Adolescents

As mentioned above, MCH collaborated with Medicaid on LaCHIP implementation and promoted the program in parish health units, school-based health centers, and CSHS clinics statewide.

Social Services

Pregnant Women, Mothers, Infants, Children, and Adolescents

OPH social workers provided enabling services in parish health units to 1,500 prenatal patients in order to assist them in coping with stress and to meet other psychosocial needs. OPH social workers provided evaluation and follow up on psychosocial, emotional, behavioral, parenting, or child maltreatment problems in 2,000 children, adolescents, and family members seen in parish health units. OPH social workers also provided services to 1,500 family planning clients in parish health units.

Children with Special Health Care Needs

CSHS social workers provided 35,452 resource and support services to patients and families. This increase from last year reflects more accurate data, due to computer data management services obtained by the Program. Figures reported in past years were estimates.

Population-Based Services

Outreach

Children and Adolescents

MCH applied for and received a \$1 million Robert Wood Johnson Foundation grant to operate Louisiana's Covering Kids Initiative - a project to assist Medicaid with LaCHIP outreach. The Covering Kids Initiative works hand in hand with Medicaid to assist them in reaching all of the target audiences specified in the State's CHIP Plan to HCFA. In the past year, this included former TANF recipients, public schoolchildren, and limited English proficient families. Covering Kids formed a state outreach coalition, recruited and mobilized a cadre of student volunteers in New Orleans, and created a Hispanic Task Force. Outreach activities have included translating the LaCHIP application into Spanish and Vietnamese, conducting the above mentioned school campaign, and working with the Department of Social Services to improve the link between the TANF and Medicaid programs. The Covering Kids Initiative manages two pilot projects in New Orleans and in Central Louisiana, where outreach efforts are intensified. In those areas, pilot coalitions work with employers, churches, and social service agencies to reach families.

Public Education and Health Promotion

Pregnant Women, Mothers, and Infants

In fiscal year 1999, MCH continued to provide funding to the Pediatric AIDS Program (PAP) at Children's Hospital New Orleans, now called FACES (Family, Advocacy, Care, and Education Services). This partnership ensured that activities in the state would continue to assist in the reduction of perinatal HIV transmission. Strategies included heightening women's awareness of HIV status prior to pregnancy, and providing information and access to AZT therapy for those pregnant women who are HIV positive. A new project was initiated to reach out to medical students at Tulane Medical School to introduce public health concepts and services to them, particularly as they relate to MCH issues.

The MCH hotline, advertised through the *Partners for Healthy Babies* campaign, received more than 5,650 calls during federal fiscal year 1999. Callers were linked with MCH services available throughout the state, many of which are Title V funded. Outreach activities continued, as the campaign strengthened its foundation through closer adoption of social marketing principles. Additional formative research was carried out to assure consumer orientation and a new commercial based on research was produced and aired. The Campaign produced and distributed two issues of *Baby Talk*, a newsletter promoting safe motherhood and lowering infant mortality in the state. Two car seat promotions were held in Lake Charles and Monroe.

The MCH Perinatal Substance Abuse Coordinator (PSAC) contributed to a public information campaign to address Fetal Alcohol Syndrome (FAS), smoking, and substance abuse in pregnancy through preparing news releases, articles, statements, and materials. Articles on FAS, perinatal substance abuse, substance use and teen pregnancy, smoking cessation, and Child Health Month appeared in the LA Perinatal Substance Abuse Coordinator Newsletter and the Louisiana MCH Coalition Newsletter. Consultations and technical assistance were provided upon request to students, families, and professionals.

The MCH PSAC maintained and expanded the Louisiana Perinatal Substance Abuse Clearinghouse, which addresses tobacco, alcohol, and drug use during pregnancy. The Clearinghouse is a collection of print and audiovisual materials that are available on loan to individuals and organizations. Circulation of materials has dramatically increased over the past year due to promotion through targeted mass mailings and exhibits at professional meetings and conferences. The Clearinghouse catalog was updated and distributed.

Infants and Children

Childhood injury prevention projects were implemented in the areas of motor vehicle injuries, bicycle safety, and general safety education through the coordinated efforts of the Louisiana Office of Public Health and Children's Hospital's Louisiana SAFE KIDS Coalition, funded by MCH.

The program maintained a statewide citizen surveillance child occupant protection program — the Don't Kid Around Program. From May 1995 to August 1999, a total of 8,423 cards from citizens statewide were received, notifying SAFE KIDS of unrestrained children in cars. From August 1998 to August 1999, 2,134 unrestrained children were observed in 77% of Louisiana's parishes. Educational materials were then sent to drivers of the cars.

SAFE KIDS continued to offer helmets at reduced rates, assist with local bicycle skills rodeos, and provide helmet educational and promotional materials. Louisiana SAFE KIDS news was published regularly. Data-driven injury prevention fact sheets were updated to include 1997 mortality data. Toy and Halloween safety flyers were distributed through local SAFE KIDS Chapters and Coalitions, and were sent to Regional Offices for parish health unit distribution. SAFE KIDS continued to support ten local SAFE KIDS Chapters and Coalitions with technical assistance, regular meetings, publicity assistance, local programs, and media materials.

Pierre the Pelican, a newsletter promoting mental and physical health and child health and development, continued to be mailed monthly to pregnant women throughout the state and to all first-time parents during their child's first five years. Over 40,000 families receive this pamphlet series.

Other public education/health promotion activities addressed child abuse prevention and parenting education. A flyer continued to be mailed out with all birth certificates in the state and was distributed to all WIC clients informing parents about the toll-free counseling hotline for parents needing support and guidance in caring for their children. A public information campaign on child abuse and neglect prevention continued, through a contract with Prevent Child Abuse Louisiana (PCAL). This campaign includes radio and print media and presentations by a statewide speakers bureau. PCAL operates the toll free counseling hotline and recruited and trained additional volunteers to staff the hotline.

Infants

The Sudden Infant Death Syndrome (SIDS) risk reduction educational card, which was developed for a low income, low literacy minority population, was finalized and distributed to the parish health units for use in counseling. This material utilized the "Face to Face" theme developed by formative research for a SIDS public information campaign targeting low income, minority families. A copy of the "Face to Face" poster was sent to all pediatricians and infant child care providers statewide.

Children with Special Health Care Needs

The CSHS Program continues to participate with the SAFE KIDS Coalition and promote safety for children with special needs.

Screening

Infants

The Genetics Program continued to provide universal newborn screening for the detection of PKU, congenital hypothyroidism, sickle cell diseases, and biotinidase deficiency through a pilot. During 1999, 102,766 specimens were tested by the State Central Laboratory, a 6% increase from the year before. This is attributed to a higher percentage of newborns receiving repeat testing. Screening for biotinidase deficiency was officially made a part of the screening battery through the passage of Act 328 in the 1999 Legislative Session. A screening pilot for galactosemia was performed on 2,000 specimens. A high yield of suspect screens suspended the pilot. Another pilot for galactosemia screening is planned. Purchase and evaluation of tandem mass spectrometry technology is being considered.

For children participating in the newborn hearing screening program, the average age of identification of hearing impairment was as follows for the year 1994: 3.64 months; 1995: 3.18 months; 1996: 3.25 months; 1997: 5.25 months; 1998: 3.25 months; and 1999: 2.87 months. These ages are all significantly below the HP 2000 17.16 objective target age of 12 months. Approximately 49% of the births in the state received universal screening during this time period. In 1999, legislation was passed mandating universal newborn hearing screening. It is anticipated that hospitals will begin screening statewide in January 2001. Hearing, Speech, and Vision staff provide follow up testing for children identified through newborn hearing screening who are unable to afford private care.

Children

In calendar year 1998, approximately 23,641 children were screened in 28,800 tests from parish health units and New Orleans City health units for blood lead by the State Central Laboratory. There were 3,354 or 13.2% of children with initial blood lead levels ≥ 10 ug/dl and 1,154 or 4.6% with a blood lead level of ≥ 15 ug/dl. This data does not, however, indicate the extent of the true population based lead hazard for certain parishes since the data included only patients screened in public health settings.

Immunization

Infants and Children

Vaccines for Children and Shots for Tots campaigns have continued. Eighty-one percent of the 24 month olds seen at parish health units were up to date on their immunizations in 1999.

Infrastructure Building Services

Provider Training

Pregnant Women, Mothers, Infants, and Children

Quarterly meetings with the Regional MCH/FP Nurses were held and educational material was presented including the following topics: Improving Access to Prenatal Care and Reducing Racial and Financial Disparities; Infant Mental Health, Nurse Home Visiting Program; Reduction of Maternal Complications from STDs; Designing Ways to Improve Clinic Flow; Reduction of Teen Pregnancy; Male Involvement; and Fostering Community Collaboration.

A Statewide Educational Conference was held in June 1999, entitled “Healthy Communities: Women and Their Families in the New Millennium.” The two and one-half day conference was attended by 214 nurses, 12 physicians, 24 social workers, 18 nutritionists, and 34 administrators. The sessions included presentations on the following areas: Nutrition’s Role in Fetal Development; High- Risk Maternity; Integrating Reproductive Health into the Surgeon General’s Health Priorities; Disparities in Reproductive Health Services; and Depression and Health. Experts in these areas led the workshops.

Training was completed in each region for all public health nurses and social workers to implement the *Bright Futures Guidelines for Health Supervision*. *Bright Futures* manuals, pocket guides, and MCH parenting brochures were distributed to staff. *Bright Futures* provides guidelines for conducting well-child care in children ages 0-21 years, and is a holistic approach to child care taking into account the influence of the family and social environment on the physical and emotional health of the child. According to participant evaluations, participants felt these trainings and supporting materials were relevant to their work, and believed the concept of *Bright Futures* could be incorporated into their work. The child health patient record used in the parish health units was revised utilizing *Bright Futures* ideas and format. The revisions incorporated an increased emphasis on psychosocial health and counseling/education. The new record was finalized and distributed to parish health unit staff.

The Infant Mental Health Educational Series (25-hours), developed by the MCH Infant Mental Health Specialist, was presented to nursing and social work staff in a second region of the state and to all of the Olds model nurse home visiting nurses statewide. This series emphasizes attachment theory and current knowledge of infant social and emotional development as the basis for recognizing the importance of the infant-parent relationship to later health and developmental outcomes.

Infants and Children

The Violence Prevention Program provided facilitation services, educational materials, and specific training and technical assistance.

As part of the CISS grant, a statewide train the trainers workshop was held in September 1999 to certify health professionals as child care health consultants. There are 150 certified child care health consultants active in the state.

Pregnant Women, Mothers, and Infants

Outreach and training to the medical community regarding prevention of perinatal HIV transmission continued through MCH's contract with the FACES program at Children's Hospital.

Packets of materials related to domestic violence prevention were mailed to private providers, and included standards of care, screening and referral sheets, educational information, and emergency referral safety cards.

Children

The Oral Health Program continued to implement the educational program Prevent Abuse and Neglect Through Dental Awareness (PANDA). PANDA is targeted to Louisiana dentists and dental hygienists to encourage identification and reporting of child abuse and neglect. A brochure on PANDA that was developed by the Oral Health Program was distributed to dentists, and will aid them in identifying and reporting child abuse. At the request of the Oral Health Program, an ongoing announcement providing a contact number for suspected cases of child abuse will be included in each issue of the Louisiana Dental Association newsletter.

Decrease in staff Eye Health positions resulted in increased priority on training personnel instead of screening activities. Training sessions for FY 1998-1999 increased compared to FY 1997-1998. In 1998-1999, 302 training sessions were held and 2,334 persons were trained, compared to 246 sessions and 1,846 persons trained the previous year.

A workshop on Childhood Lead Poisoning Prevention was conducted for parish and regional nursing, medical, and sanitarian staff for the southern part of the state. Approximately 130 staff were trained through this workshop.

Community Training

Children

As part of the Covering Kids Initiative, MCH created a training module for LaCHIP Application Assistors - individuals interested in identifying CHIP eligible families and assisting them with the enrollment process. MCH staff delivered this training to community organizations and outreach workers. MCH staff also promoted LaCHIP

through numerous community presentations to Head Starts, schools, child care centers, low income housing project tenant councils, Department of Education programs, and others.

Collaboration

Pregnant Women, Mothers, Infants, and Children

Strong collaboration continued to exist between OPH and Tulane University's School of Public Health and Tropical Medicine (TSPHTM). Several MCH staff have faculty appointments or are doctoral students at TSPHTM and a number of graduate students intern within the MCH Program each year. Several MCH staff also have faculty appointments within the Tulane University Medical Center's Community and Family Medicine Department, and MCH accepts preventive medicine residents and medical school interns. OPH also continued to work closely with the State Charity Hospital system, which provides much of the in-patient care for Louisiana's medically indigent population. OPH/MCH funded Nurse Coordinators in each Charity Hospital continued to coordinate patient services. OPH also continued to work with the Tulane and Louisiana State University Medical Schools on core public health functions and direct patient care for the MCH population.

The MCH Program has a formal Interagency Agreement with the State Primary Care Cooperative, Department of Health and Hospitals, to collaborate on current initiatives, including primary care, rural health development, and state systems development initiatives for child health.

There is ongoing collaboration at the state level between MCH and HIV/AIDS services. MCH staff in parish health units continued to provide preventive education services and HIV counseling and testing services. The HIV/AIDS program received a CDC grant to prevent perinatal HIV transmission in the summer of 1999, and MCH staff collaborate with them on implementation.

The Louisiana Genetic Diseases Program continued to collaborate with Emory University and the sickle cell programs of Georgia and Mississippi on the Comprehensive Follow-up and Treatment of Sickle Cell Disease in region four. Genetics staff are also collaborating with Louisiana State University's Center for Acadiana Genetics and Hereditary Health Care on their HRSA grant project of expanding genetics services in south Louisiana.

Pregnant Women, Mothers, and Infants

The MCH Perinatal Substance Abuse Coordinator (PSAC) served on the Louisiana Breastfeeding Task Force as an advocate of drug-free pregnancies and the Association of Substance Abuse Professionals and Providers to represent the needs of pregnant women. Collaborative efforts with the March of Dimes to provide continuing

education for nurses on the perinatal impact of substance abuse and the American Cancer Society to train smoking cessation facilitators to work with pregnant women were ongoing.

The Governor's State Advisory Council for the Identification of Hearing Impairment in Infants met quarterly throughout this time period. Eight Regional Task Forces continued local activities throughout the state to establish and maintain systems of care in communities. Collaboration was ongoing with the Department of Education resulting in data sharing to establish the average age of identification for hearing loss in Louisiana. Negotiations to explore sharing information on the date of enrollment in early intervention have begun with Part C representatives. Louisiana is one of 17 states participating in a federal MCH grant to develop systems of services for infants who are deaf or hard-of-hearing and their families. Grant activities included survey of state resources and a needs assessment. As a result of collaborative efforts and multi-agency support, universal newborn hearing screening was legislated in 1999.

Data accuracy for the newborn hearing database is a continuing concern. Links have been established with the newborn metabolic screening program, the electronic birth certificate database, and with the Department of Pediatrics at LSU Medical School for assistance in correction and data tabulation. In late 1999, a newborn hearing screening page was added to the Electronic Birth Certificate. Currently still in implementation, this resource will significantly improve data accuracy. Although continuously under revision, a system has been established, with data from the Department of Education's survey of hearing-impaired students compiled by Gallaudet University, and additions of other DOE programs to compute the past and current age of identification of hearing impairment in Louisiana.

The MCH toll-free 1-800 number, entitled *Partners For Healthy Babies* (1-800-251-BABY), was operated through a contract with D.I.A.L. (Disabilities Information and Access Line) of the Louisiana Department of Health and Hospitals and provided many referrals. The phone lines were manned by skilled counselors of D.I.A.L who provided confidential information for women who called seeking referrals for prenatal care and pregnancy testing. After hours calls were handled by an answering service to provide 24 hour coverage.

The MCH Director serves on the Louisiana Perinatal Commission. The commission has been successful in establishing the framework for regionalization of perinatal services by establishing standards for determining the level of services that each hospital can provide. These standards have been adopted as hospital licensing and Medicaid reimbursement requirements. MCH Staff gave regular presentations to the Perinatal Commission on birthweight specific neonatal mortality, perinatal outcomes by level of hospital, and trends in infant mortality by region of state.

MCH continued to collaborate with the Healthy Start projects in North Louisiana and New Orleans. MCH staff participated in consortium meetings for Concordia Parish's Healthy Start Planning Grant, sharing and researching intervention models and promoting collaboration between the project and local providers.

Infants and Children

Parish health units maintained a close relationship with LSU Cooperative Extension for the purpose of conducting parenting classes in the parish health units. Health unit nurses worked closely with OCS (Child Protection Agency). In some parishes, a designated public health nurse attended OCS staffings and routinely took part in investigations of alleged child abuse or neglect. Other parishes mainly interacted with OCS as a referral source when they suspected medical neglect had taken place.

MCH staff worked with Louisiana's Steps To Success program. This is a public-private partnership that assists in the coordination of available services for children 0-3. MCH staff worked closely with the Rapides Foundation, an organization providing grants to improve the health and well being of Central Louisiana residents. The Rapides Foundation granted funds to establish the Nurse Home Visiting Program in Allen Parish. These funds will support two full time nurses working under the supervision of the Public Health Nurse Parish Supervisor. Beauregard Parish government appropriated funds to initiate the Nurse Home Visiting, making it the first to use local parish funding for this intervention.

Infants

The MCH Program has continued its SIDS Prevention and Case Management Program through a contract with the Tulane University Pediatric Pulmonary Section for the positions of SIDS Medical Consultant and SIDS/Child Death Review Panel Nurse Coordinator. This Program monitors the functioning of a network which provides counseling and follow-up to families of SIDS infants through the Office of Public Health. In 1998, follow-up was initiated in 75% of the SIDS cases with family support services provided to 61% of total cases. The SIDS Program has continued its educational activities directed to OPH parish health unit nurses, other health care providers, and the general public. The SIDS Prevention and Case Management Program collaborated in the development of a public information campaign directed toward reduction of risk factors for SIDS.

Children

OPH participated in infrastructure building activities by enhancing collaboration between public and private child-serving agencies in Louisiana. Numerous MCH staff were active participants in statewide interagency meetings, including the Louisiana Children's Cabinet; the Louisiana Mental Health Planning Council; the Louisiana Interagency Service Committee; the Program Planning Committee of the Louisiana Office of Community Services,

DSS; the Program Planning Committee of Prevent Child Abuse Louisiana; the Louisiana Case Management Committee; the Louisiana Interagency Council for the Homeless; the Louisiana Governor's Advisory Committee on Hospice; the Comprehensive Planning Committee of the Louisiana Children's Cabinet; the Great Expectations (HealthyStart) Advisory Committee; the New Orleans Mayor's Advisory Committee on Domestic Violence; the DSS Advisory Committee on Domestic Violence; the Orleans Parish Domestic Violence Mortality Review Committee; the Metropolitan New Orleans Task Force on Child Sexual Abuse; and the Advisory Committee of Agenda for Children. MCH Program Staff participate in ChildNet, the Interagency Collaboration for Infants and Toddlers with Disabilities (Part C of IDEA) and MCH is represented on its Executive Board.

Title V continued to support the City of New Orleans Health Department services for indigent children through partial funding of their MCH Medical Director's salary. This medical director has been instrumental in assuring the quality of services through staff training and data collection and analysis.

State CSHS and MCH staff collaborate on a regular basis. At the local level, services are closely linked, and patients referred to the CSHS Program come through the parish health unit for their initial intake. Nurses in the Olds Nurse Home Visiting program refer to the CSHS Program if problems are identified through their home visits. Follow-up of nutritional problems identified in CSHS regional clinics may be provided by nutritionists in the parish health units. A health unit chart is opened on all referred children and the health unit staff help to coordinate appointments and needed services for the patient.

The MCH Adolescent School Health Initiative provided funding and technical assistance for school-based health center locations throughout the state. The program was awarded a four-year \$1.6 million Robert Wood Johnson/Making the Grade grant, and receives \$4.2 million of additional state funding annually. This system is built upon collaborative local health, education, and social service agencies. All school health center grantees worked with local parish health units and OPH Regional Offices to share information and resources with such programs as Family Planning, STD Prevention, HIV/AIDS Prevention, Immunization, Communicative Disorders, Eye Health, and Injury Prevention. State level collaboration for this Initiative include an Intergovernmental Coordinating Council including representatives from State Departments of Education, Mental Health, Substance Abuse, Medicaid, Social Services, Corrections, and the Governor's Office.

In many parishes, the school nurses are KIDMED (EPSDT) Providers. The parish health units and school nurses worked collaboratively in providing optimal services for all school age children.

The Oral Health Program (OHP) continued to coordinate with the Louisiana School Nurses Association in providing training and follow up of school nurses participating in dental screening of school age children. The Oral Health Program continued to work closely with the State Dental Medicaid Director to gain continued access to the Medicaid claims data files.

The Adolescent and School Health Program brought the Assistant Secretaries of Public Health, Mental Health, and Alcohol and Drug Abuse together to pool funding for support of licensed mental health and substance abuse prevention counselors in school-based health centers. In addition, the collaboration enables staff of the three agencies to work together year-round on mental health/substance abuse professional standards and evaluation of the quality of care at SBHCs.

The Louisiana Children's Cabinet set health, education, and family life funding priorities for recommendation to the Legislature. SBHCs were given top priority, with a goal to increase their number by 50%. The Legislature subsequently added one million dollars from tobacco settlement revenue for this expansion. Thus, by September 1999 an additional 19 applicants were scheduled to receive funds to establish new centers. The Olds Nurse Home Visiting Program was also given top priority, and the Legislature added funding to the Medicaid budget to provide reimbursement for this service. MCH worked closely with the Children's Cabinet, the Cabinet's Advisory Board, and the Advisory Board's Comprehensive Planning Committee (CPC). MCH staff chaired CPC Task Forces on Funding, Public Education/Awareness, and Community Involvement.

The Child Health Medical Director served as the Co-Facilitator for the Louisiana Chapter of the American Academy of Pediatrics (AAP) CATCH (Community Access to Child Health) Program. This included participation in the Chapter's Executive Committee meetings in efforts to work with private practicing pediatricians in improving access to health services for children in their communities. A major initiative for this year was collaboration with the State Chapter of the AAP in the expansion of Title XXI (State Child Health Insurance Program) to provide health care coverage for uninsured children in the state in families with incomes up to 150% of federal poverty level.

MCH staff met periodically with Medicaid and Department of Social Services to strategize on systems changes needed to improve the link between the Medicaid and TANF programs. MCH included many of these plans in the year one work plan for the Covering Kids Initiative. MCH submitted several proposals to Department of Social Services to be considered for funding with unspent TANF dollars, including nurse home visiting and enhanced child care health and safety.

Policy Development

Infants

The newborn screening law, R.S. 40:1299.1.,2.,3 was improved by the passage of Act 328 in the 1999 Legislative Session. This act added screening for biotinidase deficiency, but even more importantly, it allows for the Department of Health and Hospitals to add assays to the newborn screening battery through rule making instead of the long and more political legislative process. Thus, the state can now act more quickly to start screening for a certain disease as new methodologies become available.

Infants and Children

During the 1999 Legislative Session, Legislation establishing the Child Death Review Panel was amended to increase the age of children for whom unexpected deaths would be reviewed by the Panel to 14 years. The Legislation also increased the Panel membership from 10 to 25 with the addition of legislators, statewide citizen representation, the State Fire Marshal, and child advocacy representatives.

MCH staff worked with Department of Health and Hospitals' Human Resource Director to ensure that Personnel Offices throughout the Department presented LaCHIP as an insurance option when hiring new employees.

Assessment and Surveillance

Pregnant Women, Mothers, Infants, and Children

MCH continued the Louisiana Pregnancy Risk Assessment and Monitoring System (LaPRAMS), a CDC model program, which surveys women who have delivered a baby in Louisiana to determine prenatal and postnatal behaviors and risks. LaPRAMS continued its data collection activities, which began in October of 1997. In December 1998, the 1997 weighted data set was provided by the CDC for analysis to the LaPRAMS Analysis Working Group. From December 1998 to July 1999, the LaPRAMS Analysis Working Group continued to meet to conduct exploratory analysis of the 1997 data set. In September of 1999, the 1998 birth file was sent to the CDC for weighing and statistical adjustment. LaPRAMS started exploratory analysis of the 1998 data set at the end of September 1999.

Realizing the need for local involvement in the review and implementation of preventive initiatives for decreasing unexpected child deaths, the Child Death Review Panel supported the development of local Child Death Review Panels. Six panels were established in areas across the state to review the unexpected deaths in their areas and make recommendations for prevention for further deaths. Since September 1996, the MCH funded SIDS Program has reimbursed for autopsies conducted by forensic pathologists at regional centers and for death scene investigations conducted by trained investigators in cases of unexpected infant deaths. These reports of autopsies and death scene

investigations are reviewed by the Medical Director of the SIDS Program. From October 1998 through September 1999, reimbursement was given for 44 death scene investigations and 37 autopsies.

MCH staff developed a statewide plan to systematically review infant deaths; identify trends, patterns, and risk factors; recommend prevention strategies; and disseminate this information. Additionally, surveillance of low and very low birthweight mortality by level hospital was continued. The abstract of the report was submitted and accepted by the sixth Annual Maternal, Infant and Child Health Epidemiology Conference in Atlanta. The trend of infant mortality has been analyzed at a regional level and was presented at a meeting of regional administrators and medical directors.

The MCH Program has continued to provide statistical information on Infant Mortality to the Louisiana Commission on Perinatal Care and the Prevention of Infant Mortality. The information presented included geographic distribution of infant deaths, trend of infant mortality by each region, and racial disparity in birth outcomes.

Development of an Immunization Registry, a statewide tracking system for immunizations, has been under way since the passage of related legislation. A Pediatric Nutrition Surveillance of children is ongoing. Nutritionists complete a monthly nutrition services report and submit this data to the MCH Nutritionist.

An oral health screening program had previously been implemented utilizing school nurses who volunteered to perform a brief visual screen on third grade schoolchildren whom they already saw for hearing and vision screenings. The nurses had been trained in the visual screening method by the Oral Health Program staff, including screening and classification of children's dental needs into "urgency levels." Information on sealant prevalence and untreated caries was gathered. The Oral Health Program worked with the Louisiana School Nurses Association to continue the program. The Oral Health Program has been invited to be an exhibitor at the Annual Meeting of the School Nurses Association, and to present training sessions for nurses interested in beginning or continuing the oral screenings.

Primary oral health data was also collected through inclusion of oral health questions in several statewide surveys, including the Behavioral Risk Factor Surveillance System (BRFSS) and the Pregnancy Risk Assessment System (PRAMS). Secondary oral health data collection included 1998 National Institute of Dental Research Survey sample conducted in the state and the direct analysis of dental Medicaid treatment claims data. The Medicaid data analysis has enhanced the quality assurance abilities of the dental Medicaid director, and created the potential to save the dental Medicaid program a significant amount of funds. Several publications have documented the results of these findings.

A report prepared by the Centers for Disease Control and Prevention (CDC) and the Oral Health Program was published in the September 3, 1999 issue of the *Morbidity and Mortality Weekly Report*. The report stated that water fluoridation can have a substantial effect on the cost of dental treatment for children enrolled in Medicaid in the State of Louisiana. The findings suggest that children on Medicaid in communities without fluoridated water are three times more likely than children on Medicaid in communities with fluoridated water to receive dental treatment in a hospital operating room. The cost of all dental treatments per enrolled child was twice as high in non-fluoridated areas. Fluoridation of the public water systems that service at least 10,000 customers could be expected to reduce the dental treatment costs for 39,000 preschoolers by \$1.4 million annually.

Compiling statistics on violence for local communities is a regular activity of the Violence Prevention Program.

Needs Assessment/Coordination/Surveillance/Planning/Systems of Care/Policy Development

Adolescents

In September of 1995, the Family Planning Program created the Louisiana Adolescent Health Initiative, which facilitates a coordinated, multi-disciplinary approach to adolescent health care, disease prevention, and health promotion in the state. The Initiative serves as the central repository of adolescent statistical information in Louisiana through compiling and disseminating quantitative and qualitative data. It provides an infrastructure to enable local communities to address adolescent health needs. The Initiative increased coordination and networking with internal programs and external agencies involved in adolescent public health and social welfare. In January 1999, the Initiative was highlighted in the Association of State and Territorial Health Officials' newsletter as a model program. From January through March, 1999, the Initiative provided technical assistance to the LA Task Force to Prevent Teen Pregnancy for the purpose of studying the impact of teen pregnancy on Louisiana and making recommendations on prevention. From April through June, 1999, the Initiative coordinated the first National Campaign to Prevent Teen Pregnancy "Faith and Teen Pregnancy Workshop". In August 1999, the Initiative began conducting a series of statewide teen focus groups. "Teens Talk" will serve as an instrument to infuse adolescent voices into planning and policy making efforts that are geared toward improving the health status of LA teens.

Surveillance and Quality Assurance

Pregnant Women, Mothers, and Infants

Monitoring of the two private laboratories performing newborn screening on 16% of newborns has become a regular routine to assure quality. Further tightening of the quality assurance requirements is planned for 2000. The Genetics Nurse consultant performed 10 training sessions at hospitals and doctors' offices on improving specimen collection. The method of comparing the State Central Laboratory newborn screening database with birth certificates for measuring the portion of newborns tested remains problematic, given the 16% of newborns not initially screened

through the state. Securing all newborn screening records electronically from the two private laboratories is being considered, which would revive the plan to match screening records with electronic birth records.

Policy Development/Surveillance

Children

Improvements to lead poisoning surveillance will be the focus of the CDC Childhood Lead Poisoning and Surveillance Grant, awarded to MCH on July 1, 1998. Efforts have been focused on establishing a population-based surveillance system by receiving reports of all lead tests done on children in Louisiana from private laboratories as well as the State laboratory. An Administrative Rule has been formulated to require reporting of all lead tests by laboratories with accompanying demographic information. With the information from this population-based system, targeted screening recommendations for lead poisoning can be made.

Systems of Care/Coordination

Pregnant Women, Mothers, and Infants

The MCH Perinatal Substance Abuse Coordinator (PSAC) continued to maintain and support a statewide network of PSACs to enhance services for prenatal patients and with the community by producing a quarterly newsletter and providing continuing education opportunities for, and conducting periodic site visits with this network. The MCH PSAC coordinated a collaboration with the Office of Alcohol and Drug Abuse (OADA, since renamed the Office of Addictive Disorders) to offer voluntary pregnancy testing to women admitted at OADA substance abuse rehabilitation and treatment centers in two regions of the state. The MCH PSAC conducted in-service training with OADA staff from 12 facilities and continues to oversee this program.

Evaluation

Pregnant Women, Mothers, Infants, and Children

To evaluate the effectiveness and impact of the Nurse Home Visiting Program in Louisiana, MCH has initiated a randomized, controlled, evaluation of the program. This evaluation is a collaboration with the Tulane University School of Public Health and Tropical Medicine. The evaluation was initiated to coincide with the introduction of the program. Families involved in the evaluation will be followed prenatally until the child's second birthday. Trained evaluation staff will visit each participant at four distinct periods during the evaluation period. The evaluation will focus on child abuse and neglect, subsequent pregnancy, childhood injuries, and educational and workforce achievement. In addition, the evaluation will describe in detail the relationship between the primary caregiver and the baby, a key factor in predicting positive social and emotional development of the child.

Monitoring/Evaluation/Quality Assurance/Standards Development

Pregnant Women, Mothers, Infants, and Children

Monitoring and evaluation of programs throughout the state by the Child Health and Maternity Nurse Consultants are done through a Continuous Quality Improvement (CQI) Program. Information gathered from statewide audits/monitoring done by the MCH/Family Planning nurses is used to evaluate and monitor programs. In-service educational trainings are planned as a result of the information compiled from these audits. Deficits discovered are handled at the regional level, when possible. Standards guiding each program are adapted from appropriate national organizations (ACOG, NACOG, AMCHP, CDC).

Coordination/Policy Development/Planning

Infants and Children

A statewide advisory committee coordinated activities and services toward improving the health and safety of children in child care. State agencies, organizations, health care providers, and child care providers actively participated in bringing together knowledge and expertise to link health care consultants, child care providers, and families in order to maximize resources and coordinate services.

Children

The Fluoridation Advisory Board was created by the passage of Louisiana ACT 908 to enhance fluoridation promotional activities in the state. There was considerable planning for the first meeting of the Board, held in October 1999.

The Lead Toxicity Prevention Program continued to collaborate with other agencies involved in lead activities. The CDC Childhood Lead Poisoning Prevention and Surveillance Grant is a collaborative effort with the Tulane School of Public Health and the City of New Orleans Health Department. A statewide Advisory Group on Childhood Lead Poisoning Prevention with representatives of public and private agencies and organizations was established to assist in developing a prevention plan for Louisiana.

Epidemiology Program

Pregnant Women, Mothers, Infants, and Children

The third year of the CDC MCH Epidemiology Grant enabled the MCH Program to expand its capacity to carry out scientific, data-based projects. MCH surveillance indicators are now readily accessible and available through linked birth and death certificates. This allows MCH staff to identify and follow trends and patterns, plan accordingly, and make more vital information available to the public.

MCH and CSHS staff participated in the Enhancing Data Utilization Skills through Information Technology class,

offered to State MCH Programs through the University of North Carolina MCH Department.

Assessment/Surveillance/Planning

Pregnant Women, Mothers, Infants, and Children

Reports of clinic data continued to be utilized for state and federal reporting requirements and management decisions. An on-line computerized version of the PH-9 continued to be used by three of the nine regions of the state.

National Performance Measures (See Section 5.8 for Form 11, Performance Measure Data)

(1) Percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHS Program. CSHS provides rehabilitative services to children with special health care needs who meet eligibility criteria. CSHS considers all of the services it offers to children with special health care needs to be “rehabilitation services”. This includes medical treatment, surgery, therapy, provision of equipment and medications, care coordination, and family support. The data used for this measure is the total number of state SSI beneficiaries less than 16 years old (from the Social Security Administration) and the number of children on SSDI less than 16 years old enrolled in the CSHS Program. Out of 23,360 children less than 16 years old receiving SSI benefits in Louisiana, 2,348 (10%) receive rehabilitative services from the CSHS Program. This percentage has slightly increased due to reduced access to private providers. The income eligibility criteria for the CSHS Program is the equivalent of Medicaid/LaCHIP eligibility levels, resulting in larger Medicaid eligible populations. See the Annual Report, Direct Services section above for a complete discussion.

The five year goals for this measure have been adjusted accordingly.

(2) The degree to which the State CSHS Program provides or pays for specialty or subspecialty services, including care coordination, not otherwise accessible or affordable to its clients. The CSHS Program provides all of the services listed on the checklist, or 100% of the specialty and subspecialty services specified.

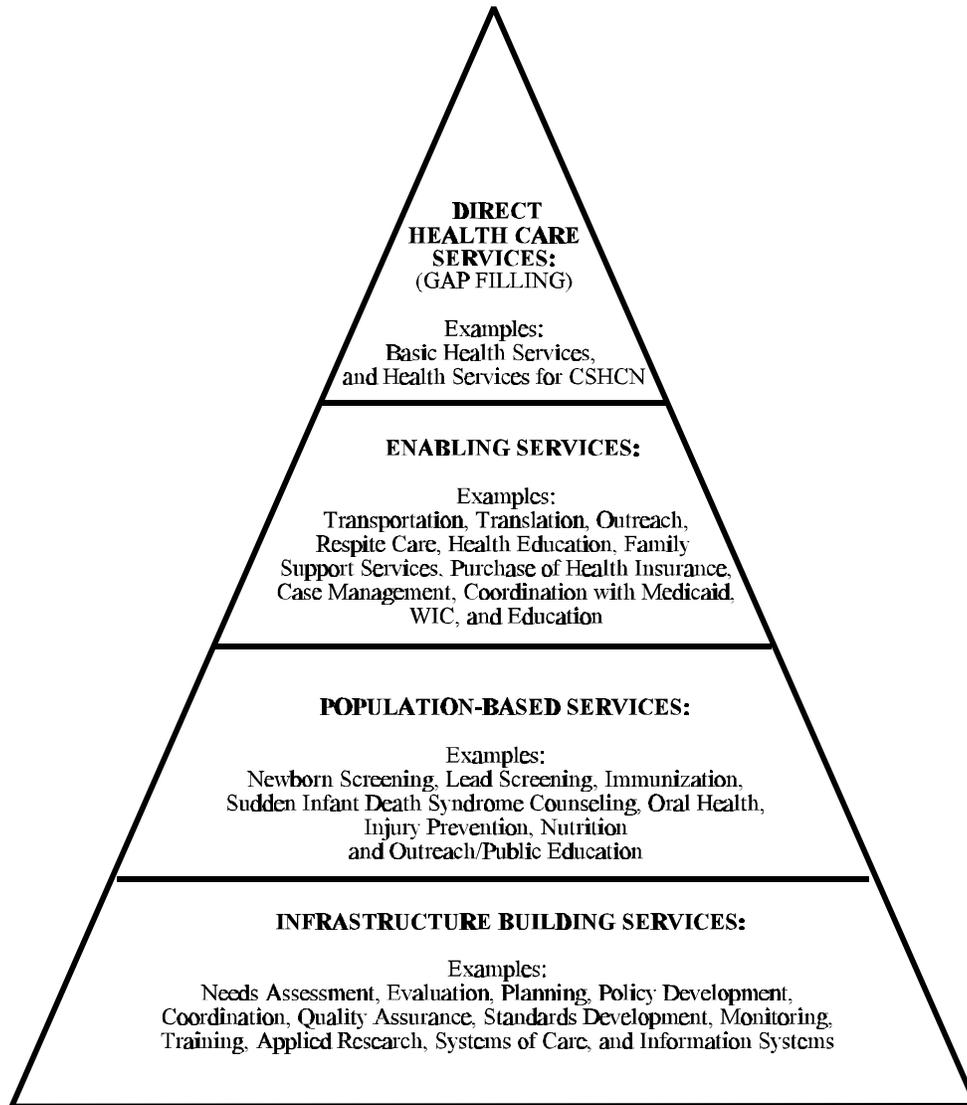
(3) Percent of CSHCN in the State who have a “medical home”. The CSHS Program has made counseling and information about a “medical home” an integral part of its nursing and social assessment. This information was retrieved from regional records for the first time in 1997, and the percentage was applied to this year’s patient count. Data accuracy will be improved by a more precise definition of medical home and by developing comprehensive data collection procedures. In the future, CSHS will rely on results from the upcoming national survey and information contained in the program database to provide information for this performance measure. The data used this year is the total number (unduplicated count) of children enrolled in the CSHS Program and the percent determined by the Regional Offices to have a medical home in 1997. Out of 7,397 children enrolled, 3,255 (44%) were determined to have a medical home. Efforts to continue to encourage CSHS families to maintain a medical home will be expanded.

(4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism,

galactosemia, hemoglobinopathies (e.g. the sickle cell diseases) combined. The Genetic Diseases Program of OPH establishes procedures and rules for newborn screening and provides patient tracking and centralized oversight of all patients requiring follow-up. The State Central Laboratory performs approximately 87% of initial screens. Laboratories performing the remainder have been reduced from six down to two approved laboratories. The percentage of Louisiana newborns screened for the full battery including sickle cell disease is estimated to be 100%, as enforcement of newborn screening quality assurance rules in 1998 terminated the policy of targeted screening practiced by a few hospitals in northern Louisiana.

Figure 2

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



(5) Percent of children through age two who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B. MCH funds support immunizations for children in parish health units statewide. Immunizations are included in EPSDT services provided at the health units, and immunizations are provided on a “walk-in” basis. Population-based data from the National Immunization Survey was used for this measure in 1996, 1997, and 1999, but was unavailable for 1998, when public health clinic data was used. The National Immunization Survey reports on rates for 19-35 month olds, rather than 24 month olds, and reports separately on rates for the combination series and HBV. This measure is 76.9% for the combination series for 1999. Development of a statewide immunization registry is underway, and will result in more accurate and consistent values for this measure. Public health clinic data is higher than the population-based estimate; public health clinic data for 1999 is 81% for the combination series and 94% for HBV.

(6) The rate of birth (per 1,000) for teenagers aged 15-17 years. MCH provides family planning services and education to teens in parish health units. In 1999, 33% of the Family Planning clients were under nineteen years old. Case management and home visits to already pregnant and parenting teens include prevention of future pregnancies as a goal. MCH staff participate in interagency efforts to reduce teen pregnancies, such as the State Interagency Task Force and the Louisiana Perinatal Commission. This measure has been decreasing for several years, and this decline is expected to continue.

(7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth. There is a lack of dental infrastructure within OPH to directly increase sealant utilization among third grade children. It will be necessary to work with other organizations to develop a state plan to increase sealant awareness and utilization. MCH will provide leadership, seed funding, and programmatic support. One pilot program at the David Raines Community Health Center is being planned. MCH will provide portable dental equipment to the Center, and the Center will provide the manpower to perform dental sealant procedures in 10 schools in Caddo Parish. Other pilot sites for school sealant programs could include elementary schools that have access to school-based health centers, as well as schools that participated in the recent oral health screening conducted by school nurses. Additional funding can be sought through dental Medicaid reimbursements and other funding sources.

The State Oral Health Program has collected dental Medicaid program treatment claims data from October 1994 to present. This data represents a high-risk population for dental caries and could be used for a targeted state sealant program. It should be noted that this population represents only those children that are receiving dental Medicaid services. The more population-based method of obtaining sealant prevalence data - a school-based oral health screening program - was undertaken utilizing school nurses. Eighty-eight school nurses throughout the state volunteered to perform a brief visual screen on 3rd grade schoolchildren whom they already saw for hearing and vision screenings. The data collected provided information regarding the urgency level of oral health, sealant prevalence, and untreated caries. Nurses completed 1,390 screens; 37% of which resulted in a referral for further treatment. Of those screened, 22.8% indicated the presence of a sealant and 38% had untreated caries.

Compared with the 1996 baseline sealant prevalence of 30%, this survey-based estimate reflects more children who are non-Medicaid but may be in a high risk group for dental caries. Goals were adjusted using this more population-based baseline. A 10% increase is expected in this measure in five years.

(8) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children. The MCH funded Louisiana SAFE KIDS Coalition conducts and supports statewide injury prevention programs. One Louisiana SAFE KIDS program is a child occupant citizen surveillance program called Don't Kid Around in which citizens mail postcards to Louisiana SAFE KIDS when a child under age five is seen riding unrestrained in a safety seat or seat belts, indicating the license plate number and other information about the event. The Louisiana Highway Safety Commission provides the name and address of the registered owner of that car and Louisiana SAFE KIDS sends information about the child safety seat law, child restraint information, and a rebate coupon for car safety. This measure was approximately 12 deaths per 100,000 prior to car seat legislation, and has measured between 6 and 8 deaths per 100,000 since.

This measure was changed this year to reflect all children aged 14 and younger (past reporting for this measure was for children aged 1-14). The rate for 1998 is 6.53 per 100,000. The MCH Program revised its goal according to this new measure, and proposes to keep this measure at or below 6 deaths per 100,000, via continued collaboration with the OPH Injury Research and Prevention Program on prevention interventions. The Child Death Review can assist in assessment of this indicator.

(9) Percent of mothers who breastfeed their infants at hospital discharge. Parish health unit staff counsel pregnant women and mothers about the importance of breastfeeding. Each parish has a designated nurse who serves as the breastfeeding coordinator. This nurse receives regular training and educational materials to share with other parish staff in order to increase the number of women who breastfeed their infants. Coordinators collaborate with other community groups such as Baton Rouge Breastfeeding Task Force, University Medical Center New Orleans' Breastfeeding Task Force, Louisiana Lactation Consultants, and Local La Leche League on efforts aimed at increasing Louisiana's breastfeeding rate. Clinics are still using the *Best Start Breastfeeding* Social Marketing Campaign, sponsored by USDA, *Loving Support Makes Breastfeeding Work*. Personnel was provided breastfeeding support items during Breastfeeding Awareness Month in August. Such items included breastfeeding model dolls to assist with proper positioning and latch-on; pedal style breast pumps; and other items for outreach. Efforts are still underway to provide 5,000 - 6,000 personal electric breast pumps.

Initially, State WIC data was used to calculate this measure for the 1996-1997 reporting period. Once PRAMS data became available, the 1997 data was replaced with a more reliable number, and the state goal was adjusted accordingly. This year, slightly more women surveyed report breastfeeding their babies in the hospital.

(10) Percent of newborns who have been screened for hearing impairment before hospital discharge. MCH works to encourage universal newborn hearing screening in hospitals. Louisiana implemented legislation for hearing screening of high risk infants in 1994. Since that time, some hospitals have voluntarily instituted universal newborn

hearing screening. The legislation designates OPH as the agency to coordinate, monitor, and collect data for this program. Initially, a State Advisory Council and eight Regional Task Forces were established to provide assistance to OPH and foster community involvement. The participation of many individuals, professionals, physicians, parents, educators, and deaf persons through the task force has been extremely successful. Regional Task Forces have been able to offer technical assistance to hospitals, establish linkages for follow-up services, provide local education and publicity, and provide feedback to the state. Hospitals continue to implement universal screening with the encouragement of the Regional Task Forces and State Advisory Council. OPH's major role is to guide the State Advisory Council and maintain tracking and surveillance of the program. Data collection continues to be a challenge and avenues of collaboration with vital records and metabolic screenings are being utilized to optimize accurate information and timely submission. In 1999, legislation was passed mandating universal screening. Rules and regulations mandating hospitals to begin universal screening by January 2001 are expected to be in place in six months.

(11) Percent of CSHCN in the State CSHS Program with a source of insurance for primary and specialty care.

Data for this item is reported on the agency encounter form. The denominator is the unduplicated count of the number of children in the CSHS Program (7,397), and the numerator is the number of CSHS enrollees who have a source of insurance, including Medicaid, to cover the costs of primary and specialty care (5,845). The current value for this measure (79.0%) is a decrease from last year's 92.9%. Last year, 82.% were covered by Medicaid, 10.1% were covered by private insurance, and 7.1% had no coverage. This year, 70% are covered by Medicaid, 9% are covered by private insurance, and 21% have no coverage. Reasons for dramatic changes in those covered by Medicaid versus those with no coverage are unknown, and will require investigation. One possibility is that the percent on Medicaid/LaCHIP seen by the CSHS Program has decreased due to parents seeking care for their children in the private sector once the child is covered by Medicaid/LaCHIP. CSHS participates in outreach activities to assure that all eligible families enroll in Medicaid/LaCHIP. With Louisiana's high rate of uninsured, it is expected that a portion of children with special health care needs will remain without any resources.

The five year goals remain at 95% until reasons for these changes in coverage are fully understood.

(12) Percent of children without health insurance. MCH is the Lead Agency for Louisiana's Covering Kids Initiative, which conducts Louisiana Child Health Insurance Program (LaCHIP) outreach statewide. MCH and Medicaid work closely on the implementation of this grant, which began in April 1999 and targets former TANF recipients, children with working parents, and families with limited English proficiency. Outreach efforts in year one included a school-based outreach campaign; translation of the LaCHIP application into Spanish and Vietnamese; creation of a Hispanic workgroup to conduct outreach and advise Medicaid on barriers unique to Hispanic families; creation of a student volunteer network at Tulane University; development of LaCHIP promotional materials with the \$500 million federal TANF fund; formation of a TANF/Medicaid workgroup to bring the two agencies together to improve the link between the programs; implementation of an action plan to crosstrain TANF caseworkers and Medicaid eligibility workers; delivery of community trainings and presentations on LaCHIP; and intense community-

based outreach in two pilot areas.

In the first year of LaCHIP implementation (November 1, 1998 - October 31, 1999), the State enrolled 27,725 children in LaCHIP, and had a net gain of 32,500 children in the regular Medicaid program, due to outreach and streamlined enrollment efforts.

The percent of uninsured children in the state was approximately 20% for several years. The number reported for 1998 is estimated from the American Academy of Pediatrics' analysis of the Census Current Population Survey. The State has not yet released any new estimates of uninsured that fully reflect the impact of LaCHIP. LaCHIP is expected to greatly impact this indicator through intense outreach and streamlined enrollment, and it is projected that its value will dip to 13.5% by 2001. This estimate assumes that LaCHIP will be implemented in three phases of Medicaid expansion. Phase One, an expansion to 133% Federal Poverty Level (FPL), began in November 1998. Phase Two, an expansion to 150% FPL, began in November 1999. Phase Three, an expansion to 200% FPL, is scheduled to be implemented next year. The State projected a 75% participation rate among those children who would become newly Medicaid eligible as a result of LaCHIP expansions. This projection was applied to state estimates of eligible children to reach a five year goal of 13.5%. The American Academy of Pediatrics predicts a lower rate for Louisiana - 16.8% in the year 2000.

(13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid program. All pregnant women, infants and children who receive services at the parish health units are screened for potential Medicaid and LaCHIP eligibility, including presumptive eligibility for all pregnant women. The MCH Pediatric Medical Consultant serves as the co-facilitator for the Louisiana Chapter of the American Academy of Pediatrics (AAP) CATCH (Community Access to Child Health) Program. As such, she has participated in the Chapter's Executive Committee meetings in the efforts to work with private practicing pediatricians in improving access to health services for children in their communities. LaCHIP outreach conducted by Medicaid, MCH's Covering Kids Initiative, and other community and government agencies will increase the numbers of currently Medicaid eligible children who enroll in Medicaid and LaCHIP (see above).

Current Medicaid participation for children is approximately 66% of the potentially eligible, and the state's goal is to increase this rate to 75%. This participation rate was calculated using American Academy of Pediatrics' analysis of the Census Current Population Survey (CPS) for Medicaid participation of children under age 19, and estimating the numbers of children at Medicaid eligible poverty levels from CPS data. Last year, MCH relied on the HCFA 2082 report for the number of children who received a Medicaid service, and we reported a Medicaid participation rate of 90%. The number reported by the State Medicaid Agency is not truly unduplicated, but it was the only numerator available last year. We expect to be able to get a truer picture next year, once the State begins to report more accurately for monitoring of its CHIP program.

We propose to keep the goals at the same levels, as 75% is still the true goal for Medicaid participation.

(14) The degree to which the State assures family participation in program and policy activities in the State CSHS Program. The CSHS Program has funded parent positions since 1989. At the present time, 20 parents are

employed to work in Regional Offices, clinics, and local communities, and one statewide parent coordinator is employed to coordinate activities and represent CSHS at a state level. Parent liaisons work within the medical and social work team to provide valuable resources, support, and information to families who have children with special health care needs. Parent participation in the block grant process and in-service training will be increased.

(15) Percent of very low birth weight live births. Consistent with national data, the percent of live births that are very low birth weight is remaining constant, this year measuring 2.1%. Major efforts to decrease this include a continual focus on the *Partners for Healthy Babies* public information and referral program; provision of low risk prenatal clinics in state parish health units for women in need and who are unable to find services privately; support and consultation for the Healthy Start programs; and funding and support for New Orleans city neighborhood prenatal programs. PRAMS data is now available, providing staff with better information to determine trends, patterns, and risk indicators that will enable the MCH Program to address this problem in a more specific manner.

(16) The rate (per 1,000) of suicide deaths among youths aged 15-19. Through MCH's Adolescent School Health Initiative, a statewide network of school-based health centers (SBHCs) provides mental health counseling and referral to teens. The number of operational SBHCs in the state have grown from 30 in 1997-98 to 36 in 1998-99. The centers collaborate with the State Office of Mental Health (OMH) to provide mental health counseling and a mechanism for referral, as well as to obtain technical assistance and quality assurance evaluations. Collaborative agreements with six of the centers and OMH have now been established. Each of these six centers has OMH staff on site. It is a goal of the Adolescent School Health Initiative for all sites to eventually have a formal collaborative agreement with OMH to provide a seamless system of diagnosis, treatment, referral, and follow-up. Each clinic has a formal, written suicide prevention protocol in place to use when confronted with a student experiencing suicidal ideation. A statewide uniform encounter form based on ICD-9 codes was implemented in the 1997-1998 school year. Tracking will assist in determining the extent of childhood depression at schools with centers and in developing intervention strategies. Trend analysis indicates that suicide deaths among youth will decrease slightly over the next five years, after a high of 14.2 in 1994.

(17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. The Louisiana Perinatal Commission has been successful in establishing the framework for regionalization of perinatal services by establishing standards for determining the level of services that each hospital can provide. These standards have been adopted as hospital licensing and Medicaid reimbursement requirements. MCH is assessing the impact of these regulations in conjunction with the Commission by conducting a study to examine areas where very low birth weight babies are delivered in non-tertiary facilities. This assessment will provide information on how best to impact this measure.

(18) Percent of infants born to women receiving prenatal care beginning in the first trimester. In 1998, this measure was 81.9% , with teens and black women continuing to have lower rates. *Partners for Healthy Babies* developed new media messages specifically targeted toward these populations in order to address this issue.

Throughout 1998, the MCH Program provided prenatal care throughout the state; home visiting services; and hotline services and prenatal care information through *Partners for Healthy Babies*.

State Performance Measures

(1) Percent of all children and adolescents enrolled in public schools in Louisiana that have access to school-based health center services. MCH's Adolescent School Health Initiative funds and provides technical assistance to school-based health centers. Expansion of these centers depends upon continued state funding and support. As of June 30, 1999, the 36 operational school-based health centers in Louisiana were serving 68 schools, which had an approximate enrollment of 42,926 students. This represents 5.3% of the approximate 780,783 students enrolled in Louisiana public schools. Thus, the Adolescent School Health Initiative has exceeded its five year goal of extending school-based health centers services to 5% of children enrolled in public schools, and now aims to reach 7% of public school students by 2002.

(2) Percent of women in need of family planning services who have received such services. Family planning services are provided at parish health units and are coordinated with MCH services. The denominator for this measure was obtained from the Alan Guttmacher Institute report on *Contraceptive Needs and Services*. The Guttmacher estimate is for 1995. Last year, the number of family planning patients served in 1995 was reported with the 1995 denominator. This year, the numbers served for 1996, 1997, and 1998 are divided by the same 1995 number of women in need. The trend is downward for several reasons. In 1995, there was a staff layoff resulting in field staff shortages and a decrease in the number of family planning clinics held and clients seen. In 1997, there was an across the board reduction of 10% in all contracts which resulted in a decrease in the numbers of family planning clients seen in delegate family planning clinics (agencies with Office of Public Health contracts to provide family planning services). Persisting staff shortages resulted in 2,000 women on a waiting list for family planning services in 1998. An ongoing budget freeze, initiated by the Governor and continued by the Department of Health and Hospitals, has prevented hiring for vacant positions and have made contracting with new partners very difficult. Therefore, in 1998, 21% of women in need were served, and the 1999 data will probably remain the same. New efforts to improve access support a projection for 2000 to 22%.

(3) The rate of children (per 1,000) under 18 who have been abused or neglected. Many MCH programs reflect a focus on the prevention of child abuse and neglect. MCH has a joint agreement with the Office of Community Services to utilize local public health nurses to assist child protection workers in the investigation of families suspected of child abuse and neglect. Also, MCH funds four home visiting programs that follow the Healthy Families America model of home visiting developed in Hawaii. Additionally, MCH launched two pilot nurse home visitation programs in two regions of the state. The nurse home visiting program follows the David Olds' model of nurse home visiting for first time mothers and began delivering services in March 1999. One additional region applied for and received a grant from a private foundation to implement nurse home visiting in one parish. It is expected that the

nurse home visitation model will be expanded to an additional region during state fiscal year 7/99 - 6/00. MCH provides the funding for Prevent Child Abuse Louisiana to coordinate a statewide media campaign and speakers bureau addressing child abuse prevention. A twenty-five hour training on infant mental health was developed by MCH. This training was piloted with Iberia Parish public health nurses and CSHS nurses from that region in 1997-1998. Due to the success of that training, statewide implementation of this training for all public health nurses is underway. As of September 1999, all public health nurses in Regions four and eight had been trained. Nurses in three additional regions will receive the training during the coming fiscal year. It is estimated that all Louisiana public health nurses will have received this training within the next two to three years. The training is intended to provide nurses with skills for clinic-based assessment of parenting and parent-child interactions, and may result in increased assessment of child abuse and neglect. MCH has revised its clinic-based Child Health Record for children ages 0 to 6, in order to facilitate psychosocial assessment of infants and children by parish health unit staff. The new record was finalized and distributed to parish health unit staff. Parish health unit staff provides parent education counseling and materials. The Prevention of Abuse and Neglect through Dental Awareness (P.A.N.D.A.) Program educates dentists and dental hygienists to recognize the early signs of child abuse and neglect and encourage reporting.

Interventions such as those mentioned above may actually result in an increase in cases of abuse and neglect, as awareness is heightened and providers become more apt to recognize and report cases. Although Louisiana did not meet its stated goal for 1999 of 10.1 cases per 1,000, the actual rate of 10.76 per 1,000 does surpass the Healthy People 2010 goal of 11.1 per 1,000.

(4) Percent of CSHS patients with case management (follow-up visits) from a nurse, social worker, or nutritionist. Louisiana's CSHS Program is placing increasing emphasis on a more holistic approach, and envisions increased case management for its program. As services are transitioned to the community wherever possible, the CSHS Program is placing increased priority on support and wrap-around services, such as case coordination and case management. A new service encounter form that will capture case management services has been implemented in three regions; this new form is expected to be used in all regions beginning in August 2000. Data for this measure is underreported due to the limited implementation of the new encounter form at this time. Available data on follow-up services provided by social workers is used as an estimate for this measure.

(5) Percent of children (0-5) on WIC over the 95th percentile weight for height. Louisiana is following the national trend; childhood obesity is increasing. The 0.3% increase from last year is not much of an increase; however, it is a move in the wrong direction. The MCH Nutrition Consultant has established a public health obesity committee to address this health problem. The committee has developed goals and objectives after thorough review of existing programs and methods. In one year, this committee has designed two data gathering tools to assess the barriers and beliefs of local communities and agencies that serve young children. The data will be assessed, analyzed, and utilized in planning and implementing preventive activities. Over the next five years, MCH's goal is to reduce the percent of children (0-5 years old) over the 95th percentile weight for height to 8%.

(6) Percent of women who have had a baby who report physical abuse either during their last pregnancy or in the 12 months prior to becoming pregnant. Training workshops were held in each region, reference packets were distributed to all parish health unit nurses, videotapes were distributed to all parish health units, and region specific emergency referral/safety cards were available in all parish health unit female bathrooms. Standards and protocols were developed and distributed to all parish health units and private providers in 1998.

Louisiana PRAMS data showed that in 1997, 10.5% and in 1998, 10.6% of women surveyed reported physical abuse during or in the last 12 months before their most recent pregnancy. The Office of Public Health is also conducting a telephone survey on safety and violence, which reported that 9.1% of its respondents were physically abused during their pregnancy.

(7) Percent of women who use substances (alcohol and tobacco) during pregnancy. Risk assessment and health education are provided to prenatal parish health unit patients, and health unit nurses work with Regional Substance Abuse Coordinators to refer patients for care. The statewide *Partners for Healthy Babies* campaign seeks to educate women about healthy behaviors during pregnancy. Case management services to pregnant teens provide education as well. The MCH Perinatal Substance Abuse Coordinator (PSAC) works to address substance abuse in a public information campaign; supports a statewide network of Perinatal Substance Abuse Coordinators; and maintains a clearinghouse of related activities. The MCH PSAC has collaborated with the DHH Office of Addictive Disorders to offer pregnancy testing to women who come in to substance abuse treatment facilities. The program is ongoing and now exists in six regions, with 33 treatment facilities participating.

In previous years, birth certificate data was used for this measure; thus, the value was an extreme underestimate. Currently, 1998 Louisiana PRAMS data is available, and indicated that 16.9% of respondents reported used cigarettes and/or alcohol in the last three months of their most recent pregnancy. Goals were revised accordingly.

(8) Percent of infant deaths due to SIDS that have a complete autopsy and death scene investigation. The MCH Program contracts with the Tulane University Pediatric Pulmonary Section for the positions of SIDS Medical Director and SIDS Nurse Coordinator. This has allowed the MCH Program to improve its capability to identify, document, counsel, and follow up families of SIDS infants and monitor the functioning of the overall program. The SIDS Program has expanded its educational activities directed to coroners, law enforcement, OPH parish health unit nurses, other health care providers, and the general public. The plans for regionalizing and standardizing autopsies have been completed and accepted, including implementing a standard death scene investigation protocol and conducting a public information campaign directed toward reduction of risk factors for SIDS. Since September 1996, the SIDS Program has provided reimbursement for a limited number of death scene investigations done by trained investigators. Investigators must submit complete death scene investigation reports to receive reimbursement. Reporting for calendar year 1996 was low, since the value reflected only four months of reports. In 1997 and 1998, 50% and 68% of infant deaths due to SIDS had a complete autopsy and death scene investigation. These numbers reflect complete

years of reports. In five years, the percent of SIDS deaths with a complete autopsy and death scene investigation is expected to increase from 17% to 80%.

(9) Percent of Central Office and regional epidemiologic positions filled and working on MCH/CSHS data and epidemiologic issues. The continuation of the CDC MCH Epidemiology Grant (1996-2001) has provided the agency and MCH with a senior epidemiologist (CDC Assignee) and the capacity to expand epidemiological capacity. In 1997, the Division of Health Services Epidemiology, Assessment, and Evaluation (EAE) Program, established additional epidemiology positions to expand its staff to nine Central Office positions and nine regional positions. In 1999, EAE added a tenth CSHS epidemiology position to its Central Office staff, and the denominator for this measure has been changed to 19. Due to a State agency hiring freeze and budget shortfall, it is unlikely that regional epidemiologist positions will continue to be filled. Goals have been adjusted accordingly.

To date, the epidemiology positions that have been filled are: one CDC Assignee, one divisional public health epidemiologist, two MCH Program epidemiologists, two CSHS epidemiologists, two PRAMS epidemiologists and two regional epidemiologists. Additionally, there are numerous other staff within the Agency who devote pieces of their time to MCH and/or CSHS data collection and analysis; however, we are counting only those Central Office staff who devote 100% of their time to these programs.

The LaPRAMS program finished its second year of data collection in November of 1999. The second year of data has been weighted and analyzed, and a descriptive report of this data was prepared. MCH, with the support of the EAE program, analyzes a variety of maternal, infant, and child health statistics; census information; and health service utilization data. MCH obtains information on patient and consumer needs and satisfaction via focus groups, surveys, and continuous quality improvement efforts. A Pediatric Nutrition Surveillance of children is ongoing in the Nutrition Program, as well as a Child Death Review which is staffed by MCH. Development of statewide immunization and birth defects registries is underway. As the EAE program develops, it will oversee MCH surveillance, and perinatal, fetal, infant, and pregnancy-related mortality reviews. It assists MCH and CSHS in tracking programmatic and health status indicators. EAE staff are also heavily involved in the Title V needs assessment and on reporting performance measures and health status indicators for the Title V Block Grant.

(10) Percent of licensed day care centers with a health consultant contact. MCH provides funding for training private and public health providers on health and safety guidelines for out-of-home child care centers, and certifies these health providers as Child Care Health Consultants. These consultants then provide training, technical assistance, and resource and referral services to child care providers.

Continuous efforts are made to increase the number of day care centers with a health consultant. In January 1999, all child care centers were mailed a brochure promoting the Child Care Health Consultant Program. The Department of Social Services, Licensing Bureau includes the brochure in licensing renewal notices mailed to every

child care center statewide. Also, the Office of Public Health Sanitarians provide child care centers with the brochure on their annual visits to all child care centers statewide. Department of Social Services' Regional Child Care Coordinators and their Resource and Referral Agencies conduct local meetings with child care providers and community interested parties to increase communications and awareness of health and safety issues in child care.

A new monthly reporting system has been put in place to more accurately report on this measure. Although the numbers of consultants participating and centers served has remained fairly constant over the past several years, efforts are being made to recruit new consultants and centers.

2.5 Progress on Outcome Measures

See Supporting Documents, Section 5.8 for Form 12.

1. The infant mortality rate per 1,000 live births

The National Performance Measures that impact infant mortality include the teen birth rate (# 6), very low birth weight (VLBW) births (#15), VLBW infants delivered in tertiary care facilities (#17), and infants born to mothers who received early prenatal care (#18). The State Performance Measures that impact infant mortality include women who have been physically abused in pregnancy (#6), substance abuse in pregnancy (#7), and SIDS activities (#8).

The 1998 infant mortality rate (IMR) of 9.1 deaths per 1,000 live births was a 4.2% decrease from the rate of 9.5 in 1997. However, the Annual Outcome Measure objective of 8.6 was not met. The decrease in the infant mortality rate in 1998 reflects a decrease in both the neonatal mortality and the post-neonatal mortality rate (see Outcome Measures 3 and 4). The race-specific infant mortality rates showed a 14.7% decrease in white infants from 6.8 to 5.8 deaths per 1,000 white births but a 2.9% increase in black infants from 13.6 to 14.0 (see Outcome Measure 2). Review of the causes of infant deaths indicates little change in the overall number and rate of deaths due to perinatal conditions.

During 1998, there was a decrease in the number of teen births, a slight increase in the percent of women receiving prenatal care in the first trimester, no change in the percentage of VLBW infants, and a slight increase in the percentage of VLBW infants born in hospitals with tertiary care services. Louisiana PRAMS data from 1998 indicates that 6.7% of women reported physical abuse during their most recent pregnancy; 14.2% of mothers reported smoking cigarettes during their most recent pregnancy; and 4.9% of mothers reported consuming alcohol during their most recent pregnancy. Approximately 68% of SIDS deaths had autopsies and death scene investigations, which is a substantial increase from 17% in 1996.

There are a multitude of factors that are related to IMR, including maternal health and habits; access to risk-appropriate prenatal, perinatal, and post-partial care for the pregnant woman; access to risk-appropriate neonatal and

infant health care for newborns and infants; and parental education in the areas of prenatal and infant care. Although low-birth weight, and especially very-low birth weight, are the primary associated risk factors for infant death, we do not know enough about the antecedents for LBW and VLBW births in this state. Despite the existence of a network of State-supported hospitals and public health clinics to provide prenatal care, as well as private provider participation in services for low-income women, there has only been slight improvements in measures of access such as early entry into prenatal care and virtually no change in the rates of VLBW infants. More information is needed on the social, economic, geographic, and social factors that are related to infant deaths in this state. More extensive data is needed to better delineate factors that are associated with infant death. The Louisiana PRAMS Program should provide further information that will establish trends and help to target MCH intervention efforts. The establishment of Infant Mortality Review Programs in the state will help define the local antecedents of infant death. Community-based efforts in areas of high infant mortality is needed to address barriers and risks present in the community.

2. The ratio of the black infant mortality rate to the white infant mortality rate

The National Performance Measures that impact this ratio include the teen birth rate (# 6), very low birth weight (VLBW) births (#15), VLBW infants delivered in tertiary care facilities (#17), and infants born to mothers who received early prenatal care (#18). The State Performance Measures that impact this ratio include women who have been physically abused in pregnancy (#6), substance abuse in pregnancy (#7), and SIDS activities (#8).

In 1998, the white infant mortality rate was 5.8 deaths per 1000 white births and the black infant mortality rate was 14.0 per 1000 black births, resulting in a ratio of the black infant mortality rate to the white infant mortality rate of 2.4. This represents an increase from the ratio of 2.0 in 1997 and fell below the Annual Outcome Measure objective of 1.8. The increase in the ratio is due to a decrease in the white infant mortality rate of 14.7% compared with a 2.9% increase in the black infant mortality rate.

During 1998, although the percentage of black women receiving prenatal care in the first trimester increased from 71.0% to 71.8%, the percentage for black women remained significantly lower than the 89.2% rate for white women. Although there was no change in the overall percentage of VLBW infants, the proportion of very low birth weight remained the same at 1.2% among white infants and increased slightly from 3.4% to 3.5% among blacks infants. Although 84.3% of all infants less than 1,500 grams were born in Level III facilities, a higher percentage of white VLBW infants (86.8%) and were born in Level III facilities compared to black VLBW infants (82.9%). Data from PRAMS indicates that a higher percentage of white women smoked during the most recent pregnancy (19.0% versus 6.6% for black women) and a slightly higher percentage of drank alcohol (5.7% for white women versus 4.5% for black women). The percent of white pregnant women who have been physically abused during the most recent pregnancy was 5.0% while the percent for black women was 9.3%. There were a disproportionate number of SIDS

deaths among black infants compared to white infants with a rate of 1.4 deaths per 1,000 live births for black infants compared with a rate of 0.6 deaths per 1,000 live births for white infants.

Efforts to decrease racial disparity include assuring access to risk-appropriate quality care services for all pregnant women and their infants. The *Partners for Healthy Babies* public information campaign uses focus groups of high risk populations, including black women and teens, in order to develop prenatal care messages. More information is needed on the reasons for delayed entry into prenatal care for black women in order to develop interventions that address these reasons. The higher mortality rate due to SIDS in black infants further indicates the need for information on risk reduction for SIDS in the African-American population.

3. The neonatal mortality rate per 1,000 live births

The National Performance Measures that impact this ratio include the teen birth rate (# 6), very low birth weight (VLBW) births (#15), VLBW infants delivered in tertiary care facilities (#17), and infants born to mothers who received early prenatal care (#18). The State Performance Measures that impact neonatal mortality include women who have been physically abused in pregnancy (#6) and substance abuse in pregnancy (#7).

Although the 1998 neonatal mortality rate of 5.9 was a 4.8% decrease from the rate of 6.2 in 1997 but still higher than the rate of 5.6 in 1996, it did not meet the Annual Outcome Measure objective of 5.3. A review of the causes of death indicate that there was little change in the number and rate of neonatal deaths due to congenital anomalies and perinatal conditions including low birthweight and short gestation. During 1998, there was a decrease in the number of teen births, a slight increase in the percent of women receiving prenatal care in the first trimester, a slight increase in the percentage of VLBW infants born in hospitals with tertiary care services, and no change in the percentage of VLBW infants. Louisiana PRAMS data from 1998 indicates that 6.7% of women reported physical abuse during their most recent pregnancy; 14.2% of mothers reported smoking cigarettes during their most recent pregnancy; and 4.9% of mothers reported consuming alcohol during their most recent pregnancy.

Factors that will have the greatest impact on neonatal mortality are low birth weight rates and access to tertiary care neonatal services. The continued high neonatal mortality rate appears to be related to the continued high number of very low birth weight infants, especially for black infants. Although 84% of the very low birth weight infants were born at facilities with neonatal intensive care units, the neonatal mortality rate of those born at non-tertiary care facilities is 50% higher than those born at tertiary facilities.

4. The post-neonatal mortality rate per 1,000 live births

The National Performance Measures that impact post-neonatal mortality include immunization rates (#5),

uninsured children (#12), and Medicaid participation (#13). The State Performance Measure that impact post-neonatal mortality include substance abuse in pregnancy (#7), SIDS activities (#8), and child abuse and neglect (#3).

In 1998, the post-neonatal mortality rate per 1,000 live births in Louisiana was 3.2, which was a 3% decrease from the rate of 3.3 in 1997. This met the Annual Outcome Measure objective of 3.2. There was a decrease in the white post-neonatal mortality rate from 2.2 to 2.0, but this was off-set by an increase in the black post-neonatal mortality rate from 4.7 to 4.8. Review of the causes of post-neonatal deaths showed a decrease in the number of deaths due to SIDS but an almost reciprocal increase in the number of injury deaths due to suffocation. Improved death scene investigations may have resulted in deaths that might have been classified as SIDS were found to be due to suffocation.

Immunization rates, rates of uninsured children, and percentages of income eligible children who receive Medicaid services are indirect indicators of access to preventive and primary health care services. Immunization rates have seen a slight increase, the percentage of children without health insurance has decreased to 18.3% , and approximately 66% of children eligible for Medicaid participated in the program. In 1996, a program was instituted through the Louisiana SIDS Counseling and Risk Reduction Program to provide partial reimbursement for infant autopsies performed at regional centers and for death scene investigations done by trained coroner investigators. Autopsies and death scene investigations were documented in 68% of deaths attributable to SIDS, which is an increase from the rate from the previous year of 50%. Nonetheless, despite the decrease in the number of deaths due to SIDS, the high mortality rate due to SIDS particularly in black infants indicates the need for continued efforts on public and professional education on risk reduction for SIDS, especially targeted to the African-American population.

5. The perinatal mortality rate per 1,000 live births and stillbirths

The National Performance Measures that impact perinatal mortality include the teen birth rate (# 6), very low birth weight (VLBW) births (#15), VLBW infants delivered in tertiary care facilities (#17), and infants born to mothers who received early prenatal care (#18). The State Performance Measures that impact perinatal mortality include women who have been physically abused in pregnancy (#6) and substance abuse in pregnancy (#7).

In 1998, the perinatal mortality rate was 12.5, which was a 2.3% decrease from the rate of 12.8 in 1997. However, it did not meet the Annual Outcome Measure objective of 12.1. The perinatal mortality rate for blacks increased from 17.7 to 18.0 deaths per 1,000 live births and stillbirths, due to an increase in the early (under 7 days) neonatal deaths in black infants. During 1998, there was a decrease in the number of teen births, a slight increase in the percent of women receiving prenatal care in the first trimester, a slight increase in the percentage of VLBW infants born in hospitals with tertiary care services, and no change in the percentage of VLBW infants. Louisiana

PRAMS data from 1998 indicates that 6.7% of women reported physical abuse during their most recent pregnancy; 14.2% of mothers reported smoking cigarettes during their most recent pregnancy; and 4.9% of mothers reported consuming alcohol during their most recent pregnancy.

An analysis of the fetal deaths was conducted to look at time trends and the geographical distribution of fetal deaths. This analysis showed that there has been little change in the fetal mortality rate over the past 10 years. The fetal mortality rate for blacks was nearly twice that of white infants. The rate varies by region, with urban mortality greater than rural. Review of the causes of perinatal deaths indicates that complications of the placenta, cord, and membranes and short gestation/low birth weight are the major causes of perinatal deaths. Further analysis on the causes and risk factors for perinatal deaths to address the preventability of fetal deaths is needed.

6. The child death rate per 100,000 children aged 1-14

The National Performance Measures that impact the child death rate include CSCHN children with a “medical home” (#3), immunization rates (#5), motor vehicle crash deaths (#8), uninsured children (#12), and Medicaid participation (#13). The State Performance Measure that impact the child death rate include school-based health center access (#1) and child abuse and neglect (#3).

In 1998, the child death rate per 100,000 children aged 1-14 in Louisiana was 32.0 deaths per 1,000 children aged 1-14 years, which was a 5.6% decrease from the rate of 33.9 in 1997. The Annual Outcome Measure objective of 36.0 was exceeded. Immunization rates, rates of uninsured children, and Medicaid participation are indirect indicators of access to preventive and primary health care services. Immunization rates have seen a slight increase, the percentage of children without health insurance has decreased to 18.3%, and approximately 66% of children eligible for Medicaid participated in the program. Assurance of accessibility to comprehensive health services for the medically high risk child population is reflected in the percent of CSCHN who have a “medical home.” Comparative data to assess progress for this measure is in the process of being collected. The rate for motor vehicle crash deaths in 1998 was 6.6, which is a 17.2% decrease from the 1997 rate of 7.97.

Services to children and adolescents in school-based health centers include education on high risk behaviors as well as assessment and management of health problems. In 1999, the percentage of children and adolescents enrolled in public schools that had access to school-based health centers remained virtually stable at 5.5% (5.6% in 1998). Increases in this performance measure would mean that more children and adolescents would have access to preventive health services which could impact the child mortality rate. Child deaths due to intentional injury and neglect are reflected in the rate of children under 18 who have been abused or neglected. This rate decreased nearly 13% in Louisiana in 1999 from 12.4 per 1,000 children in 1998 to 10.8. Screening for families at risk for abuse and

neglect, as well as interventions for prevention including education and family support services, have the potential to decrease intentional child deaths through the prevention of child abuse and neglect. Other efforts to decrease child mortality focus on the prevention of unintentional injury through public and professional education and other initiatives addressing specific causes of unintentional injury, such as those aimed at car safety seat and passenger restraints.

III REQUIREMENTS FOR THE APPLICATION

3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

MCH formed a core Needs Assessment Planning Group in late 1998 in order to make decisions about the Year 2000 Title V Needs Assessment - how it would be conducted and who would be responsible for which components. This core group included the MCH and CSHS Program Administrators, the Child Health Medical Director, the Division of Health Services Epidemiologist, the CDC assigned MCH epidemiologist, and the MCH Assistant Administrator. Over the course of the project, others have played primary roles, including the two SSDI funded epidemiologists, the CSHS Parent Coordinator and the CSHS epidemiologist. MCH also participated in the MCH Information Resource Center's Graduate Student Internship Program for two summers, which provided additional staff resources for conducting the needs assessment.

Methods of Data Collection

The Year 2000 Needs Assessment for Louisiana's Title V Program consisted of three components of data collection common to both the MCH and CSHS Programs: secondary data compilation and review; data collection and reporting on the federal health status indicators; and a survey of Title V stakeholders. CSHS also conducted a patient survey in the CSHS clinics and a provider survey; MCH also conducted a patient survey in parish health units and a community assessment survey and health planning process in each parish.

Common Methods

The first step consisted of a systematic review of existing databases, state and national reports, and websites for information relevant to the health status of Louisiana's MCH and CSHS populations. This activity was conducted primarily by one of the SSDI funded epidemiologists in the MCH Program who spent several months reviewing and compiling relevant data by seven specific subject areas - perinatal health; infant and child health; adolescent health; oral health; maternal and child nutrition; injury prevention; and children with special health care needs.

The second step was the federally required component - collecting and reporting data for the set of core and developmental health status indicators. Once these indicators were finalized by MCHB, MCH staff created a work plan for data collection. This work plan laid out the following for each indicator: the staffperson responsible; the data source that would be pursued; a backup data source; and the data limitations.

A third component of data collection was a mailing to Title V stakeholders, and a request for feedback. MCH staff wrote a three page article, summarizing some of the Title V Program's performance measure data and describing the interventions that are funded by the State Title V Program. The article asked for feedback on the appropriateness

of existing Title V activities, as well as suggestions for other interventions that would serve these populations more efficiently. (See Needs Assessment Appendix D for a copy of this article.) This article was mailed to approximately 300 key stakeholders - representatives of governmental, professional and voluntary agencies, universities, hospitals, advocacy organizations, and parent groups.

CSHS-Specific Methods

The process by which the CSHS Program asked its consumers for feedback was a survey administered in CSHS clinics statewide. A committee of CSHS staff and parents developed the survey, based in part on previous studies conducted in other states, a Family Voices study, and surveys developed by an Agency for Health Care Policy and Research Consortium including the RAND Corporation, Harvard Medical School, and Research Triangle Institute. The parent survey was organized into six areas - demographic information; medical and specialty services; mental health services; communication and coordination services; simplicity of services delivery; and other services. (See Needs Assessment Appendix E for a copy of the patient survey.) The survey tool was pilot tested in two CSHS clinics. Suggestions were incorporated, and the final version was a self administered consumer questionnaire. From June through August 1999, CSHS Parent Liaisons distributed the surveys to parents and caregivers attending CSHS clinics. Parents Liaisons were available to provide assistance to parents who had difficulty reading or understanding the questionnaire. All nine regional CSHS clinics participated; it is estimated that 15% of all CSHS patients responded to the questionnaire. Convenience sampling was the method used.

The CSHS Program also created a physician survey. (See Needs Assessment Appendix E for a copy of this survey.) This survey was addressed to those providing services in all 20 specialties to CSHS patients. Physicians were asked to indicate their level of satisfaction in 16 areas detailed in the survey. CSHS staff distributed the survey to physicians from June to August 1999.

MCH-Specific Methods

The process by which the MCH Program asked its consumers for feedback was a patient survey distributed at parish health units. (See Needs Assessment Appendix D for a copy of this survey.) The MCH survey was a random sampling method design; four clinics were chosen from each region and each were given 40 surveys. From each region, two rural parish health units and two urban parish health units were chosen. A total of 158 questionnaires was received from child health screening visits, 91 questionnaires were received from pregnancy test visits, 89 questionnaires were received from prenatal care visits, and 635 questionnaires were received from WIC/MCH education and counseling visits. Response rates were 95.8%, 94.8%, 98.9%, and 95.0 % for the four types of clinics, respectively. Surveys were distributed to parish health unit clients at the selected clinics between January 2nd and February 19th, 2000. Clients

completed the surveys confidentially, and dropped them into a box at the health unit. Once the survey period was over, the questionnaires were mailed back to the Office of Public Health. Survey results provided MCH with information on customer satisfaction with services currently offered, as well as suggestions for improvements and the need for additional services.

The most intensive of the MCH data collection components was the community assessment survey and health planning process. A community assessment survey tool was created to capture parish level information on numbers of providers, MCH-related services available in a parish, and the accessibility of those services. The survey tool was entitled the “Environmental Scan of Health Infrastructure” and contained separate sections to be completed by different types of service providers - clinics, private providers, hospitals, dentists, community agencies, and parish health units. (See Needs Assessment Appendix D for a portion of the Scan survey tool.)

Data Collection and Reporting Using the Scan The Division of Health Services Epidemiologist designed a training for all regional nurse managers and parish health unit supervisors statewide to instruct them how to complete the Scan in their own areas. This training was provided to each region in the Fall of 1999. Parish health unit nurse supervisors were asked to take the lead on using the Scan to collect data on all health care providers in their parish. The intent was not only to provide MCH with information for its needs assessment, but also to provide communities with data for health services planning and future grant applications. Collaboration with the State Boards of Medical and Dental Examiners, statewide medical and dental societies, and various nursing schools facilitated data collection. The Office of Public Health provided MCH with a contracted computer programmer to develop a database program for regions to enter their Scan data. A training was provided at Central Office in January to teach regions how to use this database product for data entry and analysis.

The next step was another round of regional training, provided from February through May, 2000. MCH developed parish data books of parish level epidemiologic and health service delivery data. Epidemiologic data chosen included vital statistics and service delivery data, and each parish's data was adjusted by race and compared to the region, state, and nation. A team of MCH staff, led by the Division of Health Services Epidemiologist and the MCH Director, trained regional and parish staff to analyze the provider data they had collected and to interpret their parish-level data books. This primary and secondary data formed the basis of the parishes' needs identification. The training also provided instruction on priority setting using various methods of health planning and prioritizing health problems. Parish staff then had six weeks to prioritize the MCH needs in their areas in collaboration with community members, and report their findings back to their Regional Administrator. MCH created a worksheet for parishes to follow as they went through this process, including a summary chart of the availability of all MCH services in the parish and a space to list final prioritized needs for the parish. (See Needs Assessment Appendix D for a copy of this worksheet.)

Data Limitations

Some of the secondary data that was available was either not recent enough to be relevant, or was not broken

down by race. Major gaps in data available for health status indicators included hospital discharge data and Medicaid data. Preliminary hospital discharge was supposed to have been available this past winter; however, the State Division of Health Information is still cleaning the data and predicts that it may be another year before any data is available. This forced the MCH Program to rely on a secondary source of data for asthma, and made it impossible to report on the nonfatal unintentional injuries. The State Medicaid Agency denied the MCH Program access to its claims database; thus, PRAMS data was used in the comparison of the health status of Medicaid with the general population. Another limitation in the data used for reporting of the health status indicators is the availability of race breakdown. This is true especially when reporting enrollment in programs such as TANF and Food Stamps. When a race breakdown is available, it is often only available by white and black percentages. Yet another limitation was the year available; data was almost never available for 1999, and often 1997 or 1998 was the most recent year.

Information obtained on the CSHS survey indicated a need for several critical services such as primary care and dental services. The CSHS Program had intended to conduct a series of focus groups with families in order to further investigate the answers obtained and to complement the qualitative data from the patient questionnaire. Due to the State budget freeze and the resulting difficulty in getting contracts approved, the contract for the focus group facilitator was not approved in time for the needs assessment. The qualitative data that was collected is limited by the fact that it was collected via a convenience sampling method; however, it reflects 15% of all CSHS patients statewide and can be used to provide feedback to individual regional clinic sites.

The major limitation of the parish health unit consumer survey is in the random sample design. Although this method of data collection helped MCH staff generalize about client satisfaction and needs statewide, the results are not useful as a means to provide feedback to individual health units. In previous years, similar surveys were distributed at each of the 105 health units statewide, and reports of the individual clinic results were provided to each site. The goal of this data collection process was to provide a statewide picture of consumer needs; however, the results have limited use beyond the scope of this Needs Assessment. A survey is planned for the remaining parishes this year.

Scan results were not complete for all areas of the state. The tool was more efficient in rural parishes, where a parish health unit nurse supervisor knows most of the providers in her/his area and could collaborate easily to provide a complete picture of health services. In urban areas, especially in New Orleans, this was a monumental undertaking, and often the nurses in those areas relied on their own knowledge and the perceptions of some of the major providers in the area. Even the Scan data in rural areas was often limited by low response rates; many providers did not return their surveys, and consequently, results for many parishes do not reflect all of the providers in that parish.

Collaboration

MCH and CSHS worked closely with community partners at every step of the needs assessment process. Parish health unit and CSHS clinic users provided feedback via the survey that was distributed at clinics. Specifically, 973 MCH consumers and over 1,100 CSHS consumers gave their opinions on existing MCH and CSHS services and the need for additional services.

Three hundred key stakeholders were asked to provide feedback on current Title V interventions and to make suggestions for improvement and new interventions. Stakeholders included representatives of governmental, professional and voluntary agencies, universities, hospitals, advocacy organizations, and parent groups. Responses were received from important collaborators, including the State Superintendent of Education, the State Medicaid Director, the Director of the Department of Social Services' Office of Community Services, and the Director of the State Office for Addictive Disorders. The CSHS Program engaged the physician community in providing feedback and suggestions for future operations.

Engaging community partners was an integral component of the Environmental Scan process, and community input was sought at every step: data collection, analysis, needs identification, priority setting, and strategic planning. In the majority of Louisiana's 64 parishes, nurses worked closely with community partners to complete the Scan surveys, review secondary data books, and complete prioritization exercises.

The collaborative efforts put forth by the nurses assisted the MCH staff in identifying the needs and diversity within each of Louisiana's regions/parishes. These efforts facilitated the planning process of the MCH needs assessment, thereby being instrumental in the establishment of priority needs within each region and the entire state. Community partners from each region represented a variety of organizations, including hospitals (Byrd Regional Hospital, Sicily Island Medical Center, Woman's Hospital, Opelousas General Hospital, Eunice Community Medical Center, St. Patrick's, East Louisiana Rural Health Clinic, Madison Parish Hospital); social service agencies (United Way, Steps to Success, Family Counseling Services, Child Net Program, East Carroll Community Action Agency, Housing Authority, Community Action for Children, VOA Crisis Pregnancy Center, Metropolitan Battered Women's Association, Central Louisiana AHEC); private providers (physicians, nurses, dentists); and local government (Office of Addictive Disorders, Office of Mental Health, Office of Community Services, Office of Family Support). Other participants included school nurses, local parish governments, school boards, school-based health centers, local businesses, and religious organizations. (See Needs Assessment Appendix D for a complete listing of community partners.)

Extra efforts were made to extract community input in the New Orleans area. Because it was difficult to use the Scan tool in such a large, metropolitan area, a different tool was used and administered by an existing community coalition - the New Orleans Turning Point Collaboration. (See Needs Assessment Appendix D for the survey tool.) This tool was sent out to 1,000 citizens, representing each zipcode in the City. The survey asked for community perceptions of the top health concerns and priorities for Orleans Parish. Over 150 individuals participate in New Orleans' Turning Point collaboration, including representatives from community organizations (Great Expectations, Family Services of Greater New Orleans, Agenda for Children, United Way, Volunteers of America, Catholic Charities); churches (St. Stephen's, Agape Community Baptist Church, St. Joseph's, Galilee Baptist Church, Union Bethel AME Church); universities (Tulane University, Dillard University, Tulane/Xavier National Center of Excellence in Women's Health, Delgado School of Nursing); hospitals (Touro, Charity Hospital, Children's Hospital); schools (Booker T. Washington High School, Lawless High School, New Orleans Public Schools); and health agencies (New Orleans City

Health Department, State Department of Health and Hospitals). (See Needs Assessment Appendix D for a complete list of Turning Point members in New Orleans.)

Other efforts to solicit input were more routine - a notice of OPH's intent to apply for Title V funds appeared in the June State Register, and explained how the public could obtain copies of the block grant and needs assessment to review. The Block Grant Application and Needs Assessment were reviewed by the CSHS Parent Coordinator as well.

Process to Consolidate Data Components and Community Input

State Process

MCH and CSHS utilized a group planning process to incorporate all of the data collected into one cohesive list of priorities and set of plans. In May 2000, Title V Program staff formed seven health planning workgroups related to specific subject areas within the MCH scope - perinatal health; adolescent health; infant and child health; oral health; maternal and child nutrition; injury prevention; and children with special health care needs. Groups were assigned an "epidemiology contact" - one of the epidemiologists on staff - to provide technical support or additional data to the workgroups. Group leaders were also assigned, and were responsible for convening their groups and providing programmatic leadership. Group members included not only MCH staff working that particular area, but local leaders in research and program implementation for each subject area. (See Needs Assessment Appendix D for a list of groups and group members.)

Workgroup meetings were held from May 16th - June 2nd. Led by group leaders, planning group members reviewed all data that had been collected that pertained to their particular subject area. This data included the following: secondary data reports; health status indicator and performance measure data; parish health unit survey results; CSHS clinic survey results; feedback received from Title V stakeholder mailing; regional Scan results, priority needs, and interventions; additional data on numbers of health care providers by parish; survey results from the "Louisiana Children's Cabinet Need Survey of State Agencies"; the current list of Louisiana's Title V priority needs; last year's Title V Annual Plan; and any other relevant data to which group members had access.

Group members reviewed all data and prioritized the needs that emerged, utilizing tools for prioritization of health problems such as the CDC's Basic Priority Rating System and PEARL method. Groups used a template for reporting their steps. (See Needs Assessment Appendix D for a sample of a planning group template and a set of planning group instructions.) Groups were also responsible for identifying the interventions currently in place to address priority areas, and discussed their feasibility and effectiveness. Group members made recommendations for the addition of new interventions, the continuation or discontinuation of current interventions, or the modification of current interventions.

Planning groups submitted their final ideas to the core Needs Assessment Planning Group (described above) by June 9th, and this group met to compile the final list of ten priority needs (See Section 3.2.1 for a full discussion of how these needs were selected). Through this planning group process, MCH staff considered all of the data available, thus

reflecting all community and consumer input in the final recommendations of priority needs and activities for the State Title V Program.

Regional and Parish Process

Although the main goal for the state was to complete the Title V needs assessment requirements and to create a blueprint for future operations, the process for regional and parish participation is ongoing. The Environmental Scan community assessment and the training on data use and prioritization of health problems was an attempt to empower the regions to use their primary and secondary data for local decision making.

This summer, MCH will turn the regions' submissions of health priorities and plans into final Regional MCH Plans. These documents can then serve as blueprints for MCH operations at the regional and parish levels, assuring that resource allocations for MCH services are based on data collected during this needs assessment process, and that regions are equipped to address their needs and/or seek grant funding for new activities in their areas. Also, recognizing that the Title V program cycle incorporates needs assessment, strategy development, planning, implementation, monitoring, and evaluation, the regions' participation has helped staff gain the capacity to participate in the entire process.

3.1.2 Needs Assessment Content

3.1.2.1 Overview of the Maternal and Child Health Population

According to the 2000 Kids Count Data Book, Louisiana ranked 50th among the states in "Indicators of Child Well-being." Louisiana ranked 48th for the percent of children in poverty; 50th for the percent of low birth weight babies and percent of children in single-parent families; 46th for infant mortality rate; 45th for child death rate; 47th for teen violent death rate; 42nd for teen birth rate; and 34th for the percent of high school dropouts. Although some of these indicators are not directly related to health status, they do reflect socioeconomic and environmental factors that affect the health of children and their families. The 1999 Kids Count reported that an estimated 22% of Louisiana's children live in a "high-risk" family (defined as a family with four or more of the following characteristics: child not living with two parents; household head is a high school drop out; family income is below the poverty line; child is living with parent(s) who do not have steady, full-time employment; family is receiving welfare benefits; and child does not have health insurance) as compared to 14% of children nationally.

Louisiana has the 10th highest number of children under age 16 receiving federally administered SSI payments. Since Louisiana ranks 22nd in terms of population, this indicates a significantly higher than expected number of children with special needs in the state.

Teen Births, Unintended Pregnancies and Initiation of Prenatal Care: The country has seen a general decrease in births to teens. In Louisiana, the teen birth rate dropped from 41.9 births per 1,000 females age 15 through 17 in 1997 to 40.2 in 1998. In 1994, the teen birth rate was 50.7. The total still remains high, especially among black teens. In 1998, there were 12,294 births in Louisiana to teens under age 20 years, comprising 18.41% of all births. There were 4,868 births to white teens in 1998, representing 7.3% of all births and 12.8% of all white births. There were 7,260 births to black teens, representing 10.9% of total births and roughly one-fourth (26.5%) of all black births. Unintended or mistimed pregnancies can have many devastating effects, physical and psychosocial. Of the 66,773 live births in 1998, approximately 53% of pregnancies in the state were unintended, according to the Louisiana Pregnancy Risk Assessment Monitoring System (LaPRAMS). It is not unusual for women experiencing unintended pregnancies to begin prenatal care later than women enjoying desired conceptions. At a time when over 50% of pregnancies are unintended, the promotion of preconception counseling is a great need. In Louisiana, the percentage of women entering prenatal care in the first trimester is improving. In 1997, 81.3% of all women giving birth began prenatal care in the first trimester and in 1998 the percentage went up to 81.9. Rates for both white and black women improved in 1998, but the disparity between the groups continues to be excessive with rates of 89.2% for white women and 71.8% for black women.

Maternal, Infant, and Child Mortality: Maternal deaths in Louisiana have numbered between 2 and 14 per year, from the years 1979 to 1998, with 2 resident maternal deaths in 1998. In 1999, the MCH Program conducted an expanded pregnancy-related mortality review, following CDC guidelines and definitions of pregnancy-related and pregnancy-associated deaths. This review covered maternal deaths from 1995–1997, and identified 49 deaths that were pregnancy-related, or to a woman by any cause related to or aggravated by her pregnancy. These included ectopic pregnancy, spontaneous abortion, hemorrhage, toxemia, infection, emboli, hepatic failure, cardiomyopathy, etc. The review identified 29 deaths that were pregnancy-associated, or to a woman while pregnant or within one year of termination of her pregnancy, irrespective of cause. Fifteen of these were intentional deaths (strangulations, stab wounds, or gunshot wounds). Fourteen were unintentional (motor vehicle accidents, burns, drug overdose, or suffocation). Racial disparities in maternal mortality exist nationwide, and this expanded review also showed higher rates of black mortality than white.

A high **infant mortality rate (IMR)** continues to be one of the major concerns of the Louisiana MCH Program. Although there has been a gradual decline in the infant mortality rate, the rate still remains among the highest in with nation with a large racial disparity existing between the infant mortality rate for black and white infants. From 1994 to 1998, the average infant mortality rate was 9.6, with an average IMR for whites of 6.4 and blacks of 14.3 (See Figures 5 & 6, Appendix A). In 1998, there were 66,773 live births, a 1.2% increase from 1997, with 606 infant deaths, a 3.6% decrease from the 629 infant deaths in 1997. This decrease occurred despite an actual increase in the mortality rate for black infants. There has been little change in the low and very low

birthweight rates, which are the primary risk factors associated with infant deaths. A striking racial disparity is evident with blacks having twice the rate of low birthweight infants. In 1998, there were 6,768 infants born weighing less than 2,500 grams, representing 10.1% of all births. Low birthweight white infants totaled 2,639, 6.96% of all white births. Low birthweight black births totaled 4,013 births, 14.6% of all black births. Similar results can be seen in very low birthweight statistics. In 1998, 2.2% of all births were very low birthweight (less than 1,500 grams). Among white births, 1.2% were very low birthweight. Among black births, 3.5% were very low birthweight, nearly three times the rate for white births.

Low birthweight and short gestation remain among the major causes of infant deaths, along with congenital anomalies, disorders related to the perinatal period, and SIDS. SIDS, the major cause of post-neonatal deaths, has declined, but the rate remains almost twice the national rate, with the rate for black infants being almost twice that for white infants. SIDS is the third highest cause of infant death in New Orleans, and rates have decreased only slightly in the past few years.

In 1998, the **child death rate** per 100,000 children aged 1-14 in Louisiana was 32.0 deaths per 1,000 children, a 5.6% decrease from the rate of 33.9 per 1,000 in 1997. However, this remains higher than the national rate of 23.7 deaths. **Injury, unintentional and intentional**, is the major cause of death in Louisiana between the ages of 1 and 14 years. In 1998, there were 291 deaths, of which 157 or 54% were due to injury. Of these injury deaths, 138 were unintentional injury deaths and 19 were intentional injury (18 homicides and 1 suicide). Motor vehicle crashes accounted for 62, or 45% of the unintentional injury deaths with a rate of 6.6 per 100,000 children, a 17.2% decrease from the 1997 rate of 7.97. Submersion, suffocation, and fire related deaths are among the next leading causes. Disparity also exists here, with black children more likely to suffer injury-related deaths than white children. The relative risk of unexpected childhood death for black children was 1.52 times that for white children from 1989-1998. Information gathered through the Child Death Review Panel, which is staffed by the MCH Program, on the circumstances of unexpected child deaths indicate that most of the injury deaths were preventable by the actions of a reasonable caretaker. Lack of supervision was the most common preventable factor in almost all types of injury deaths.

Maternal, Infant, and Child Morbidity: Substance use during pregnancy is a problem for certain sub-populations of women in Louisiana. According to the 1998 LaPRAMS data, 4.9% of pregnant women drank alcohol during pregnancy and 14.2% smoked during pregnancy. Pregnant women over age thirty were four times more likely to drink during pregnancy than women under age 30. White women were three times more likely to smoke during pregnancy than black women. **Physical abuse** during pregnancy is a significant problem for women in Louisiana. According to the 1998 LaPRAMS data, 7% of pregnant women experienced physical violence during pregnancy. **Diabetes**, a major maternal disease that can significantly affect pregnancy outcome, occurred in approximately 1.5% of pregnancies in Louisiana in 1998. Achieving optimal preconception glycemic control in women with pre-existing diabetes and assuring that gestational diabetics are receiving high-risk care will reduce many of the effects of inadequate

glucose control.

Information on general morbidity in childhood is limited by lack of access to population-based data. However, information is available on some areas of childhood morbidity from some specific programs and data collection systems. **Child abuse and neglect** remains a significant problem for children in Louisiana, although the number of validated cases found by the Office of Community Services (Child Protective Services) has decreased. In 1999, there were 12,814 validated cases of child abuse and neglect, which is a 13% decrease from the 14,804 valid cases in 1998. Data on **lead poisoning** for children screened through public health units in the state during 1999 showed that 12.8% had an initial lead level of 10µg/dl or greater and 4.9% were 15µg/dl or higher. In some areas of New Orleans, up to 50% of children have lead levels above 10µg/dl. However, previous studies have shown that approximately one-third of the initial elevations are confirmed on venous testing. In 1999, the Newborn Genetic Screening Program identified five infants with PKU, 15 with congenital hypothyroidism, and 85 with sickle cell disease. No children were detected with biotinidase deficiency.

Provision of risk-appropriate prenatal care services is necessary in order to identify risk factors - both medical and behavioral - for poor birth outcomes. In 1998, 89.2% of white women and 71.8% of black women entered prenatal care in the first trimester. Many areas in the state continue to lack private prenatal care services for women in need. In this year's community-based needs assessment, 58% of the parishes statewide expressed early prenatal care as a top need for the MCH population.

Provision of preventive health care services, including screening, immunizations, and health and parenting education, is essential in maintaining and improving the health of infants, children, and adolescents. Delivery of such routine care is of particular importance to the low-income population who may require more visits than those traditionally recommended. Participant and screening ratios for the Medicaid population give an indication of health maintenance of low-income children in Louisiana. In 1998, 292,856, or 90% of children who were due a KIDMED (EPSDT) service received at least one screening visit. However, the screening ratio, which reflects the different screening visit requirements for different age groups, drops to 67% overall. Of concern is the screening ratio for infants, only 37%. Although the ratios for older children and adolescents are high, they are based on provision of one screening every two years which may not be sufficient for the age group (HCFA 416 Report, 1998, Louisiana Medicaid Program). Immunization rates, which are another indirect indicator of receipt of preventive care, showed a slight decrease in 1999 from 82% to 81%, remaining below the national target of 90%.

Adolescent Morbidity and Mortality: The main threats to adolescents' health are the risky behaviors they engage in and the choices they make. These high-risk behaviors can lead to intentional and unintentional injury, pregnancy, sexually transmitted disease, and cardiovascular disease. These behaviors are all interrelated and share

common root causes including: poverty (31% of Louisiana children <18 years live in poverty-US Census, 1995), stress, depression, hopelessness, emptiness, fear, anger, and environmental factors.

In 1998, **unintentional injuries, homicides, and suicides** accounted for 76% of all deaths of adolescents (aged 10-24 years) in Louisiana. Death by firearm (intentional and unintentional deaths) was the leading cause of mortality in this age group. Firearm death has been the leading cause of death in this age group since 1989 when it surpassed motor vehicle crashes. The juvenile violent crime arrest rate was 485 per 100,000 in 1996 compared to 471 per 100,000 nationally.

There were 33 per 100,000 motor vehicle related deaths, 28 per 100,000 homicides, and 12 per 100,000 suicide deaths in 1998. In Orleans Parish, homicide rates are an alarming 287 per 100,000 for 15-24 year olds. It is estimated that 38.5% of all fatal motor vehicle crashes are alcohol related (NHTSA, 1999). In the 1997 Louisiana Youth Risk Behavior Survey (YRBS), 46% of students reported that during the 30 days preceding the survey they had ridden one or more times with a driver who had been drinking alcohol and 18% admitted that they had recently driven after drinking alcohol. The YRBS reported on other risky behaviors as well. Nine percent of students surveyed reported that they had recently carried a gun compared to 6% nationally and 22% said they had seriously considered attempting suicide in the preceding 12 months.

Risky sexual behaviors leading to **pregnancy and sexually transmitted diseases** are also a problem for Louisiana's youth. In 1998, there were 4,320 births to teen mothers, representing 18% of all births in the state. Adolescents (15-24 years old) have the highest rates of gonorrhea and chlamydia in the state. In 1999, 10.9% of 15-24 year old females screened in parish health unit family planning clinics were positive for chlamydia infection. Forty-two percent of reported cases of chlamydia were among 15-19 year olds. Seven percent of HIV-infected persons in Louisiana are 13-24 years old.

Among adults, **cardiovascular disease** is the leading cause of death in Louisiana. Tobacco use, physical inactivity, and poor dietary habits are all risk factors for heart disease, and are all behaviors initiated in youth. In Louisiana, 18% of high school students smoke regularly and 36% had smoked recently (YRBS, 1997). Tobacco is often the first drug used by adolescents who go on to use other drugs including alcohol and marijuana. Only 59% of students had engaged in physical activity at the level recommended by the Surgeon General and only 19% reported that they had recently eaten five or more servings of fruits and vegetables (YRBS, 1997).

The **provision of adolescent health care services** is fragmented. The MCH Adolescent School Health Initiative funds and provides technical assistance to 40 school-based health centers to provide comprehensive primary and preventive physical and mental health services. Through prevention and early intervention, the school-based health centers (SBHCs) strive to prevent and reduce the negative outcomes of teens' health-risk behaviors. Currently, 40,466 children, or approximately 5% of public school students, have access to a SBHC in Louisiana.

A school-based STD (chlamydia and gonorrhea) adolescent screening program has been in operation in the New

Orleans' Public High Schools since 1995 through funding from the Office of Public Health. In 1998-99, over 6,000 students in 12 high schools were screened. Out of the youth screened, 8.7% were infected with either chlamydia and/or gonorrhea. Among participating girls, 3.1% were currently pregnant and 16.7% were infected with chlamydia and gonorrhea. As in other years, the infection rates among girls was about twice as high as among boys. A higher percentage (9%) of youth who did not participate in after-school activities were infected than youth who did participate (5%). Lack of additional funding has prevented expansion of the program to other areas of the state.

The OPH Family Planning Program receives supplemental funding from Title V to contract with community-based organizations/clinics to provide comprehensive, adolescent-oriented services in addition to supporting teen services in the parish health units. Parish health units statewide provide maternity, family planning, and STD services to adolescents. Approximately 30% of the patients served by OPH's Family Planning Program are adolescents and can receive services in 93 clinics (parish health units and contract agencies) throughout the state.

Nutritional Health Status: Data from the 1998 population-based survey, Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS), was linked to weight gain data on the birth certificate to assess adequate weight gain during pregnancy. Approximately half of pregnant women are in the normal Body Mass Index (BMI) weight range for pre-pregnancy weight, 18% are in the underweight BMI range, and 31% are in the overweight BMI range for pre-pregnancy weight. Twenty-nine percent of pregnant women less than 19 years of age are underweight, compared to 15% of pregnant women over 19 years of age. Data from the Supplemental Nutrition Program for Women, Infants, and Children (WIC) Program for 1999, shows the same percentage of women in the underweight BMI range. The WIC data also shows that 18% of women participating in the program had anemia during their pregnancy.

Of the underweight women, 37% did not gain the minimum amount of recommended weight during pregnancy. Forty-seven percent of the underweight women less than 19 years of age did not gain the minimum amount of recommended weight during pregnancy as compared to 29% of underweight women age 20-29. Forty seven percent of underweight black women did not gain the minimum amount of recommended weight during pregnancy compared to 34% of underweight white women.

Pregnancy weight gain is a major influencing factor of fetal growth, infant birthweight, and length of gestation. Anemia and inadequate weight gain in pregnancy, particularly in underweight women, are associated with higher rates of prematurity and the delivery of low birthweight and small-for-gestational-age infants. The Institute of Medicine recommends that young adolescents and black women gain at the upper end of the ranges of recommended weight gain during pregnancy for women with similar weights for height. Underweight women are recommended to gain more weight and at a higher rate per week than normal weight women.

Adolescents and black women are at increased risk of delivering smaller infants than white women. Louisiana PRAMS data shows that teens have a higher rate of being underweight prior to pregnancy. This data indicates a need for nutrition services targeting weight gain in pregnancy among pregnant black women and adolescents who are underweight.

Nutrition related indicators of morbidity in children collected through the Pediatric Nutrition Surveillance System

on all WIC-enrolled children in 1999 showed that 11.6% are short for age, 2.3% are underweight, and 14.3% are anemic. This data also indicates that 9.1% of Louisiana's children 0-5 years old on WIC are over the 95th percentile weight for height, compared with 8.8% in 1998 and 8.9% in 1997. The 1997 Louisiana Youth Risk Behavior Survey found that 26% of children in grades 9-12 described themselves as slightly or very overweight, and 41% were trying to lose weight. Louisiana is following the national trend; childhood obesity is increasing. One in five children in the U.S. between the ages of 6 and 17 is overweight (NHANES III). Nutrition services play a vital role in the prevention and management of weight control.

Oral Health Status: Louisiana PRAMS data from 1998 shows that the percentage of women who had dental problems during pregnancy was 25.4%, and the percentage of women who went to see a dentist during pregnancy was 29.4%. The percentage of women who talked to a dental or other health care worker about dental care during pregnancy was 34.6%.

A study by the Oral Health Program, in which school nurses screened third grade children throughout the state, revealed that 38.1% of the children had untreated caries. The prevalence of dental sealants among the children was 22.1%, well below the national objective of 50%. Of the 1,435 children screened, 532 (37.07%) were referred for care, demonstrating a strong need for dental services. A study of Louisiana Medicaid claims data (1994-1996) showed that the prevalence of sealants for children ages 6-12 was 30%. Another study of Louisiana Medicaid claims data (1998-1999) showed that the total number of 6-9 year old Medicaid eligibles was 98,776, and the total number of this population receiving dental services from Medicaid during the year was 37,091 (37.5%).

A study of Louisiana Medicaid data by the Centers for Disease Control, published in the September 3, 1999 issue of the *Morbidity and Mortality Weekly Report*, showed that the average treatment costs for Medicaid-eligible children in non-fluoridated areas were twice as high as the average treatment costs for Medicaid-eligible children in fluoridated areas. The study also showed that Medicaid-eligible children in non-fluoridated areas were three times as likely as Medicaid-eligible children in fluoridated areas to receive dental treatment in a hospital operating room. Meanwhile, the number of water systems adjusting fluoride content decreased from 73 in 1986 to 45 in 1998, and the percentage of the state's population receiving optimally-fluoridated water decreased from 54% in 1986 to 49% in 1998. This trend is moving away from the national objective of 75% of the population receiving optimally-fluoridated water.

Data from the 1996 Behavioral Risk Factor Surveillance System (BRFSS) survey shows that the length of time since the last dental visit was greater than two years in about 30% of the cases. The main reasons for not visiting a dentist were 1) no reason to go - 51.0%, and 2) cost - 22.2%. The data also shows that 54.9% of those surveyed had no insurance coverage to pay for some or all routine dental care.

Children with Special Health Care Needs: Louisiana's indicators, such as the previously stated high number of children receiving SSI, suggest a disproportionate number of children with special health care needs. According to the U.S. Census Bureau (1990), Louisiana has the sixth highest (29.08%) prevalence in the nation of disabilities among children under 18. Due to the high rates of poverty and uninsured children, this finding is not unexpected. In addition, Louisiana has a significantly higher incidence of genetic disorders, such as Ushers' Syndrome, thought to have resulted from the state's unique cultural and geographic factors.

These statistics reflect an enormous need for services for children with special health care needs and a large underserved population. Rural areas of the state have virtually no access to pediatric subspecialists because of an insufficient number of providers and a lack of transportation. Increasing access to comprehensive, coordinated care is a major emphasis of the Children's Special Health Services Program.

Priority Health Problems:

A high infant mortality rate continues to be one of the major concerns of the Louisiana MCH Program. Reducing the numbers of preterm births, low birthweight babies, and SIDS deaths are priority needs that could influence infant mortality in Louisiana. There are areas of the state with particularly high late prenatal care entry, infant mortality, and low birthweight rates; the Baton Rouge and Shreveport regions have seen a continuous rise in infant mortality in past years. These areas, along with areas that have prominent racial disparities in these indicators, will be targeted. Women of reproductive age, pregnant women, and their providers need education about the influence of certain behaviors on morbidity and mortality. Public, professional, and patient education is needed to raise awareness preconceptually (folic acid, planned pregnancy, substance use), prenatally (substance use, entry to prenatal care, physical abuse, STD/HIV, adequate weight gain, nutrition) and postnatally (SIDS risk reduction, family planning, breastfeeding).

Inadequate access to comprehensive prenatal care is a top concern of the MCH Program. Certain areas of the state lack private prenatal care providers and high risk OB services. Local arrangements with prenatal care and transportation providers are needed in underserved areas. Assuring psychosocial risk assessment and case management components of prenatal care is crucial to meeting the social, emotional, and psychological needs of pregnant women, especially those at risk for poor birth outcomes. Access to care is also a priority health concern for children. Many children in Louisiana lack access to a medical home to provide quality, comprehensive, and continuous care. Also lacking are services that address children's social, emotional, and psychological needs. Improving the infrastructure and coordination of services for children and families would result in improved access and quality, and is a priority for the MCH Program.

Decreasing intentional and unintentional injury emerges as essential to improving rates of child and adolescent mortality and morbidity. Especially concerning are the areas of family violence and firearms. Other priority areas for adolescents include the need to reduce substance use and risky sexual behaviors in order to influence rates of teen pregnancy, sexually transmitted disease, and injuries. Nutrition counseling and education must be integrated into health services in order to influence infant and child morbidity and mortality, and the lack of access to nutrition services is a

problem. These services are especially needed to address the state's growing problem of obesity in children. Oral health related morbidity can be reduced by improving community water fluoridation, increasing access to dental services, including sealants, and enhancing surveillance activities in order to monitor oral health status.

Access to care for children with special health care needs is a priority that must be addressed on several levels. Eligibility criteria for the CSHS Program limits access to only very low income families, since the income criteria have not been revised since 1985. There are currently many families in the income range from 150%-200% of poverty, up to 400% of poverty, who lack health coverage or adequate health coverage for their special needs child. Rural areas of the state do not have pediatric subspecialists available, except for those whom the CSHS Program brings into their regional clinics. Transportation to clinic services is unavailable, and Medicaid transportation is severely limited. Transportation for highly specialized services, such as surgery, is even more critical, and yet even more inaccessible due to the long distances that families must travel to major pediatric treatment centers. Care coordination may help to address some of these needs; however, fundamental changes in program eligibility is needed to make a difference in health care for children with special health care needs.

Gaps in Health Services:

Although there is a publicly financed system of health services through the State-supported hospital system and the parish health units, the degree of coordination varies in different areas of the state. There is also an overall lack of coordination of services between the private and public sector. Although there are some local initiatives to improve access to health care for individuals in rural areas, much needs to be done to assure that a quality system of health care services that is coordinated and allows pregnant women, infants, children, adolescents, and their families access to quality, comprehensive, continuous care exists in all areas of the state.

Medicaid is one of the most common sources of coverage for prenatal care; however, parish health units and the system of State-supported hospitals continue to provide "safety net" services as the primary sources of care for maternity patients without Medicaid or other health insurance or in areas where there is a shortage of private health care providers. Lack of private physicians who accept Medicaid is a significant barrier throughout much of the state.

Medicaid expansions have helped to provide health coverage for many low income infants, children, and adolescents. Although there have been inroads into decreasing financial barriers through changes in the Medicaid Program and through the Louisiana Child Health Insurance Program (LaCHIP), access to child health care services remains a problem in many areas of the state, especially in rural areas. A lack of health care providers in general, as well as in the number of providers available to see Medicaid clients, creates a barrier.

Transportation is also a major barrier for pregnant women, children, and children with special health care needs. There are few publicly-supported transportation systems and Medicaid policies limit the distance that clients can be transported for services. Lack of transportation is the top reason for missed clinic appointments in parish health units (30% of patients cited transportation as the reason for missing an appointment) and two-thirds of regional and

community partners consulted cited transportation as a priority need. Transportation for treatment services such as surgery is a barrier for children with special health care needs, even when medical services are provided in the family's community.

The number of dentists who accept Medicaid patients is insufficient. Access for special needs children is especially inadequate, since the Dental Clinic for special needs' children in New Orleans has faced reduced funding, and rural areas in other parts of the state are completely unserved. Sealants, which are excellent preventive measures, need to be more widely utilized; sealant programs could reach the populations most susceptible to dental caries. Although fluoridation is the safest, most cost effective way to reduce caries prevalence, fluoridation is underutilized and is actually declining in Louisiana. Many water systems need to repair or replace outdated and broken equipment in order to fluoridate their water.

The existing services for adolescents are fragmented. Clinics serving adolescents often are not open during non-traditional hours; do not provide walk-in services; are not youth friendly; have services that are compartmentalized and not comprehensive (i.e, Sexually Transmitted Disease Clinic, Family Planning Clinic); and lack continuity with a consistent provider. There are major gaps in physical and mental health services for youth. These gaps include: inadequate prevention programs/out of school programs designed to bolster family support and to curtail risky behaviors; lack of outpatient mental health, substance abuse and social services for youth; lack of comprehensive health education in grades K through 12; lack of coordinated school health programs; and lack of residential treatment centers for emotionally disturbed, behaviorally disordered adolescents.

Enrollment in CSHS has declined due to outdated eligibility requirements. High levels of asthma and diabetes among children present a new gap in coordinated service delivery. CSHS tried unsuccessfully to expand CSHS eligibility criteria to cover these conditions.

3.1.2.2 Direct Health Care Services

See section 3.1.2.3 below.

3.1.2.3 Enabling Services

In 1998, Louisiana ranked lowest in the nation in terms of access to primary care, with 24.1% of state residents lacking such access. Most medical and other health care providers are located in the eight major urban areas.

In 1997, 56 of the state's 64 parishes had fewer than 10 primary care physicians per 10,000 population. Thirty parishes qualify as high or very high Health Professional Shortage Areas with an additional 15 sub-areas also qualifying. Twenty-five parishes qualify as a Health Professional Shortage Areas for Mental Health Providers and 14 parishes qualify for Dental Providers with 6 additional Dental sub-areas.

Louisiana has 25 nutritionists providing services to all public health patients. WIC patients (including pregnant women, infants, and children) visiting the health units for services in 1998 had limited access to a nutritionist. Of those patients who were high risk and required nutrition counseling, only 32.7% had access to a

nutritionist. The number of Office of Public Health nutritionist positions is limited, and vacancies can't be filled due to the current State hiring freeze. Patients coming in for WIC services reported they would like to see more nutritional classes and weight management services for adults offered at the parish health units.

Pregnant Women

As stated earlier, providing early prenatal care is a top concern of the MCH Program; early prenatal care can identify and address risk factors for poor birth outcomes. In 1998, 89.2% of white women and 71.8% of black women entered prenatal care in the first trimester. Many areas in the state continue to lack private prenatal care services for women in need. Regions three, four, five, six, seven, and eight report shortages of private prenatal care providers and/or high risk OB services. In this year's community-based needs assessment, 58% of the parishes statewide expressed early prenatal care as a top need for the MCH population.

Financial Access

The availability of pregnancy testing and prenatal care at no or low cost is a crucial component to assuring early entry into prenatal care. According to Louisiana's PRAMS survey, 23% of women reported that their household income during the 12 months prior to their delivery was less than \$8,000 a year.

Office of Public Health parish health units and the State-supported regional hospitals provide pregnancy testing and prenatal care services without regard to ability to pay or Medicaid status. The adoption of OBRA 1989, which included increased eligibility criteria (pregnant women are eligible for Medicaid benefits if their family incomes are below 133% of the Federal Poverty Level), and OBRA 1990, which increased reimbursement rate to providers, resulted in a shift in the provision of maternity care from the public sector to the private sector. The percentage of births in the State hospital system has dropped from 32% in 1988 to 18.3% in 1998. Regardless of method of payment, women in PRAMS most often report that a private doctor's office is the source of their prenatal care (59% for those on Medicaid and 88% for those with private insurance). According to the State Medicaid Program, approximately 48% of deliveries in 1999 were paid for by Medicaid, compared with 40% in 1998 and 53% in 1997. Fifty percent of women in Louisiana's PRAMS survey reported that their deliveries were paid for by Medicaid, and the most commonly reported sources of payment for prenatal care in 1998 were Medicaid (49%) and private insurance (45%).

Despite this broad participation of pregnant women in the Medicaid Program, parish health units continue to serve approximately 45,000 women statewide primarily for WIC services, prenatal education, and pregnancy testing. Parish health units often initiate prenatal care for women, providing presumptive eligibility determinations for Medicaid. Many women then continue their care in the private sector. At the present time, there is no system to monitor the timeliness and appropriateness of care for these private sector patients. Parish health units and the system of State-supported hospitals continue to provide "safety net" services as the primary sources of care for maternity

patients without Medicaid or other health insurance or in areas where there is a shortage of private health care providers. In 1998, health units provided comprehensive prenatal visits to over 9,000 maternity patients. Lack of private physicians who accept Medicaid is a significant barrier throughout much of the state; in a regional survey conducted by MCH, parishes in five of nine regions report serious shortages of private prenatal care providers. Parish health units must also provide care in areas where transportation to private providers is prohibitive; private providers will not accept presumptive eligibility; and private providers may not accept patients until they are at a certain stage in their pregnancy. Medicaid funding for transportation for Medicaid clients has decreased significantly in the past several years, and six of nine regions report that transportation significantly hampers access to prenatal care.

Louisiana's current Medicaid managed care program, Community CARE, is a fee-for-service program that utilizes the primary care physician case manager model and operates in 20 largely rural parishes. The State Medicaid Agency released a shortened application form for pregnant women in May 2000. The new form eliminates the need for a face to face interview, allowing pregnant women to mail in their own applications. The streamlined process is expected to reduce Medicaid's administration and allow for faster processing and certification. The new form can be used in outreach to pregnant women as well, to encourage them to apply on their own.

Availability

A distinct shortage of women's care specialists is present throughout the state. Twenty-six parishes are without a practicing OB/GYN, and even in urban parishes, many OB/GYN providers do not accept Medicaid. Louisiana ranks last in the nation for utilization of Certified Nurse-Midwives and 47th in the nation for utilization of Nurse Practitioners and Physician Assistants. The shortage of primary care providers in many areas, especially non-urban locales, could be addressed by exploring utilization of other practitioners trained in delivery of primary care services.

Parish health units in 105 locations and regional State-supported hospitals provide safety net services for pregnant women who are uninsured or who live in areas of the state with insufficient prenatal care providers. Contract maternity clinics exist in high risk neighborhoods in Orleans Parish. Parish health units in all other regions of the state, except for regions two and six, provide prenatal care in parishes where access is poor. Many have arrangements, formal and informal, with private providers to provide prenatal care for patients once they become Medicaid eligible. There are often too few private providers in a parish who will accept Medicaid, and patients must be followed by the parish health unit. Another problem results when private providers do not accept women who are presumptively eligible for Medicaid until they receive their actual Medicaid card, as is the case with the providers in region six. This can result in a delay in the receipt of prenatal care, since Medicaid has 45 days to issue the permanent card. The streamlined application process for Medicaid, described above, is expected to shorten processing time and begin to alleviate this problem. Delivery services and high risk OB services are often located 40 or more miles away, and transportation is a major barrier to care, as is the case in many parishes in regions three, five, six, seven, and eight. Washington and Tangipahoa parishes in region nine also report transportation barriers. Of the parishes that completed the

Environmental Scan survey, 31% report inadequate high risk prenatal care and delivery services in their areas.

In addition to direct medical services for pregnant women, there is a need for additional health and social services to enhance and assure that needed services are received. This is especially true for pregnant women who are at high risk for social and emotional as well as medical problems. Needs include smoking cessation, substance abuse treatment services, psychosocial risk assessment, and nutrition counseling and education. Although a regional system of nutritionists and social workers exists through OPH to provide some of these services, provision of services at the local level are limited by staff availability. Teams of nurse home visitors in 12 parishes provide nurse home visiting services to first time, low income mothers. Nurses work with mothers, beginning prenatally until the baby's second birthday, to improve health and social functioning. The nurses home visit weekly to bi-weekly, and work intensely with families to improve women's health behaviors, family caregiving for the child, and maternal life-course development.

Infants and Children

While access to comprehensive, community-based, culturally-sensitive, and continuous care (i.e., a medical home) for all children is a goal, a medical home has remained out of reach for most of Louisiana's low-income children. Access to health care has largely utilized measures which are indirect indicators of difficulties in obtaining health care. Levels of participant and screening ratios for EPSDT populations reflect access to preventive services for low-income infants, children, and adolescents. Additionally, the numbers of uninsured children can be used. Although the current participant ratios for EPSDT are high at 90%, the screening ratio for infants at 37% indicates the need for improvement in this area. Since childhood immunizations are an integral part of preventive services in children, the immunization rate can be used as an indirect indicator of receipt of preventive health care services. The immunization rate for 2-year olds of 81% has seen an overall increase over the past few years with the development of the Shots for Tots initiative. However, the rate remains below the national goal of 90%, and actually decreased from 82% to 81% in 1999. Factors that influence access to a medical home for infants and children include financial access and availability of providers and other needed services.

Financial Access

Louisiana has had the highest child poverty rate and one of the highest rates of uninsured children in the nation. In 1999, approximately 17% of the state's population were enrolled in the Medicaid Program. Beginning in 1989, Federal legislation was enacted to decrease the financial barriers to health care for low-income children. OBRA 89 expanded Medicaid benefits to all low-income children and the 1997 State Child Health Insurance Program (SCHIP) increased the availability of health care coverage for uninsured children up to 200% of Federal Poverty Level. Louisiana's Child Health Insurance Program (LaCHIP) expanded Medicaid eligibility to 133% of Federal Poverty Level to age 19 years in November 1998, and then to 150% beginning in November 1999. As a result of the expanded eligibility and programmatic changes to facilitate enrollment, there was an increase in the enrollment in both the

LaCHIP program and the regular Medicaid program. The first year of LaCHIP operation resulted in a total LaCHIP/Medicaid enrollment of approximately 60,000 children (27,725 LaCHIP children and approximately 32,000 regular Medicaid children.) In 1998, the percentage of uninsured children dropped to 18.3% from 22.9% in 1997.

The MCH Program provides child health services through the network of parish health units statewide which serves as a “safety net” for low income populations who lack financial access or who live in areas where there are no available providers. Parish health units charge an administrative fee for immunization services and will begin on July 1, 2000, to charge a fee for MCH services for non-Medicaid eligible families above 100% FPL. Approximately 46% of children over age 1 attending the parish health units for services are uninsured or underinsured. The public health units have been part of an aggressive outreach effort to enroll all eligible children in LaCHIP, and the rise in the percentage uninsured seen at the health units from 40% is possibly due to the fact that more low income children are enrolled in Medicaid/LaCHIP and seeking care in the private sector.

There is a great need for improved funding of mental health services for children. Medicaid covers inpatient services; however, funding for outpatient services, which are often more preventative in nature and frequently preferable for young children for whom admission can be traumatic, is almost non-existent.

The 1996 BRFSS survey shows that 54.9% of the patients surveyed had no dental insurance to pay for part or all of their routine dental care. The survey also showed that cost was a major barrier to obtaining dental care. Although Medicaid and LaCHIP cover dental services, many families report difficulty finding a dental provider who will accept new Medicaid patients at the current Medicaid dental provider reimbursement rates.

Availability

Certain areas of the state remain without private pediatric providers - 20 parishes have no licensed pediatricians registered with an address in that parish and 13 parishes have only one registered pediatrician. The situation is worse for Medicaid providers. Many areas have a limited number of physicians who accept Medicaid, and many who do accept Medicaid limit the numbers of Medicaid patients that they will accept. Thus, the total number of Medicaid providers does not provide a true picture of the actual number of providers currently accepting new Medicaid clients. Additionally, recent cutbacks in the Medicaid and EPSDT fees due to a State budget shortfall has created concern regarding a further decrease in the number of Medicaid and EPSDT providers. A recent (May 2000) survey of Medicaid Providers in Orleans Parish showed that 70% of the responding pediatricians (response rate 43 out of 60 contacted, or 72%), 66% of the responding Family and General Practitioners (response rate 47 out of 74 contacted, or 64%), and 75% of the responding dentists (response rate 13 of 20 contacted, or 57%) were accepting new patients.

OPH parish health units in 63 of the 64 parishes and nine State-supported hospitals have continued to provide “safety net” services as the primary source of no or low cost preventive and primary care services for low-income uninsured children, especially in areas where there is a shortage of health care providers. A Hospital Nurse Coordinator, who is an OPH employee, is housed in each of the State-supported hospitals and assists in transferring information

between the hospital and health unit. However, parish health units have also been affected by the recent State budget shortfall, and capacity for direct care services in some areas of the state has been reduced. Welfare reform, with its concomitant work requirements for families, has also affected the ability of families to receive services that are delivered in the State-supported system with its traditional work hours.

Other providers of care for low-income children and families include school boards, FQHCs, and rural health clinics in some areas. Children with identified health problems are referred by parish health units to local practitioners of the patient's choice, the nearest State-supported hospital, or the OPH Children's Special Health Services Program, which provides speciality services for children who qualify for the program. (See Appendix C for locations of public health units and State-supported hospitals.)

Although there has been a significant increase in number and frequency of genetics clinics, the number of patients referred represent a small percentage of the projected number of individuals affected. Records indicate that only 11% of infants affected by a genetics condition were seen by a geneticist.

The multiplicity of public providers in addition to private providers, and the movement on and off Medicaid, leads to a lack of continuous care and fragmentation of services. This is further complicated by the fee-for-service payment system for Medicaid through most of the state which allows clients to receive acute care services from multiple providers. Medicaid's Community Care Program provides primary care case management for Medicaid recipients in just 20 of the state's 64 parishes.

The lack of local providers in communities has made transportation a barrier to services for many. Transportation for health care services is listed as a need for children and families in many areas of the state particularly in the largely rural areas. Changes in the transportation program for Medicaid enrollees has decreased accessibility for many, due to a policy of transporting clients to the closest provider although that provider may not be able to meet the needs of the individual client.

In addition to direct medical services for infants and children, there is a need for additional medical and social services to enhance and assure that needed services are received. This is especially true for infants and children who are high risk for social and emotional as well as medical problems. The OPH regional system of direct health services includes nutritionists and social workers, in addition to nursing and medical personnel. Local public health staff are able to provide health education, home visiting, and care coordination services for high-risk infants and children seen in their clinics. Regional nutrition and social work staff assist the local nursing and medical staff in the care of high risk clients. However, provision of services at the local level is affected by staff availability. For example, a mere twenty-five nutritionists and twenty-nine social workers provide services statewide.

A declining number of Medicaid dental providers is resulting in a lack of access to dental services for low income populations in the state. While more children are on Medicaid and LaCHIP, the demand on the state's limited number of dental care providers is intensified. This leads to longer waiting times for eligible patients and can lead to a worsening of dental disease before it can be treated. Of the parishes that completed the Environmental Scan

survey, 35% report poor accessibility of dental services in their parishes.

Adolescents

Financial Access

Because school-based health centers (SBHCs) are located in areas of socioeconomic need, (at least 50% of student population is on the free/reduced lunch program), no fee schedules for SBHCs have been established to date. However, each center is required to become a Medicaid provider and collect Medicaid revenue to help support clinic operation. There have been several barriers to collecting Medicaid reimbursement, including the fact that many services provided by the centers are not reimbursable. Centers are also required to become official LaCHIP Application Centers. All centers distribute applications and assist families in completing the application forms. They collect verification documentation and send in applications to Medicaid. Numbers of LaCHIP applications sent in from SBHCs have been low; although centers are good at promoting the program and distributing the applications, they often lack the staff necessary to follow up on individual applications.

Although LaCHIP has increased the number of adolescents eligible for Medicaid from 10% of poverty to 150% of poverty, there are still many barriers that prevent adolescents from both enrolling in Medicaid/LaCHIP and accessing the needed primary and preventive services. Many adolescents remain unenrolled because their families are not aware of the program especially in rural areas, mistakenly believe that they earn too much to qualify or that working families are ineligible, or distrust Medicaid and the enrollment process. In addition, thousands who are currently enrolled are in jeopardy of termination because their families have not submitted the re-certification form after 12 months, as is required by Medicaid.

The barriers to accessing care even for those with insurance include: lack of public transportation; an inability of working parents to take time off of work for doctor visits; and lack of providers in the community. In a study published in the *Journal of the American Medical Association* (December, 1999), reasons adolescents gave for not seeking care included thinking the problem would go away, fear about what the doctor would do or say, inability to pay, concerns about confidentiality, inability to get a parent or guardian to accompany them to get care, and difficulty making an appointment.

Availability

Fluctuations in Medicaid provider reimbursement rates have caused an already small pool of providers who accept Medicaid/LaCHIP patients to decrease even further. In addition, many pediatricians do not want to see adolescent patients and many internists are not willing to see them either. There are currently only 15 known Adolescent Medicine Specialists in the state. Prescriptive authority for advanced practice registered nurses has somewhat helped the problem of provider shortage in Louisiana, particularly for rural areas.

There is a lack of mental health services and alcohol and drug abuse counseling available to adolescents throughout the state. The Office of Addictive Disorders provides only limited alcohol and drug abuse services. The

Office of Mental Health treats only the most severely disturbed children. Many primary care providers, because of inadequate reimbursement and time constraints, are unable to provide adequate anticipatory guidance/preventive health education to youth. A study in the *Journal of Pediatrics* found that nearly one-half of adolescent office visits did not include counseling or education and a mere 3% of teens actually received counseling on important issues for adolescents such as smoking cessation, sexually transmitted diseases, and weight control. The availability of inpatient treatment centers is also diminishing; a State operated inpatient mental health facility in New Orleans may be closing due to lack of funding. Forty-two percent of the regional OPH staff and their community partners who provided feedback for this needs assessment mentioned the need for substance abuse prevention and treatment for teens, as well as the need for smoking cessation programs.

SBHCs are one avenue that OPH has used to provide direct services to adolescents who are affected by barriers to care as previously discussed. Nearly 20% of the regional OPH staff and their community partners who provided feedback for this needs assessment reported that increasing the number of SBHCs should be a top priority. The centers are located in communities where there is a demonstrated socioeconomic need and lack of access to care. Located on the school campus and in operation during school hours, the 40 SBHCs in 68 schools are convenient for students. SBHCs assure comprehensive services for youth through referral agreements with community providers. SBHCs are required to have this referral network of providers in place, including specialty care providers, when these services can not be provided on site.

Much work remains to be done in Louisiana to bring services to adolescents. Patient level outreach is needed to both enroll adolescents in Medicaid/LaCHIP and to assure that adolescents receive necessary services and health education. Innovative approaches are needed in order to reach this difficult to reach population, and involving teens in the process is one way to do this. In Teens Talk 2000, a series of focus groups conducted by OPH, teen centers designed by adolescents for adolescents was a consistent recommendation made by teens.

Children with Special Health Care Needs

Financial Access

Because of the high child poverty rate, the high rates of uninsured children, and the high rates of children with disabilities in Louisiana, children with special health care needs have greater than average barriers to getting their financial needs met for health care. On the CSHS Parent Survey, only 54% of the respondents indicated that their child's insurance or Medicaid paid for all of their health costs. It is well known that families of CSHCN pay more out of pocket health expenses than families of children who do not have special needs, but in Louisiana, with the high rates of uninsured children, basic medical coverage is lacking for many families who need it.

The CSHS Program provides subspecialty medical care in its nine regional clinics for families who meet financial and medical eligibility. The financial eligibility has not been changed in fifteen years, and because of these limitations in eligibility, fewer and fewer families are able to access the clinic services. The CSHS Program tried to

address this problem by raising its financial eligibility and making more families eligible for CSHS medical services, but this was unsuccessful due to severe State budget problems. There are currently many families of CSHCN who have incomes in the 200%-400% of poverty range and have no health insurance. These families currently utilize the public system of health care, including the OPH parish health units and the State-supported hospital system. These services do not provide coordinated, comprehensive care for CSHCN.

Availability

Pediatric subspecialists are centered in the major metropolitan areas of the state, especially around New Orleans and to a lesser degree, Shreveport where there are medical schools, children's hospitals, and leading medical institutions. (See Table 4, Appendix B for the number of pediatric specialists as reported to the Medical Society.) There are many areas of the state without access to appropriate physicians, and without the CSHS clinics to bring these subspecialists to the area, there would be no availability. The fluctuations in Medicaid reimbursement rates will only further exacerbate this lack of providers when subspecialists decline to accept Medicaid. The CSHS clinics bring the services to the local areas so that families may receive services as close to their home as possible. Unfortunately, due to the limited eligibility for CSHS, fewer families are able to access the services.

In addition, availability of services is significantly affected by transportation problems. Having access to transportation was one of the top ten needs for the CSHS patient population as reflected in the Parent Survey. Since only the families who were attending CSHS clinics were surveyed, an even greater need is expected among families who were unable to get to the clinic. Transportation to specialized services, especially surgery, is a continuing unmet need. Many times, the CSHS Program is asked to fund transportation for children requiring transportation from rural areas to the major medical centers because Medicaid transportation is not available across parish lines or for long distances. This limits access to services and drives State costs up. CSHS has begun to document each instance where Medicaid transportation is denied to eligible patients and has close communication with Medicaid transportation and KIDMED to attempt to arrange for services when needed.

Although Special Needs children can receive services at the Special Children's Dental Clinic at Children's Hospital in New Orleans, more access is needed for those patients who live outside the New Orleans area. There has also been a reduction in the funding of the contract for the Dental Clinic. Although many Special Needs children are Medicaid eligible, the decline in the number of Medicaid dentists makes it more difficult for these children to find care. Many general dentists are not trained or equipped to treat special needs children. There is a lack of dentists who can treat special needs children, especially outside the New Orleans area. The CSHS Program attempted to expand services to the Alexandria area of the state (region six); however, the limited number of trained dentists to provide services in the area was a barrier.

Other prominent needs expressed by CSHS parents are related to emotional and social support services such as support groups, respite care, counseling, psychiatric services, and child care. Mental health services for children are not available except for the most critical individuals. CSHS has begun a dialogue with the Office of Mental Health

to try to address some of the fundamental needs of families of CSHCN in this area. CSHS provides parent support with paid Parent Liaisons who attend over 95% of the CSHS clinics throughout the state. The Parent Liaisons provide resources and emotional support to families whom they can easily relate to emotionally.

3.1.2.4 Population-Based Services

Preventative interventions that are available for the entire MCH population are an important component of the

Louisiana MCH Program. Population-based services are those that are available for an entire population, rather than for an individual in a one-to-one situation, and are integral for a comprehensive approach to addressing the needs of the MCH population in the state.

Pregnant Women

Prenatal Care

There are racial disparities between white and black entry into prenatal care in Louisiana. In 1998, 89.2% of white women entered prenatal care in the first trimester compared to 71.8% of black women. The community-based needs assessment conducted this year resulted in 58% of the parishes stating the need for early prenatal care. In order to reduce this disparity and increase the number of women overall who initiate prenatal care in the first trimester, MCH funds the *Partners for Healthy Babies* project. This project is a multi-media, multi channel outreach effort geared towards pregnant women statewide. The main messages of the program encourage prenatal care and healthy behaviors during pregnancy. The project is administered out of the MCH office, and includes a contract with an advertising agency to spearhead many of the media and public relations activities. Media message development and testing target the African American population in order to address the racial disparity in seeking early prenatal care.

A central component of the program is the statewide Title V toll free helpline, which links women and their families to services throughout the state. This helpline is managed through a contract with another state program, the Louisiana State Planning Council on Developmental Disabilities, which houses DIAL (Disability Information and Access Line). DIAL handles the *Partners for Healthy Babies* helpline. An answering service is in place to handle overflow, weekend and evening calls, in order to assure 24-hour coverage of the helpline.

Messages and efforts are targeted primarily to pregnant women in the state. The project also reaches out to other agencies and service providers to assist in assuring coordinated efforts. Agencies such as Head Start, Healthy Start projects, the parish health units, the March of Dimes etc. assist in dissemination of *Partners* materials, and messages.

Community outreach is a valuable channel of communication that supports media efforts. Due to limited staffing/funding, the project is only able to become involved in and maintain outreach activities in the New Orleans area, and then, only when student interns are available. Statewide expansion of such efforts would be beneficial.

Through a relationship with Tulane University School of Public Health and Tropical Medicine, many student interns assist with project implementation (community outreach), monitoring, and evaluation of project efforts.

The project is funded by Title V and the WIC program.

Perinatal HIV Transmission

In 1999, approximately 2,850 women were living with HIV in Louisiana and accounted for 30% of new HIV/AIDS cases in the state. HIV/AIDS case rates were 4 per 100,000 for white females and 44 per 100,000 for African American females. Of all the women with HIV, 79% were of childbearing age. Data from Louisiana's Pregnancy Risk Assessment Monitoring System (PRAMS) showed that in 1998, 83% of women's providers discussed HIV testing with them and 54% discussed HIV prevention methods. In 1997, the CDC funded Surveillance to Evaluation Prevention Perinatal Transmission Study showed that only two-thirds of HIV infected women in Louisiana completed the AZT perinatal prophylaxis regimen for the prevention of perinatal HIV transmission.

MCH partners with the FACES (Family, Advocacy, Care and Education Services) program of Children's Hospital to address the reduction of perinatal HIV transmission. The educational efforts are targeted to two distinct populations 1) women of childbearing age who may be at risk for HIV infection, and 2) their primary care providers. At this time, the efforts for both of these populations are limited to the Baton Rouge and New Orleans areas, which have the highest numbers of HIV/AIDS cases. Though some components of the project's efforts target population groups of the entire state (i.e mailings to physicians), expansion of the project into all regions of the state, including Monroe and Shreveport, needs to be considered. As part of these efforts, a Coordinated Care Committee has been established and meets regularly. The members of the committee include agencies and other State programs that are addressing HIV and/or perinatal issues.

Funding for this project is through Title V monies. The FACES program also receives direct funding through Ryan White Title IV.

Perinatal Substance Abuse

The 1998 PRAMS data shows that 14.2% of Louisiana women smoked and 4.9% drank alcohol during pregnancy. Three times more white women smoked during pregnancy than black women. Women over age 30 drank alcohol at over four times the rate of women under age 30. Fifty-six percent of the parishes' community-based needs assessment results stated that substance abuse prevention and treatment services were needed.

To address the need for substance abuse prevention services, MCH maintains a clearinghouse of substance abuse prevention resources and materials (including audiovisual and print) for statewide distribution. A statewide network of Prenatal Substance Abuse coordinators provides counseling, education, and referral for substance abuse services at parish health units. MCH has a collaborative agreement with the Office of Addictive Disorders (OAD) to offer pregnancy testing to women who visit OAD substance abuse facilities. Currently, six of the ten regions are enrolled in this effort. Full statewide participation is slated for the year 2002.

Folic Acid

A representative from the MCH Program chairs the statewide Folic Acid Council, and a representative from the CSHS Program participates on the council. The council is in its formative and development stages, yet intends to function to encourage, support, and implement statewide education and outreach efforts. A small stipend to support the council has been received from the National March of Dimes.

Physical Abuse

The 1998 PRAMS data showed that 9% of the women surveyed experienced physical abuse prior to pregnancy and 7% experienced physical abuse during pregnancy. Twenty-nine percent of the women surveyed stated that their provider discussed physical abuse with them. MCH will continue to supply safety cards to each parish health unit in the state. These safety cards provide information about domestic violence and region specific shelters and other related resources.

Infants and Children

Many population-based activities for infants and children, such as newborn screening, immunization, and lead screening, are at the core of public health efforts to address child health. There is great opportunity to use population-based activities for influencing specific outcomes, such as SIDS, unintentional injuries, and health coverage.

Newborn Genetic Screening

The Office of Public Health is responsible for oversight of newborn screening efforts in the state. Current estimates indicate that 88% of newborns are screened for PKU, congenital hypothyroidism, and sickle cell diseases by the State Laboratory. There are two private labs that also participate. The State Newborn Screening Program needs to continue to improve on the capacity to compare State Laboratory data with birth certificate data. An amendment to the Newborn Screening Rule requiring that all results be reported by the two private labs will move the program closer to accomplishing the goal of assuring that all newborns are screened.

Newborn Hearing Screening

The Hearing, Speech, and Vision Program is responsible for the development and implementation of the law pertaining to the identification of hearing impairment in infants. Thirty-two of 73 birthing hospitals provide universal screening, covering approximately 49% of the births in the state. In 1999, legislation was passed mandating universal newborn hearing screening, which will greatly assist the need to expand newborn hearing screening. Data accuracy and linkages with other State databases, such as vital records and genetics screening, are a major priority. Establishing systems of care for deaf and hard of hearing infants and their families are a continuing need addressed by the State

Advisory Council and regional task forces. The Hearing, Speech, and Vision Program was recently awarded a MCH grant to address systems building for newborn hearing screening in Louisiana.

SIDS

The MCH Program oversees and funds the statewide SIDS Counseling and Risk Reduction Program. Education and counseling is provided by local public health nurses and/or social workers to families who have lost an infant to SIDS. Although there has been a decrease in the number of deaths due to SIDS, the mortality rate for SIDS in Louisiana remains approximately twice the national rate and the rate for black infants remains twice that for white infants. Public and professional education on risk factors for SIDS, especially for low-income, minority populations, needs to be increased to further decrease mortality from SIDS.

Lead Screening

The Louisiana Childhood Lead Poisoning Prevention Program (LACLPP) in the Office of Public Health oversees the lead screening program in the parish health units, and conducts follow-up of those children identified as lead poisoned. Results of lead screening in these children indicate that there are large numbers of children with lead levels greater than 10 ug/dl. This is particularly true for certain areas of the state, such as New Orleans. Data on lead poisoning for children screened through public health units in the state during 1999 showed that 12.8% had an initial lead level of 10mg/dl or greater and 4.9% were 15ug/dl or higher. However, information on children screened in the private sector or through other providers is not included in the database. Through a Childhood Lead Poisoning and Prevention Grant from the Centers for Disease Control, OPH is developing a system for collecting population-based data for lead levels in children. This surveillance system will be used to determine high risk populations in the state and to develop a targeted screening plan to assure screening for all those at risk with the most efficient use of available resources. LACLPP works with other agencies and organizations with an interest in childhood lead poisoning such as the Department of Environmental Quality and the Tulane School of Public Health, Center for Applied Environmental Health.

Immunization

The Office of Public Health Immunization Program is responsible for oversight of immunization efforts in the state, and the MCH Program works closely with the Immunization Program in their efforts. Immunization rates for children at age two seen through the parish health units has increased overall in the past few years, but still remains low at 81% with an actual decrease from 82% the previous year. Immunization rates vary from parish to parish. The Shots For Tots campaign, conducted by the Immunization Program, coordinates local initiatives to increase immunization levels and needs to continue efforts in the areas of public education and service offerings to increase these rates.

Medicaid/LaCHIP Outreach

Although aggressive outreach efforts have been successful in decreasing the number of uninsured children in Louisiana, 18% still remain without health coverage. OPH has been active in screening all eligible children coming into the parish health units for Medicaid under Titles XIX and XXI. There is a need for continued outreach efforts by the Medicaid Program to enroll all eligible children, especially adolescents and limited English proficient populations. MCH is currently a recipient of a Robert Wood Johnson Foundation outreach grant and is working closely with the Medicaid Program on outreach efforts for Medicaid and CHIP.

Unintentional and Intentional Injury

The preventability of the major causes of mortality and morbidity in infants and children indicate the need for continued initiatives to provide information and education to the public. The impact of unintentional injury as the leading cause of death in children from 1 to 21 years of age reinforces the need for continued efforts to provide information to families. Public education campaigns and other initiatives need to be continued and expanded to focus community-based efforts on decreasing injury deaths. Child deaths due to intentional injury and the number of child abuse and neglect cases indicate the need to sustain statewide child abuse prevention education, as well as the need to increase efforts in the areas of parenting education and resources.

Since 1991, violence has been recognized as a leading public health problem in Louisiana. The Injury Research and Prevention Section of the Louisiana Office of Public Health established a violence prevention program coordinator. Over the last nine years, the violence prevention program coordinator has provided technical support to community-based alliances through a number of mechanisms. The program facilitated multi-agency task forces, provided statistics on the burden of violence, disseminated information on promising programs to reduce violence, conducted training in violence prevention programs, and published a directory of violence prevention and victim support programs. Services and programs are available and distributed statewide; however, the New Orleans metropolitan area is the primary recipient of these services. Louisiana's SAFE KIDS Coalition is a cooperative venture between OPH and Children's Hospital in New Orleans. The MCH Program funds the State SAFE KIDS Coordinator, who is housed in OPH's Injury Prevention and Research Program. This comprehensive public information injury prevention program organizes local chapters throughout the state, distributes newsletters and pamphlets, conducts special events, and participates in health fairs. Interventions address car, gun and fire safety, child-proofing homes, bicycle helmet use, and sports injury prevention. A public information campaign for the prevention of child abuse and neglect is supported by the MCH Program in collaboration with Prevent Child Abuse Louisiana (PCAL).

Nutrition Outreach

The Pediatric Nutrition Surveillance Survey is collected on patients 0-5 years of age who are served in the parish health units for WIC services. Information is collected on the nutritional and health status of approximately 100,000 children each year and this information is submitted to the CDC. Reports are sent back to the State and then

distributed to the regional nutritionists to follow up with high risk children. In this way, this surveillance system is used to initiate outreach to improve the delivery of preventive and high risk services to patients and to identify problems areas in the state.

Through a collaborative effort, nutrition education cards are distributed by Louisiana State University Cooperative Extension Services nutritionists statewide to Food Stamp recipients. More population-based activities such as this one could be used to educate the public about the importance of good nutrition.

Oral Health

The national goal for the proportion of children who have at least one sealant in place is 50%. Studies in Louisiana have shown sealant prevalence rates of 30% and 22%. Ongoing oral health screening programs need to be in place to monitor the oral health status of the children in the state. Public information and education materials are needed to promote oral health activities. The population-based activities which are being emphasized by the Oral Health Program at this time are fluoridation, PANDA, sealants, and screening trainings.

Fluoridation

Although fluoridation has been proven to be the most cost-effective and safest way to reduce caries prevalence, fluoridation in Louisiana is underutilized and is actually declining. MCH's Oral Health Program coordinates a Fluoridation Advisory Board, providing administrative support and materials for Board members and for water systems managers. The Oral Health Program works with the Fluoridation Advisory Board to get fluoridation information out to the water systems statewide that have been targeted for fluoridation. The Louisiana Rural Water Association has agreed to evaluate the targeted systems and develop cost estimates for fluoridating the systems. Information on community water fluoridation is available from Fluoridation Advisory Board regional representatives; these regional representatives cover the nine Louisiana Dental Association regions of the state and help get information out to water systems statewide. MCH will hire a Fluoridation Specialist in the near future to administer the fluoridation program and provide assistance and expertise for the Advisory Board.

PANDA (Preventing Abuse and Neglect Through Dental Awareness)

There are 35 validated cases of child abuse and neglect every day in Louisiana, and population-based activities can help to raise awareness of this problem. Through the PANDA program, MCH trains dental providers on how to recognize child abuse and neglect in their patients. MCH provides handouts to all dentists and hygienists in the state which show what to look for in child abuse and neglect and how to report it. MCH coordinates a PANDA coalition, whose members will help to provide future training sessions for dental providers. PANDA "train the trainer" sessions are also available to anyone who wishes to become a PANDA trainer. These trainers then go to various areas throughout the state to provide training for dental providers. The Louisiana Dental Association and the Louisiana

Dental Hygienist Association will mail PANDA pamphlets to their members, and the Louisiana Dental Association Alliance has provided funding for the printing of the pamphlets.

Sealants

Previous screenings conducted by school nurses revealed that only 22% of Louisiana third grade schoolchildren had dental sealants - well below the national objective of 50%. Sealants are excellent preventive measures, and population-based efforts to supply them should be considered. MCH has contracted with the David Raines Community Health Center (DRCHC) in a collaborative effort to provide dental sealants to children in 10 schools in the Shreveport area. MCH provided portable dental equipment which will be used at the various school sites by DRCHC dental staff. DRCHC will provide the dental professional staff to provide sealants to the children and will provide materials and supplies. The superintendents and principals of the schools and the School Board were involved in providing access to the schools and in granting approval of the program. This will be a pilot program which will be considered for replication in other areas of the state in conjunction with other community health centers or school-based health clinics.

Screening Trainings

Previous screenings conducted by school nurses have demonstrated a need for dental services - 38% of the children seen had untreated caries. Screening is a population-based activity that can identify problems and refer children for dental services. MCH's Oral Health Program works closely with the Louisiana School Nurses Association to instruct nurses on how to conduct oral health screenings on children. MCH provides "train the trainer" sessions and makes presentations at annual school nurses meetings, supplying manuals and materials for the nurses. Screening training is available to any school health nurses who want the training. They in turn perform screenings in their respective schools throughout the state. MCH provides the training materials and staff to hold training sessions, and the school health nurses volunteer their time to attend the training sessions and to provide the screenings in their schools.

Adolescents

The extent of, need for, and benefit of public awareness campaigns that target youth and that focus on risk behavior prevention need to be further explored. One specific area where population-based activities are needed is in the promotion of health coverage. Youth and their families need more information on LaCHIP and its benefits. At present, there is no state funded public awareness campaign regarding LaCHIP. Access to medical and dental care is an important need among adolescents, but adolescent enrollment in LaCHIP remains very low. This is in part due to lack of information and public awareness regarding LaCHIP. A public awareness campaign targeting youth and appealing to their aesthetic concerns (clear skin, healthy teeth) is greatly needed.

Tobacco Use

High rates of tobacco use in Louisiana's teens indicate the need for population-based activities targeting youth and smoking. The Tobacco Control Program at OPH is in the process of developing a comprehensive tobacco media campaign focusing particularly on the prevention of tobacco initiation among youth, environmental tobacco control, and availability of cessation programs. This statewide campaign will be funded through a grant from CDC and implemented in 2000-2001.

Immunization

The Office of Public Health Immunization Program offers to all eligible adolescents the Hepatitis B vaccine and also the Varicella, Tetanus/diphtheria boosters, and MMR (second dose) vaccines when indicated. All adolescents on Medicaid/LaCHIP or without health insurance are eligible to receive these vaccines through a federally funded program. OPH works in collaboration with local school districts and the local health units to provide the vaccinations to the youth. School-based health centers (SBHCs) are heavily involved in the administration of vaccinations; over 10,000 vaccines were administered at SBHCs during the 1998-99 school year.

Teen Pregnancy Prevention

Louisiana's high teen birth rate (Louisiana is ranked 43rd in the nation for percent of teens giving birth) supports the need for education and awareness programs aimed reducing teen pregnancies. The *Keeping It Real* Program is a statewide public awareness campaign of the Department of Social Services that has as its goal the reduction of teen pregnancies. The Louisiana Initiative for Teen Pregnancy Prevention (LITPP) is a non-profit organization whose goal is to reduce teen pregnancy in Louisiana through public awareness, education, and advocacy. Funding is through private donations and membership dues and the role of OPH is to provide technical assistance. The Governor's Program on Abstinence, funded by Title V, includes a media campaign to promote sexual abstinence among youth.

Prenatal Care

Pregnant teens have lower rates of early initiation into prenatal care than older pregnant women, indicating a need to promote the importance and the availability of prenatal care to teens. MCH's *Partners for Healthy Babies* campaign targets young women, encouraging them to seek early and regular prenatal care. *Partners'* newest outreach effort is aimed at pregnant teens, using a commercial with a local rap artist to secure teens' attention. A website for the project is under construction.

Children with Special Health Care Needs

Outreach

Information and referral is provided to any parent of a CSHCN through the nine CSHS Regional Offices. Outreach efforts so that parents are aware of this service is needed. Training was held for staff to provide expanded outreach activities over the past year. This training was also designed in anticipation of expanded eligibility. Because expansion of eligibility criteria did not occur, this outreach has been postponed.

Birth Defects Registry

Louisiana is one of only seven states without a birth defects registry. A planning group within OPH, led by the CSHS Program, was strengthened by a Senate Resolution establishing a Task Force to make recommendations to the Legislature regarding the feasibility of establishing a surveillance system for Louisiana. This will not only provide population-based data for program planning, but will be an initial resource to obtain referral information on families of CSHCN.

3.1.2.5 Infrastructure Building Services

An infrastructure that assures comprehensive, continuous, community-based, quality care for all low-income pregnant women, infants, children, youth, and children with special health care needs requires the combined efforts of the many providers of care as well as the financiers and supporters of the care. First there must be the information systems to provide data on mortality and morbidity, as well as the needs of this population. Next, there must be commitment from the state government to develop programs and policies to respond to these needs. Following that, there must be commitment among the public and private providers of care to collaborate and coordinate efforts to provide the services needed in the most-cost efficient and effective manner. There must be ongoing feedback and evaluation on efforts to assure that the desired outcomes are being achieved and that quality is maintained

Pregnant Women

Systems of Care

In order for local systems of care to meet the health needs of the population, there must be accessibility of services, availability of providers, wrap-around health and social services, and financial access. Preventive and primary care services for pregnant women are provided through parish health units, regional State-supported hospitals, community health centers, and private providers. There is the need for public providers to coordinate more closely with private providers in the delivery of prenatal care services. One possible first step is through a monthly news bulletin to be disseminated to major health care providers, ACOG members, and family/parent advocacy organizations in the state. There is also a need to monitor the development of community-based service systems for pregnant women. All

contract facilities for MCH should be monitored annually to ensure guideline maintenance and contract deliverables. Collaboration with the State Laboratory is needed in order to provide prenatal testing for community partners, and collaboration with the State Pharmacy is critical to the provision of vitamins, folic acid, and calcium for prenatal clients attending community partners' facilities.

Provider Training

Regularly scheduled quarterly meetings held with the MCH/Family Planning nurses will continue. Information imparted during these meetings will then be disseminated to the field staff. There is a need to distribute similar information to private providers who serve pregnant women. A one page, two-sided, monthly bulletin will be developed and distributed to private providers and community partners that will highlight various educational issues/risk factors relevant to women of reproductive age.

Collaboration

It is critical that MCH work closely with the State Medicaid Program on outreach to enroll eligible pregnant women using the new abbreviated application form for Medicaid coverage. The MCH Program will also continue to collaborate with Tulane School of Public Health, State Hospitals, Nurse Coordinators, March of Dimes, Perinatal Task Force, and Maternal and Child Health Coalition on issues and services related to women's health.

Assessment and Surveillance

Assessment and surveillance activities are critical to MCH's ability to target certain needy areas for intervention, as well as its capacity to monitor health status and program effectiveness. MCH assessment and surveillance activities include matched birth and death file, PRAMS, and the Environmental Scan survey. The Chlamydia Infertility Project is an assessment of chlamydia trends to enable the treatment and subsequently prevent and/or reduce the incidence of PID, ectopic pregnancy, infertility and premature labor and delivery. MCH is in the process of developing a prenatal risk assessment questionnaire to be complete by public health nurses before the second prenatal visit in order to recognize the risk of and prevent the delivery of low weight infants. Continuing the expanded pregnancy-related mortality review that was begun by the MCH Program in 1998 would assist MCH in identifying and preventing the factors associated with maternal deaths in Louisiana. Tracking the geographic disparities in entry to prenatal care will help parish and regional stakeholders address their specific health needs.

Standards Development

Manual revisions, annual updates on all clinical information, chart review, and updates of clinical competencies and Advanced Nurse Practitioner policies and protocols are activities that are in place in order to monitor and develop standards. Other efforts include bi-annual patient satisfaction questionnaires and collaboration with the STD Program on recommendations for STD screening and treatment during pregnancy. In-service education on

preterm birth and psychosocial risk assessment, referral, and follow up will be provided.

Information Systems

MCH relies on birth certificate data for much of its reporting and health status monitoring activities. One way to improve this data source would be to develop a task force to evaluate and monitor the information on the birth certificates to ensure accuracy and relevancy.

Quality Assurance

MCH provides prenatal health care guidelines for all parish health units and contract facilities; however, it is more difficult to monitor the care received by private providers. Randomized telephone inquiries are being instituted to monitor clients' access into prenatal care. The addition of a question to the PRAMS questionnaire regarding diabetic screening during pregnancy could be used as a CQI parameter to monitor all health care providers.

Infants and Children

Information Systems / Assessment and Surveillance

Development of information systems that are capable of providing timely, appropriate data for program planning and evaluation has been identified as a major need of the MCH Program. The MCH Program has been the recipient of a CDC MCH Epidemiology Grant since 1996, and has used this as the basis for developing the Epidemiology, Assessment, and Evaluation Program for the Division of Health Services. Through this Program, monitoring and analyzing the rates, causes, and factors associated with infant and childhood mortality is an ongoing function that is needed to target new program efforts and evaluate current initiatives. Access to Louisiana hospital discharge data, which will provide information on morbidity in children and adolescents, is essential to assisting the MCH Program in developing programs and policies. The Childhood Lead Poisoning Surveillance system is needed to develop a targeted screening plan for the state.

MCH works closely with the OPH Injury Research and Prevention Section, which monitors injury mortality in the state through death certificate data, the head and spinal cord trauma registry, child death review, and SIDS databases. MCH helps support an epidemiologist position within the Injury Research and Prevention Section. Additional sources of information include PRAMS for violence during pregnancy and the Department of Social Services' Office of Community Services for data regarding child abuse and neglect. The Dental Medicaid Program provides Medicaid claims data to the MCH Program so that studies on sealant prevalence, the number of exams performed, and utilization rates can be conducted. This data will continue to be monitored. Medicaid data needs to be made available by region or parish in order to inform efforts to increase provider participation in targeted areas. The number of dental professionals reporting child abuse or neglect needs also needs to be monitored. Surveys that have been done by PRAMS and BRFSS contain questions on oral health, and results of these surveys are shared with the Oral Health Program.

Program and Policy Development/Standards Development/Guidelines

MCH has parish health unit guidelines for preventive care services for children based upon recommendations of the American Academy of Pediatrics. Guidelines have also been developed in conjunction with the Lead Poisoning and Prevention Program for screening and management of lead elevation in children. The *Bright Futures* approach to child health services in the parish health units is being developed.

The MCH Program has worked closely with Medicaid on the development of their outreach program for LaCHIP, and continues to work on issues around recertification and linking certified children with providers. The MCH Program has also worked with the State EPSDT Program in providing information and ideas for program development. In addition, the Child Health Medical Director has been a member of the AAP Liaison to State Government Committee, which acts as an advisory committee to the State Medicaid/EPSDT Program. Issues that are addressed include number and content of the visits, personnel to provide services, reimbursement for services, and quality of care.

Collaboration/Policy Development

Because of the multiple needs of the children that the MCH Program serves, coordination with other programs and agencies is necessary to address the complex problems that these children and their families face. The MCH Program also needs to work with the local public health systems as well as the State-supported hospital system to assure that a system exists that provides comprehensive, seamless services. MCH will need to continue to collaborate with Medicaid's outreach efforts related to LaCHIP, in order to enroll all eligible children in Medicaid.

A committee has been established by the MCH Nutritionist to address the state's problem of obesity in children less than five years of age. This committee is comprised of state level nutrition, nurse, and physician consultants, regional nutritionists, and regional and parish nurses. The first objective of the committee is to evaluate the community and health care providers to determine what type of prevention strategies and/or interventions will be appropriate. This committee will work with the Louisiana Council on Obesity Prevention and Management, a group whose formation has been recently mandated by the State Legislature.

MCH coordinates extensively with Prevent Child Abuse Louisiana, the Governor's Children's Cabinet, Steps to Success, and Agenda for Children to disseminate information to decrease morbidity and mortality from intentional and unintentional injuries.

Since funding for fluoridation equipment and portable dental equipment is not readily available, MCH's Oral Health Program relies on strong collaborations to operate many of its activities. These collaborations are essential to these success of these programs. A contract is in place with the David Raines Community Health Center whereby MCH provided portable dental equipment for a sealant program. The Health Center provides the

manpower, supplies, and materials for the program. MCH needs to collaborate with other providers on similar sealant programs in other areas of the state.

MCH works closely with the Louisiana School Nurses Organization on oral health screenings, and must continue this collaboration in order to expand screening activities. The Fluoridation Advisory Board has regional representatives that work with regional groups in promoting and encouraging water fluoridation. The Louisiana Rural Water Association has agreed to survey the targeted water systems to give an estimate of what it would cost to fluoridate or re-fluoridate the systems. The Louisiana Dental Association and the Louisiana Dental Hygienists Association will work with the Fluoridation program to lobby for mandatory water fluoridation in the state. The Louisiana Dental Association (LDA), Louisiana Dental Hygienists Association, and the Office of Community Services collaborate with MCH on operation of the PANDA program.

MCH directs the Child Care Health Consultant Program, a activity that was begun as part of the Community Integrated Services System Initiative (CISS) grant. The Initiative is coordinated with the Department of Social Services, the Agency responsible for administering the State's Child Care Assistance Block Grant and licensing child care centers. A local child advocacy organization, Agenda for Children, works with MCH to reach child care providers and promote the utilization of child care health consultants through a statewide network of Child Resource and Referral Agencies. MCH coordinates a state level advisory council on child care health and safety, and participants represent the State Chapter of the American Academy of Pediatrics, Agenda for Children, and the Department of Social Services. Close collaboration with these entities must be maintained so that MCH can continue to promote health and safety in child care centers.

Provider Training

Training to local public health unit staff has been provided through a network of regional MCH/Family Planning nurses in addition to periodic statewide training efforts. Training in the area of assessment of parent-child interaction and infant mental health issues has been identified as a need of public health unit staff. Training in risk-reduction for SIDS for private as well as public providers is seen as a need to further decrease mortality due to SIDS. Training related to prevention of childhood lead poisoning for physicians and other health care providers is indicated to assure that all are knowledgeable on the current recommendations for screening and management.

With increasing numbers of mothers in the workforce, there is a great need for quality child care. Both center-based and family home day care facilities need to assure healthy and safe environments for young children. MCH trains health professionals to become child care health consultants. Participants are trained on out-of-home child care health and safety. By combining professional health experience with knowledge and training in child care, consultants work to support and assist child care providers in providing safe child care. Consultants provide technical assistance, referrals, and health care information.

Monitoring and Evaluation

Ongoing monitoring of process and outcome indicators of program efforts is needed to assure that the desired outcomes are being achieved. Evaluation must be built in as an essential element of program development. In the Office of Public Health, health care services in the local parish health units are monitored through a Continuous Quality Improvement (CQI) System. This includes local record review and patient satisfaction services. Audits conducted by the Medicaid EPSDT Program are reviewed to assure that health unit services are in compliance with state standards. Audits by State and federal staff for the WIC Program assure compliance with program requirements. The Genetics Diseases Program continues to participate in a multi-state evaluation of newborn sickle cell screening and follow up coordinated through Emory University and the Southeastern Regional Genetics Group.

Systems of Care

In addition to monitoring vital statistic, patient utilization, and other child health indicator data, a system for working with parishes to address the child health needs in their communities needs to be established. Parish and region-specific data can be distributed to parishes to help them determine priorities and direct program activities. Information and support to the local level will be essential in assisting them to look at the needs in their community and establish the necessary systems of care. The MCH community needs assessment this year was the first step in this process.

Quarterly meetings with regional MCH/Family Planning nurses and periodic meetings with other regional staff are held to maintain communication with the local level staff. Other MCH supported programs that function at the community level to enhance services to children and their families, as well as provide information on community programs and needs, include the Shots for Tots immunization efforts, the SAFE KIDS Coalitions, child care systems development, violence prevention coalitions, and school-based health centers.

Surveillance/Provider Training/Policy Development

An ongoing screening activity should be put in place to be able to assess the oral health status of the state's children. This could be accomplished through enhanced training of school nurses. The possibility of obtaining Continuing Education credits for oral health screening training needs to be pursued. The possibility of identifying sentinel schools that are representative of a segment of schools needs to be researched and oral health screenings need to be performed at these schools. Making oral health screenings for school children mandatory, through legislation similar to vision and hearing screening mandates, would ensure an ongoing way of assessing oral health.

Policy Development/Provider Training/Quality Assurance/Collaboration

MCH has a Fluoridation Specialist position to oversee the Fluoridation Program and to educate the public and providers about the benefits of community water fluoridation. This person will provide training for water systems operators and collaborate with the Fluoridation Advisory Board and the Louisiana Rural Water Association to provide

cost estimates for the fluoridation of these systems. Assistance will be given to help the systems in developing standards, evaluation procedures, and quality assurance for those systems which do fluoridate. Coalitions need to be established in regions/parishes to promote funding for local fluoridation systems.

Provider Training/Assessment

There needs to be an increase in the number of PANDA trainers so that the number of providers trained can be increased. The network being built by the PANDA Coalition will help to bring more trainers into the program. Another avenue to explore is making a child abuse and neglect course mandatory for all dental professionals as a requirement for initial licensure and licensure renewal. The Office of Community Services has also agreed to train providers in what happens when a child maltreatment report is made and how the reports are prioritized. This will give dentists a better idea of what to expect when calling Child Protective Services. There is now a mechanism in place to note when a report comes in from a dental provider. This will allow an ongoing assessment of the claims to see if the PANDA trainings have an impact on the number of reports made.

Pregnant Women, Infants, and Children

Collaboration

The State Supplemental Food Program for Women, Infants, and Children (WIC) and the MCH Program are closely coordinated at the state and local levels. State level coordination includes a jointly funded media campaign to promote early prenatal care and healthy nutrition and other behaviors during pregnancy. At the local level, pregnant women and children receive WIC benefits at the same time they receive preventive MCH services. Families who receive their health services from private providers and use parish health units for WIC services can also receive health education and case management services from MCH funded health unit staff. There is a need to balance the large numbers of women, infants, and children receiving WIC services and the careful assessment and follow up of psychosocial problems among pregnant women and families served by MCH. Through infant mental health training for public health nurses, *Bright Futures* materials, and psychosocial risk assessment, public health staff will be better prepared to provide needed wrap-around services for the MCH population at risk.

Children, Adolescents, and Children with Special Health Care Needs

Collaboration

The CSHS Program and MCH's Adolescent School Health Initiative attempted to institute a joint asthma treatment project. State funding was not obtained due to State budgetary restrictions. Several grant opportunities have been explored. To date, no funds have been secured, but efforts continue, as asthma treatment is a critical need, given the scope of the problem among Louisiana's children and youth.

Adolescents

Systems of Care

A report on teen focus groups recently held across Louisiana cites Teen Centers as the single most useful effort any health promotion/disease prevention program could support. Research certainly supports the benefit of after school programs for youth and indicates that successful programs for adolescents should address the root causes of high-risk behaviors; should involve parents, youth, and the community; and should be multi-agency and multi-component. Other specifications are that such programs should enhance educational achievement; be culturally appropriate; connect youth to college or jobs giving them a reason to stay in school; provide adequate program model replication; and be sustained over a long period of time. However, in Louisiana there is no central agency to facilitate the establishment of such after-school programs and to provide the necessary funding, technical assistance, and certification standards to assure the health and safety of children who participate. Currently, the Department of Social Services funds ten after-school programs in the New Orleans area.

Collaboration

Louisiana school-based health centers (SBHCs) have been an effective model, not only for the delivery of comprehensive health and mental health services, but also for successful collaboration with other agencies and community groups involved in the care of youth. The following agencies and organizations collaborate with the OPH SBHC program: Office of Mental Health, Office of Addictive Disorders, KIDMED/Medicaid, Local School Boards, The State Department of Education, Bogalusa Heart Study, the LSU Medical Center, the American Cancer Society, the American Lung Association, and the Excellence in Health and Education Project at Southeastern Louisiana University. Each school-based health center has a local sponsor and is required to establish a Community Advisory Board made up of parents, teachers, school staff, and community leaders.

Quality Assurance

All SBHCs in Louisiana are required to comply with *The Principles, Standards, and Guidelines for School Based Health Centers in Louisiana*. There is a comprehensive quality assurance program in place to assure compliance with the Standards.

Provider Training

There has been considerable research into the development and evaluation of teen-friendly services. The Focus on Young Adults in Reproductive Health Project, funded by USAID, determined core elements of youth friendly services that cover provider characteristics (privacy, respect, peer counselors, etc.), health facility characteristics (hours, location, etc.), and program design characteristics (youth involvement in design, drop-in appointments, affordability, inclusion of young men, wide range of services, etc.). This document has proven useful to the Family Planning Program at OPH. Dissemination of this information to all health providers serving adolescents, however, is needed.

Children with Special Health Care Needs

Systems of Care/Provider Training

The system of care for CSHCN is fragmented in Louisiana. Lack of access to services is a major barrier that will be addressed by the CSHS Program. Coordination of services is essential for comprehensive, seamless care for CSHCN. Although the CSHS staff of nurses, social workers, nutritionists, audiologists, etc. currently provide some service coordination, a more formalized procedure is needed. Standards are currently being developed for care coordination within the CSHS Program.

CSHCN in Louisiana, like many of the children living in poverty and uninsured, have no access to a medical home. The CSHS Program, in conjunction with the Louisiana Chapter of the American Academy of Pediatrics and Shriner's Hospital, is planning a Medical Home training to increase capacity in this area, training primary care providers to enable them to become a medical home to CSHCN. The CSHS staff also provides training to school nurses and other providers in the care of medically fragile CSHCN. The current system, which includes the CSHS clinics and services, is in need of expansion so that more of the population of CSHCN in Louisiana will have access to medical subspecialty services. The expansion of program eligibility will continue to be a goal of the CSHS Program.

An effort to increase the number of oral health providers who will treat Special Needs Children is needed, along with more training for providers on how to handle Special Needs Children.

Collaboration

The CSHS Program, in attempting to coordinate the system of care for CSHCN in Louisiana, collaborates with many partners in sharing resources, developing new initiatives in areas of unmet needs, and working to address barriers to comprehensive care. Collaboration was initiated with the Medicaid KIDMED (EPSDT) program as a result of the CSHCN Tri-Regional Conference. The KIDMED Program is using the CSHS clinics as a resource for subspecialty care throughout the state and has agreed to assist CSHS staff in linking Medicaid eligible children to a medical home and assisting with transportation issues. Close coordination with Medicaid must continue in order to improve the system of care available to CSHCN.

CSHS has entered into a pilot project for the treatment of Type 1 diabetes. The partnership with Children's Hospital in New Orleans provides medical services for the children, while CSHS supports team services that are not reimbursable. This project has shown phenomenal potential for cost savings and prevention of secondary disabilities caused by poor control of this chronic disease.

CSHS continues its strong partnership with Shriners' Hospital in Shreveport. CSHS staff attend Shriners

clinics, providing care coordination and support for wrap-around services that Shriners does not provide. Through the committee to develop the Medical Home Training and the Birth Defects Task Force, the CSHS Program collaborates with both medical schools in New Orleans and one in Shreveport. This interaction, as well as with the Medical Advisory Board for CSHS, assures that medical input is current, constant, and guaranteed.

Assessment and Surveillance/Information Systems

Improving data on the State's CSHCN continues to be a need of the State CSHS Program. The CSHS Program database is in the final stages of development, and more accurate and complete data will be collected by each regional office in the near future. This will provide a more complete picture of the population of patients served by the program. Planned surveillance of birth defects will complement data already obtained from Vital Records.

Monitoring and Evaluation/Quality Assurance

The CSHS Program has been performing a Quality Assurance program for many years and is now in the process of converting to a Continuous Quality Improvement program. After over a year of collaboration with field staff and parents, a new manual is ready for implementation. This will provide staff with opportunities to improve services and obtain continuing consumer input to service delivery decisions.

The Parent Survey indicated high levels of satisfaction with the services provided by the CSHS Program. The Provider Survey also indicated that providers, especially physicians, were significantly more satisfied with CSHS clinic services than similar services in the private sector. (See Needs Assessment Appendix E for complete results of the Patient and Physician Surveys.)

3.2 Health Status Indicators

See Supporting Documents, Sections 5.4 through 5.7, for the Core and Developmental Health Status Indicator Forms and Detail Sheets.

3.2.1 Priority Needs

See Supporting Documents, Section 5.8 for Form 14.

MCH and CSHS staff created the original ten Title V priority needs for the State's Block Grant Application in 1998. These were devised based on the 1995 Needs Assessment, and were the result of staff discussion and review of past needs assessment results. Those ten needs were (1) to reduce infant mortality; (2) to

decrease intentional and unintentional injury; (3) to increase access and utilization of comprehensive primary, preventive, and specialty care services for women of reproductive age, infants, children, adolescents, and CSHCN; (4) to assure services for adolescent health including but not limited to comprehensive mental and physical health services; (5) to develop the epidemiologic capacity of the MCH and CSHS Programs to obtain and utilize data for the development and evaluation of these programs; (6) to assure that the oral health needs of the MCH population are met; (7) to ensure provision of nutrition services, including nutrition education, for the MCH and CSHCN populations; (8) to assure the necessary support services and infrastructure in order to provide a seamless system of care for the MCH and CSHCN populations; (9) to assure that all children with special health care needs have a medical home for primary and preventive health care, as well as specialty medical services; and (10) to promote healthy behaviors that reduce morbidity and mortality in the MCH and CSHCN populations through public, professional, and patient education.

This year, staff again reviewed and discussed Year 2000 Needs Assessment results in order to create a new list of top needs for Louisiana's Title V Program. Specifically, regional and parish level MCH staff were asked to prioritize their needs after a lengthy data collection process. Also, state level planning groups reviewed data and established priority needs for seven areas: perinatal health, infant and child health, adolescent health, oral health, injury prevention, maternal and child nutrition, and children with special health care needs. Finally, a single state level planning group met to consider all the needs that had been submitted, to prioritize them, and to collapse them into a final list of ten. (See Section 3.1.1, Needs Assessment Process, for a complete discussion of the entire needs assessment process.) The new needs are as follows: (1) to decrease infant mortality and morbidity, preterm births, and low birthweight; (2) to decrease mortality and morbidity among adolescents; (3) to decrease intentional and unintentional injury in the MCH and CSHCN populations; (4) to increase care coordination among children with special health care needs; (5) to increase access to and utilization of comprehensive primary, preventive, and specialty care services for women of reproductive age, infants, children, adolescents, and children with special health care needs with particular emphasis on transportation and provider availability; (6) to assure that all children, especially those with special health care needs, have a medical home for comprehensive primary and preventive health care, with coordination of all health and support services; (7) to assure the oral health needs of the MCH and CSHCN populations are met; (8) to address the social, emotional, and psychological needs of the MCH and CSHCN populations; (9) to assure early identification and referral of substance abuse, domestic violence, and child abuse and neglect; and (10) to reduce unhealthy and risk taking behaviors of adolescents, pregnant women, and parents through public, professional, and patient education.

Many areas that were the focus of the original set of ten priority needs in 1998 continue to be priorities. Infant mortality, low birthweight, prenatal care access and utilization, care coordination, oral health, teen pregnancy, adolescent health, intentional and unintentional injuries, and child abuse and neglect remain focus areas of the MCH Program. Assuring access to primary care practitioners, for both the uninsured and Medicaid populations, continues to be more of a priority than ever, as recent fluctuations in Medicaid reimbursement rates threaten the existing number of available providers. In 1998, increasing the rates of insurance

for Louisiana's children was a priority. In 2000, assuring access for those children who are becoming insured through LaCHIP must be a priority. A number of children continue to lack access to CSHS services.

Several other needs that had been priority areas in past years have been replaced. Development of the epidemiologic capacity of the Title V Program was a major thrust in 1998, and was the fifth need on the 1998 list of priority needs. Much has been done to address this need in the past two years. The MCH Program has a CDC assigned MCH epidemiologist on staff; two epidemiologists have been hired with SSDI grant funding; CSHS has a full time epidemiologist as well as a Birth Defects Registry coordinator; and PRAMS has been in operation for three years and PRAMS data is now available for Block Grant performance measures. Although MCH still has many gaps in available data, much of the reason is either a delay by other departments in development of a new data source (hospital discharge data) or denied access to existing databases (Medicaid claims data). Building epidemiology capacity will continue to be a focus; however, it was not included in the new list of top ten priority needs since it has been so heavily addressed by the Title V Program in the past several years. Another area, provision of nutrition services, fell off the original list of priority needs. Nutrition services and education are among the primary services offered in health units statewide. Childhood obesity is included as one of the state-negotiated performance measures. Nutrition services will play a key role in addressing priority need 1 (reducing low birthweight) and priority need 10 (public, patient, and provider education).

New areas have emerged as priorities, and have been specified in the new list of priority needs. The need to reduce preterm births and low birthweight in an attempt to decrease infant mortality and morbidity was specifically mentioned in priority need #1. Although assuring access to services remains a top priority, improving transportation and provider availability emerged as the most critical components of access and are mentioned specifically in priority need #5. Title V activities have increasingly addressed the psychosocial needs of the MCH and CSHCN populations in recent years, and mental health needs were reiterated by central office, regional, and parish level staff throughout the needs assessment process as critical areas, especially for the New Orleans area. Priority need #8 concentrates on these needs for the MCH and CSHCN populations. Issues that are particularly concerning in the MCH and CSHCN populations are substance abuse, domestic violence, and child abuse and neglect (priority need #9). MCH has undertaken many activities in recent years to address child abuse and neglect; however, it was not specifically mentioned as a focus area in the previous list of ten priority needs. The scope of the problem - there are approximately 35 cases of child abuse or neglect everyday that are validated - necessitates its inclusion in the list of priority needs for Title V. Other areas were emphasized specifically in discussions with state, regional, and parish staff but were not mentioned by name in the final list of priorities. These areas include gun-related injuries and deaths, SIDS, and community water fluoridation. These areas will be focus areas within the ten priority needs, and will be discussed further in the Annual Plan (See Section 4.1).

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

See Supporting Documents, Section 5.8 for Forms 2,3,4, and 5.

3.3.2 Other Requirements

BUDGET INFORMATION -- Non-Construction Programs					
SECTION A - BUDGET SUMMARY					
Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised	
		Federal	Non-Federal	Federal	Non-Federal
1. CHILD HEALTH	13.994	\$	\$	\$ 6,653,485	\$ 18,786,65
2. CSHS	13.994			4,866,428	5,855,3
3. MATERNITY / FAMILY PLANNING	13.994			3,739,436	5,629,0
4. MCH RELATED AGENCY FUNDING	-----				

5. TOTALS		\$	\$	\$ 15,259,349	\$ 30,271,1
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SECTION B - BUDGET CATEGORIES					
6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				
	(1) CHILD	(2) CSHS	(3) Maternity/FP	(4) RELATE	
a. Personnel	\$ 12,157,640	\$ 3,686,536	\$ 5,196,651	\$	
b. Fringe Benefits	2,533,563	696,249	995,860		
c. Travel	230,787	66,763	90,943		
d. Equipment	72,678	15,620	200		
e. Supplies	1,034,309	746,428	661,810		
f. Contractual	5,880,618	3,410,959	790,594		
g. Construction	i	i	i	i	
h. Other	3,530,585	2,099,213	1,632,469		
I. Total Direct Charges (sum of 6a-6h)	25,440,180	10,721,768	9,368,527		
j. Indirect Charges	i	i	i	i	
k. TOTALS (sum of 6i and 6j)	\$ 25,440,180	\$ 10,721,768	\$ 9,368,527	\$	
7. Program Income	\$ 4,471,500	\$ 840,000	\$ 1,798,500	\$	
TITLE XIX					
FEES	670,000		i	i	
3RD PARTY		150,000			

Standard Form 424A (4-88)

*STATE SUPPORT IS CONTINGENT UPON LEGISLATIVE APPROVAL

Prescribed by OMB Circular A 102

SECTION C - NON-FEDERAL RESOURCES			
(a) Grant Program	(b) Applicant	c) State	(d) Other Sources

8.	CHILD HEALTH	\$	\$ 12,371,750	\$ 6,414,945
9.	CSHS		4,865,340	990,000
10.	MATERNITY/FAMILY PLANNING		3,577,647	2,051,444
11.	MCH RELATED AGENCY FUNDING			
12.	TOTALS (sum of lines 8 and 11)	\$	\$ 20,814,737	\$ 9,456,389
SECTION D - FORECASTED CASH NEEDS				
13.	Federal	Total for 1st Year	1st Quarter	2nd Quarter
		\$	\$	\$
14.	Non-Federal			
15.	Total (sum of lines 13 and 14)			
SECTION D - FORECASTED CASH NEEDS				
(a) Grant Program		FUTURE FUNDING PERIODS (YEARS)		
		(B) First	© Second	(d) Third
16.		\$	\$	\$
17.				
18.				
19.				
20.	TOTALS (sum of lines 16-19)	\$	\$	\$
SECTION F - OTHER BUDGET INFORMATION				
(Attach additional Sheets if Necessary)				
21.	Direct Charges:		22. Indirect Charges:	
23.	Remarks Section C.-Col. C.-The state may be affected by the amount of Title XIX and Self-Generated funds actually coll funding, however, will equal or exceed the level of state funding provided in State Fiscal Year 1989. Section B - Administrative allocated cost are estimated to be \$1,525,934 or 10% of the Federal funds.			

Budget Justification

The following services and projects are funded by the MCH Block Grant, Title XIX, patient fees, insurance

reimbursements, and local and state funds:

1. **Maternity/Family Planning**
2. **Child Health - Preventive/primary services for children birth to 21.**
 - a. Child Health
 - b. Eye Health - Preventive
 - c. Communicative Disorders - Preventive
 - d. Immunization
 - e. Tots and Teens Program
3. **Children's Special Health Services**
 - a. Children's Special Health Services
 - b. SSI - Disabled Children's Program
 - c. Eye Health - CSHS
 - d. Communicative Disorders - CSHS
 - e. High Risk Newborn - Baton Rouge - Primary Care and case management
 - f. High Risk Newborn- Alexandria - Case Management
4. **Earmarked Funds 502(c) (2)**
 - a. St. Thomas Health Services, Inc.
 - b. Teen Advocacy Program
 - c. Children's Hospital Case Management

The MCH Block Grant supports the state central and regional administrative/consultative staff who set standards of care, develop policies and procedures, train field staff, and provide quality assurance. The amount budgeted for the Central Office of Public Health MCH staff represents the cost of building the capacity of the state to develop community-based systems of care. This amount is presented for each of the program components. In addition, other core public health services, direct personal health services, enabling services, and population-based services outlined in Section II B.4 are included in the following budget. The remainder of this section lists each type of service (project) for each program component, including the amount budgeted for the service separated into the federal and state match contributions.

MATERNITY/FAMILY PLANNING				
<u>PROJECT</u>	<u>FEDERAL</u>	<u>% OF</u>	<u>STATE</u>	<u>% OF</u>
		<u>FEDERAL</u>	<u>MATCH</u>	<u>STATE</u>
Maternity	\$2,639,436		\$1,979,577	
Family Planning	\$1,100,000		\$ 825,000	
TOTAL	\$3,739,436	24.5	\$2,804,577	24.5

PREVENTIVE/PRIMARY CARE SERVICES FOR CHILDREN

<u>PROJECT</u>	<u>CODE</u>	<u>FEDERAL</u>	<u>% OF FEDERAL</u>	<u>STATE MATCH</u>	<u>% OF STATE MATCH</u>
Child Health Sys	605	\$4,917,395		\$3,668,046	
Eye Health	705	319,621		259,716	
Communicative Dis.	805	316,469		237,352	
Immunizations	041	<u>1,100,000</u>		<u>825,000</u>	
TOTAL		\$6,653,485	43.6	\$ 4,990,114	43.6

The service areas (projects) which relate to preventive and primary care services for children are listed above. The amount of funds budgeted in these service areas (projects) for fiscal year 2000 exceeded 30% of the total MCH Block grant. Thus, there is no need to redirect the MCH Program in order to comply with this requirement. Compliance verification based on the actual funds disbursed will be performed and documented by the Fiscal Office at the end of each state fiscal year.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

<u>PROJECT</u>	<u>CODE</u>	<u>FEDERAL</u>	<u>% OF FEDERAL</u>	<u>STATE MATCH</u>	<u>% OF STATE MATCH</u>
CSHS	007	\$4,775,000		\$3,581,250	
SSI	107	<u>91,428</u>		<u>68,571</u>	
TOTAL		\$4,775,000	31.9	\$3,649,821	31.9

A minimum of 30% of federal funds received for use in subsequent fiscal years and the associated match will be budgeted for use in programs that provide services for children with special health care needs. The amounts listed above will be budgeted for fiscal year 2000. Compliance verification based on the actual funds disbursed will be performed and documented by the Fiscal Office at the end of each state fiscal year.

Sources of State Match and Overmatch Funds

Funds for Maternal and Child Health Services will be obtained from state general funds.

Program Income

Program income comes from Title XIX funds, fees, and third party payers. The following table presents the distribution of this income by program component.

<u>PROGRAM</u>	<u>SOURCE OF INCOME</u>			<u>TOTAL</u>
	<u>TITLE XIX</u>	<u>FEES</u>	<u>THIRD PARTY</u>	
Maternity/FP	1,798,500	0	0	1,798,500
Child Health	4,471,500	670,000	0	5,141,500
CSHS	<u>840,000</u>	0	<u>\$150,000</u>	<u>990,000</u>
TOTAL	\$7,110,000	\$670,000	\$150,000	\$7,930,000

Budgeting for Cross-cutting Programs

The Office of Public Health is able to associate each staff person's work activity with the correct funding source by a system using reporting categories. The Office of Public Health budget is divided into approximately 40 service or

project areas, each identified by a reporting category. Most Office of Public Health employees utilize this Project Code system to allocate their time and other expenditures to a particular project or service area. This system allows staff who work across many programs to allocate their time and other expenditures appropriately. For example, for a nurse who spent four hours in a child health clinic and half of her time was spent providing WIC related services (i.e., determination of financial categorical eligibility and/or assessment of nutritional risk for certification/recertification; or provision of nutrition counseling), two hours would be charged to the child health project codes and two hours to the WIC code.

The Maternal and Child Health Block Grant is also budgeted into several project or service areas identified by a code. These codes are used by all staff working in MCH Block Grant funded programs to allocate their time to specific service areas for payroll, supply and equipment purchases, travel, and contracts.

Allocation for Activity Conducted to Continue Consolidated Health Programs

The following federally funded programs were consolidated by the Maternal and Child Health Block Grant in fiscal year 1981 - 82 in Louisiana:

1. Maternal and Child Health Program;
2. Crippled Children's Services Program (in Louisiana called Children's Special Health Services);
3. Supplemental Security Income/Disabled Children's Program - \$298,330 - statewide;
4. Lead-Based Paint Poisoning Prevention Program (previously funded only in City of New Orleans in Louisiana) - \$213,032;
5. Genetic Diseases Program (incorporated previous funds for sickle cell disease at Flint Goodridge Hospital in N.O.) \$3,407,593;
6. Sudden Infant Death Syndrome (SIDS) - not funded in Louisiana; and
7. Adolescent Pregnancy Program - not funded in Louisiana.

The following state funded programs in effect in Louisiana at the time of Block Grant Legislation in 1981 were also incorporated into the Maternal and Child Health Block Grant:

1. Genetic Diseases Program - statewide screening for certain inherited disorders such as PKU, hypothyroidism, and sickle cell anemia.
2. Sudden Infant Death Syndrome (SIDS) Program - follow-up and counseling of affected families statewide.

Special Projects In Effect Before August 31, 1981

1. Maternal and Infant Care Project - discontinued;
2. Children and Youth Project - discontinued;
3. Family Planning - absorbed into general Family Planning Program; Title V funding for Family Planning Program is \$1,750,000;
4. Dental Health For Children - reduced services - current funding for Dental Services for Children's Special Health Services - New Orleans District Office \$158,400;
5. Neonatal Intensive Care - absorbed by Louisiana State University Medical Center in Shreveport.

Use of Overmatch Funds

There is no overmatch that is under the control of the State Title V Agency that is used to match other federal programs.

Fees

No fees are currently charged to maternity and child health patients. Individuals who receive only immunizations and who are above 100% of the poverty level are charged \$5.00. Family planning patients are charged fees according to a sliding fee scale. During the 2000 Legislative Session, fees for parish health unit services were authorized for non-Medicaid eligible families above 100% of the poverty level. A fee of \$5 will be charged for maternity and child health visits and \$10 for an immunization-only visit.

Administrative Costs

Administrative costs are the portion of costs incurred by the following service units that are directly allocated to Maternal and Child Health Services Programs in accordance with Sections 3 and 5 (where applicable) of the Department of Health and Hospitals Cost Allocation Plan:

- Office of Assistant Secretary
- Human Resources Section
- Administrative Services
- Healthy Communities Section
- Statewide Costs (Purchasing, Civil Service, Treasurer, Fiscal, etc.)
- Health Education Unit
- Policy, Planning and Evaluation
- Operations and Support Services

Collectively these are referred to as Executive Overhead costs. Compliance verification of the 10% administrative restriction will be performed and documented by the Fiscal Office at the end of each state fiscal year.

The estimated administrative costs for the total budget are \$5,600,000 for fiscal year 2000-2001. The estimated Federal

share is \$1,525,934 or 10.0% of the federal funds requested.

Administrative Cost Limit - The administrative budget represents 10.0% of the federal funds requested.

"30-30" Minimum Funding Requirements - The preventive and primary care services for children represents 43.6% of the Block Grant and Children's Special Health Services represents 31.89% of the Block Grant budget. The definitions and descriptions of the services for these project components can be found in the program narratives.

Maintenance of State Effort - The State Office of Public Health intends to pursue and expects to obtain state general funds for Maternal and Child Health Services that equals or exceeds the level of such funds provided during state fiscal year 1989. Compliance verification will be performed and documented by the Fiscal Office at the end of each state fiscal year. The state support in state fiscal year 1989 was \$6,207,276.

3.4 Performance Measures

FIGURE 4
PERFORMANCE MEASURES SUMMARY SHEET

Performance Measure	Pyramid Level of Service				Type of Service		
	DH C	ES	PBS	IB		P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a “medical/health home”		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X

Performance Measure	Pyramid Level of Service				Type of Service		
	DH C	ES	PBS	IB		P	RF
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN program				X		X	
15) Percent of very low birth weight live births				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester				X			X

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

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PB	IB	C	P	RF
1) Percent of all children and adolescents enrolled in public schools in Louisiana that have access to school-based health center services.							
2) Percent of women in need of family planning services who have received such services.							

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PB	IB	C	P	RF
3) Rate of children (per 1,000) under 18 who have been abused or neglected.							
4) Percent of CSHS patients with care management (follow-up visits) from a nurse, social worker, or nutritionist.							
5) Percent of children (0 - 5 years old) on WIC over the 95 th percentile weight for height.							
6) Percent of women who have had a baby who report physical abuse either during their last pregnancy or in the 12 months prior to becoming pregnant.							
7) Percent of women who use substances (alcohol or tobacco) during pregnancy.							
8) Percent of infant deaths due to Sudden Infant Death Syndrome (SIDS) that have a complete autopsy and death scene investigation.							
9) Percent of Central Office and regional epidemiologic positions filled and working on MCH/CSHS data and epidemiologic issues.							
10) Percent of licensed day care centers with a health consultant contact.							

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

3.4.1 National “Core” Five Year Performance Measures

3.4.1.1 Five Year Performance Targets

See Supporting Documents, Section 5.8 for Form 11.

See Supporting Documents, Section 5.9 for the National Performance Measure detail sheets.

3.4.2 State “Negotiated” Five Year Performance Measures

3.4.2.1 Development of State Performance Measures

See Supporting Documents, Section 5.10 for the State Performance Measure detail sheets.

3.4.2.2 Discussion of State Performance Measures

From the original set of ten priority needs submitted in the 1998-1999 Block Grant Application, MCH Program staff created the state-specific performance measures. Many of the State's priority needs were already addressed by the core national performance measures. However, there were important program areas that were not adequately reflected in the national measures. MCH Program staff formed committees with staff throughout the Office of Public Health to develop the state-specific performance measures. After a considerable amount of negotiation, the following measures were chosen:

1. Percent of all children and adolescents enrolled in public schools in Louisiana that have access to school-based health center services.
2. Percent of women in need of family planning services who have received such services.
3. Rate of children (per 1,000) under 18 years old who have been abused or neglected.
4. Percent of CSHS patients with case management from a nurse, social worker, or nutritionist.
5. Percent of children under 6 years old on WIC over the 95th percentile weight for height.
6. Percent of women who have had a baby who report physical abuse either during their last pregnancy or in the 12 months prior to becoming pregnant.
7. Percent of women who use substances during pregnancy.
8. Percent of deaths due to SIDS that have a complete autopsy and death scene investigation.
9. Development of the epidemiologic capacity of the MCH and CSHS programs.
10. Percent of licensed day care centers with a health consultant contact.

The first and second state performance measures were selected to reflect major programs - the Adolescent School Health Initiative and the Family Planning Program - whose activities were not represented in the set of national measures. The third state performance measure, the rate of children who have been abused or neglected, was chosen because of the high rates of violence in the state and the many MCH activities focusing on preventing child abuse and neglect. The fourth state performance measure, CSHS case management, related to the priority needs that emphasized comprehensive and seamless care. The fifth state performance measure, percent of children over the 95th percentile weight for height, related to the high level of childhood obesity in Louisiana. The sixth performance measure, percent of women who have been physically abused, related to decreasing infant mortality and injuries, and impacts the infant mortality outcome measure. The seventh state performance measure, percent of women who use substances during pregnancy, related to the priority need for health education and promotion, and also impacts the infant mortality outcome measure. The eighth state performance measure, SIDS autopsies and death scene investigations, is related the need to decrease infant mortality and increase health education and promotion. It impacts postneonatal and infant mortality outcome measures. The ninth state performance measure,

the epidemiologic capacity of the MCH/CSHS Programs, related to the 1995 priority need to develop this capacity and the continuing emphasis on this area. The tenth state performance measure, percent of licensed day care centers with a health consultant contact, impacts the child death outcome measure.

The placement of the state performance measures in the pyramid is illustrated in Figure 4.

3.4.2.3 Five Year Performance Targets

See Supporting Documents, Section 5.8 for Form 11.

3.4.2.4 Review of State Performance Measures

State performance measures were reviewed during negotiations between State MCH staff and Maternal and Child Health Bureau staff, and results were incorporated.

3.4.3 Outcome Measures

See Supporting Documents, Section 5.8 for Form 12.

IV. REQUIREMENTS FOR THE ANNUAL PLAN

4.1 Program Activities Related to Performance Measures

For a complete discussion of each national and state performance measure, activities that impact each measure, and plans for meeting performance measure targets, see Section 2.4.

Priority Need 1: Decrease infant mortality and morbidity, preterm births, and low birthweight

Related National Performance Measures (NPM) and State Performance Measures (SPM):

NPM-The percent of newborns screened for PKU, hypothyroidism, galactosemia, and sickle cell diseases.

NPM-The birth rate (per 1,000) for teenagers aged 15 through 17 years.

NPM-Percentage of newborns who have been screened for hearing impairment before hospital discharge.

NPM-Percent of very low birth weight live births.

NPM-Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

NPM-Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

SPM-Percent of infant deaths due to Sudden Infant Death Syndrome (SIDS) that have a complete autopsy and death scene investigation.

SPM-Percent of women who use substances (alcohol and tobacco) during pregnancy.

SPM-Percent of women who have had a baby who report physical abuse either during their last pregnancy or in the 12 months prior to becoming pregnant

Direct Health Care Services

By continuing to provide and/or fund health services for women, children, adolescents, and CSHCN who do not have access to the private sector or other providers, MCH will work to reduce infant mortality. Services are provided through parish health units, contract agencies, medical schools, school-based health centers, CSHS clinics, and through coordination of services with other Office of Public Health programs.

The Office of Public Health operates 105 parish health units, located in 62 of Louisiana's 64 parishes, through which the MCH Program provides a safety net of health care for uninsured women and children or families with Medicaid coverage who have limited access to private providers. Maternity, infant, and child health services are coordinated with immunization, family planning, WIC, sexually transmitted disease and TB services within the health units. Earmarked Title V funds supplement the statewide Immunization and Family Planning Programs. Children's Special Health Care Services provides subspecialty care in nine regional clinics. These services greatly reduce morbidity of secondary disabling conditions and prevent complications of serious chronic disease.

Pregnant Women, Mothers, and Infants

Prenatal care services are directed at assuring maternal and fetal optimal health, healthy behaviors, minimization of risk factors, and early recognition, treatment, and referral of problems that may put mothers and infants at risk of morbidity directly related to infant mortality. Services provided are consistent with the ACOG and AAP perinatal care guidelines and include pregnancy tests; regular nursing assessments; periodic evaluation by physicians, nurse practitioners, or nurse midwives; laboratory tests; HIV education for all and HIV screening and counseling for those who choose; nutrition services and counseling to assure appropriate maternal weight gain; WIC and referral for other food assistance programs; breastfeeding counseling; health education; social services; and home visiting when indicated. Initial and continuing medical risk assessments are performed on all patients receiving prenatal care in the parish health units, with consultation and referral services from the medical school physicians responsible for the obstetric service at the regional State-supported hospitals for high risk patients. Revised prenatal weight gain grids were implemented in 1996 in all parish health units. The MCH Title V Block Grant also funds prenatal care services in certain areas where infant mortality and teenage pregnancy rates are very high, including low-income housing projects in New Orleans. These include the New Orleans Health Department near the Fisher Housing Project and St. Thomas Health Services primary care center near the St. Thomas Housing Project. In addition, through a contract with Louisiana State University Medical Center (LSUMC) Department of Obstetrics and Gynecology, a team of health providers offer prenatal, postpartum, and family planning services in the Desire Housing Project. The City of New Orleans collaborates with this program by providing the facility. A "Tots and Teens" program continues to be funded at the LSUMC in Shreveport to provide interdisciplinary primary care services to pregnant and parenting adolescents and their infants and children.

The needs assessment has identified other areas of the state as needing improved access to prenatal care. Two regions experienced an increasing infant mortality rate over the past decade, while the rest of the regions experienced a

decreased rate. The regions with the increasing rates and the current highest infant mortality rates include the seven parish area surrounding Baton Rouge and the nine parish area surrounding Shreveport. The region with the next highest infant mortality rate is the eight parish area surrounding Alexandria. MCH staff will work with each of these regions/parishes to develop plans to address prenatal care access problems through the hiring of nurse practitioners in regions with poor access to other providers and by assisting regions in applying for Healthy Start funding. Other interventions proposed in the community needs assessment included the initiation of smoking cessation programs, collaborating with other community agencies to address the need for transportation, mental health and substance abuse prevention and treatment services.

Enabling Services

Pregnant Women, Mothers, Infants, and Children

Case Management

MCH funds the Teen Advocacy and the Moms and Babies Programs in Baton Rouge, a community-based case management program for pregnant and parenting teens and pregnant women at risk for HIV infection and substance abuse.

MCH funds four para-professional home visiting programs in four different regions of the state. These programs follow the Healthy Families America model developed in Hawaii that utilized paraprofessional home visitor supervised by social workers or nurses. These programs seek to prevent child abuse and neglect by focusing interventions on promoting healthy pregnancies, child growth and development, modeling and fostering positive parenting skills and parent-child interactions, assuring provision of needed health care, and developing support systems for families.

MCH funds nurse home visiting programs in four regions of the state. This nurse home visiting program is based on the David Olds Nurse Home Visitation Model. This is a program for first time mothers of low socio-economic status. Nurses follow a very strict program protocol which calls for regular visits to the family starting prior to twenty-eight weeks gestation until the infant is 2 years of age. The objectives of the program are improving women's health behaviors during pregnancy, including nutrition and prevention of substance use; improving family caregiving for infants and toddlers including reducing childhood injuries and family violence; and improving maternal life-course development including reducing subsequent pregnancy and improving educational achievement and workforce participation. The average age of the women currently enrolled is 20, but the majority of women are under 19 with a large segment of early adolescents. This intervention should directly affect the birth rate for teenagers between 15 - 17 who are enrolled in the program.

A Prenatal Risk Assessment tool focusing on psychosocial risk factors will be developed and piloted in Louisiana. These risk factors include substance use, domestic violence, financial/social service needs, and mental health problems. The risk assessment tool will be based on the one developed by the Florida Healthy Start Program. Evaluation of the Florida program has shown a decreased low birth weight rate for pregnant women receiving case management through health department clinics. The pilot in Louisiana health department clinics will include referral and follow up for women identified as needing intervention to address these risk factors.

Outreach

Pregnant Women, Mothers, Infants, and Children

MCH provides outreach services for high risk and hard to reach families. Parish health unit staff provide home visiting and other follow up for high risk families. Each health unit provides presumptive eligibility determination for Medicaid coverage of pregnant women. After the PE determination, health unit staff provide a Medicaid application for the woman to complete and mail in herself for final certification. Medicaid has recently shortened the application form for pregnant women to two pages, and eliminated the need for a face to face interview. Health unit staff are available to assist women if they need help, but if not, women may complete the forms themselves and submit to Medicaid by mail. Streamlined processing is expected to shorten the time that women must wait for a permanent Medicaid card. This delay can often cause a delay in care, since many private providers will not accept the temporary PE card. Louisiana's Child Health Insurance Program (LaCHIP) has and will continue to work closely with MCH staff to reach eligible families. The parish health unit staff will play a vital role in increasing Medicaid/LaCHIP coverage for the large number of unenrolled infants and children by identifying and enrolling eligible families.

The *Partners for Healthy Babies* campaign is an outreach effort to link women with prenatal care. The program utilizes multiple partnerships, media messages, a toll free information and referral hot-line, and other promotional activities to reach pregnant women and impact the determinants of low birthweight and infant mortality.

Population-Based Services

Pregnant Women

Prenatal Behaviors

In addition to providing outreach to pregnant women and linking them with prenatal care, the *Partners for Healthy Babies* campaign promotes healthy behaviors during pregnancy. Media messages focus on the risks of substance use in pregnancy, as well as the importance of getting early prenatal care. A new focus area will be the promotion of healthy weight gain during pregnancy, and *Partners'* newsletter will be mailed to all registered dietitians in the state in order to increase awareness and referrals. Another focus of *Partners* will be recognizing preterm labor. A statewide Folic Acid Council is in its formative and development stages, yet intends to function to encourage, support, and implement statewide education and outreach efforts.

Infants

Screening

The Office of Public Health is responsible for oversight of newborn screening for genetic diseases in the state. The Hearing, Speech, and Vision Program is responsible for the development and implementation of the law pertaining to the identification of hearing impairment in infants, this includes refinement and improvement of a statewide system of services for infants who are deaf or hard of hearing.

Sudden Infant Death Syndrome

The MCH Program contracts with Tulane University School of Medicine, Pediatric Pulmonary Section, for the positions of Sudden Infant Death Syndrome (SIDS) Medical Director and Nurse Coordinator. This has allowed the MCH Program to improve the state's capacity to identify, counsel, and follow-up families of SIDS infants and monitor the functioning of the overall program.

The MCH Program provides a SIDS Program Coordinator who supports the statewide SIDS Program in establishing community-based education on SIDS risk reduction in areas with infants who are at high risk of death from SIDS. This position will develop, implement, and evaluate a statewide SIDS community risk reduction education program to provide public education and awareness on SIDS. The public information campaign will be implemented within high risk target population areas of the state through interagency collaboration with existing community-based agencies and organizations including family day care/child care providers, senior citizen organizations, infant mortality reduction initiatives, and the faith-based community. SIDS informational kits will be developed to assist community-based agencies and organizations in dissemination of the risk reduction message.

The public information campaign, entitled "Face to Face", focuses on reduction of risk factors for SIDS and was developed in conjunction with Tulane School of Public Health, Health Education/Communication Section. SIDS risk reduction posters have been developed and distributed to parish health units, private pediatricians, and child care centers statewide. The SIDS Program is also coordinating with Children's Bureau to provide grief counseling for families of SIDS victims in the New Orleans region and ongoing support through the formation of a SIDS support group. The SIDS Program will also provide professional education and information for public health nurses, other health providers, social workers, emergency medical staff, police officers, and medical examiners.

Infrastructure Building Services

Pregnant Women, Mothers, and Infants

Needs Assessment/Planning/Policy Development

The community portion of this year's needs assessment included training for each parish health department nurse supervisor, regional staff, and community partners on their parish's maternal and child health status, including data from vital statistics, PRAMS, and the child protection agency. MCH patient and visit counts were also included. A survey of health care and social service resources for the MCH population was part of the community-based needs assessment. Follow up of these assessments will be conducted with regional and parish staff to help move from the assessment phase to policy development and implementation phases. A plan addressing infant mortality will be developed in the regions with increasing rates and in those with the highest rates. MCH staff will assist parish and regional staff in obtaining funding to implement interventions aimed at reducing infant mortality. Ongoing reporting to parish, regional, and state level stakeholders will be handled by the State Systems Development Initiative (SSDI) staff. Other needs identified will be addressed through communication with appropriate agencies, such as Medicaid, regarding transportation and other access problems.

Review of vital statistics related to infant mortality is ongoing by the MCH Program staff and information is distributed widely to state and community stakeholders through the annual MCH Block Grant application, other MCH reports, and the Vital Statistics Report. Technical assistance support from the CDC has facilitated the implementation of the Title V and Title X funded Pregnancy Risk Assessment Monitoring System (PRAMS). The PRAMS survey enables MCH to determine prenatal and postnatal risk taking behaviors and develop targeted interventions. Newly available PRAMS data will be analyzed and reports will be widely distributed to stakeholders. MCH will undertake a statewide assessment to determine current activities and needs related to fetal and infant mortality, and will begin to use linked birth/death certificate data to investigate determinants and distribution in order to direct efforts in this area accordingly. The Louisiana Child Death Review Panel reviews all unexpected deaths in children under age 15, including all SIDS deaths. These processes are intended to guide planning and policy development. Special reports are given to State Commission on Perinatal Care and Infant Mortality in order to inform policy development.

Standards Development/Monitoring/Evaluation

The MCH Director serves on the State Commission on Perinatal Care and Infant Mortality, which has been successful in establishing the framework for regionalization of perinatal services by setting standards for determining the level of services that each hospital can provide. These standards are utilized by the Hospital Licensing Section and for Medicaid reimbursement. MCH will assess the impact of these regulations in conjunction with the Commission by examining areas where very low birthweight babies are delivered and cared for in non-tertiary care facilities. A chart review study of very low birthweight infants born in non-Level III hospitals is being conducted to determine the reasons for delivery at these institutions. Findings from this study will be used to develop interventions to increase the percent of very low birthweight infants in hospitals with appropriate care facilities.

The effectiveness of the Nurse Home Visiting Program is being evaluated through a randomized controlled trial. This evaluation will measure the effectiveness of the intervention in Louisiana based on outcomes of child abuse and neglect, subsequent pregnancy, childhood injuries, educational achievement, and workforce participation. In addition, the mental health component will be evaluated to determine the added benefit of this component to the standard home visiting intervention and will look at outcomes of depression, partner violence, substance abuse, and parent/infant relationship.

The pilot testing of the Prenatal Risk Assessment tool will be evaluated for both efficiency and effectiveness. The Acting Women's Health Medical Director and the MCH Epidemiologist will conduct a literature search for best practices regarding prenatal health issues.

Coordination and Training

MCH staff continue to be involved with the two Healthy Start Programs in the state, New Orleans and Northeast Louisiana. Collaboration is ongoing through joint meetings and regular communications. Public health nurses will receive training on preterm labor prevention education. These training sessions will take place in each region of the state. Training

will also be conducted on the prenatal weight gain grids and their application in clinical assessments and patient education and counseling. Training will emphasize the importance of healthy weight gain during pregnancy.

Training

The nurse home visiting program being implemented is based on of the David Olds Nurse Home Visitation Model. Nurses must complete an intense (40-hour) training course prior to client interaction. Additionally trainings are required by the nurses as defined by the model.

Coordination/Policy Development

MCH worked closely with Medicaid to establish nurse home visiting case management as a Medicaid reimbursable program, and MCH Program Staff continue to collaborate with Medicaid for reimbursement for the nurse home visiting program.

Infants

Surveillance

A task force has been meeting in order to design a birth defects registry and make recommendations for implementation to the Legislature next Spring . Goals for the implementation of a Birth Defects Monitoring Network for Louisiana include a statewide active surveillance system, activities to prevent birth defects (one of the leading causes of infant mortality in the state), and direct linkage with service programs for children identified with special needs.

Priority Need 2: Decrease mortality and morbidity among adolescents

Related National Performance Measures (NPM) and State Performance Measures (SPM):

NPM- The birth rate (per 1,000) for teenagers aged 15 through 17 years.

NPM - Percentage of children with health insurance.

NPM- The rate (per 100,000) of suicide deaths among youths 15-19.

SPM- Percent of all children and adolescents enrolled in public schools in Louisiana that have access to school-based health center services.

Direct Health Care Services

Adolescents

The MCH Adolescent School Health Initiative funds and provides technical assistance to 40 school-based health centers to provide primary and preventive physical and mental health services including medical and psychosocial history; physical examination; risk assessment; dental assessment; hearing and vision screening; immunizations; assessment of

educational achievement and attendance problems; treatment of minor and acute problems; management of chronic problems; dispensing medications; referral for STD management; HIV testing and counseling; counseling and referral for physical and sexual abuse; conflict resolution/anger management skills; social service assessment; and health education.

The Louisiana Children's Cabinet has continued its top priority support for increasing the number of school-based health centers for 2000-01. Additional funds requested in the Executive Budget have been approved in the 2000 session of the Legislature. The funds will cover five centers funded by the Robert Wood Johnson Foundation Making the Grade grant, which expires June 30, 2000, and will expand access to health care to a potential 7,500 additional children at six additional centers.

OPH supports the expansion of School-Based Health Centers in Louisiana through continued MCH Block Grant funding for the SBHCs. They are a well established, effective means of providing the much needed comprehensive health and mental health services to adolescents, of addressing the health risk behaviors encountered in adolescents, and of facilitating the implementation of coordinated school health. SBHCs overcome the traditional barriers adolescents have faced in accessing care, including financial and cultural barriers.

The OPH Family Planning Program receives supplemental funding from Title V and provides comprehensive medical, educational, nutritional, psychosocial, and family planning services to adolescents. Approximately 30% of the patients served by the Family Planning Program are adolescents. Parent involvement is a component of the adolescent services. Family Planning is expanding services to teens by contracting with community-based organizations and clinics who can offer more non-traditional hours and offering its parish health unit staff clinic design tools for offering more youth-friendly services. The MCH funded "Tots and Teens" clinic in Shreveport provides medical and psychosocial health services for pregnant and parenting adolescents and their children.

Comprehensive after-school programs for youth are an effective way to address all of the major health risk behaviors that contribute to the morbidity and mortality of this age group. The Office of Public Health is a natural fit to assume a leadership role in seeking funding, setting standards, developing policy, providing technical assistance, and assuring quality for local entities to establish and operate after school programs. First, these risk behaviors are public health issues. OPH has the epidemiological expertise, technology, and staff to track the health outcomes associated with these risk behaviors. Second, OPH has the contract management expertise needed to monitor such programs. Third, it can model the successful community-based SBHC program that has been developed through the Adolescent School Health Initiative at OPH. Lastly, OPH has established partnerships with many community-based organizations to implement these programs. In the coming year, MCH Adolescent School Health Initiative and Family Planning Program staff will explore possible funding opportunities for after-school programs.

Adolescents with Special Health Care Needs

The CSHS Program provides subspecialty care for adolescents with special health care needs.

Enabling Services

Adolescents

Coordination with Education

MCH continues to collaborate with the Department of Education, the Office of Mental Health, and the Office of Addictive Disorders to fund the Excellence in Health and Education Project (EHEP) at Southeastern Louisiana University. Goals of the collaboration include providing state-of-the-art teaching and learning opportunities, advocating for the health and well-being of individuals in schools and communities, conducting research and evaluating services, and establishing a clearinghouse of resources for coordinated health and education. Since 1998, EHEP has conducted an annual Summer Institute Training for teachers and other professionals who work with youth. In addition, the Department of Education Cadre of Trainers, organized and educated by EHEP, continues to conduct numerous training throughout the year. EHEP plans, in the coming year, to revise the Louisiana Health Education Standards for K through 12th grades based on National Standards and to assist with their dissemination

Case Management

The Title V funded Teen Advocate Program in Baton Rouge provides case management services to pregnant teens aimed at healthy pregnancy and preventing future teen births.

Population-Based Services

Adolescents

The Abstinence Education Program, run by the Governor's Office, is promoting abstinence by funding 16 community-based projects, a pilot parish project, a clearinghouse center, a statewide grassroots campaign, and a statewide media plan.

The Keeping It R.E.A.L. (Reality Education About Life) Program, run by the State's Department of Social Services, is creating awareness on the issue of teen pregnancy statewide by funding 10 community-based projects whose mission is to reduce teen pregnancy. The six components of this program are youth development, comprehensive health/family life education, policy enforcement, parental involvement, mental health/counseling, and male involvement. The Office of Public Health's Family Planning Program, in partnership with St. Luke's Episcopal Church, administers two of the ten community-based projects: The Real Men Male Involvement Project and the Real Talk Parent Education Project. The Department of Social Services is also be conducting a statewide media campaign as part of the Keeping It R.E.A.L. Program. Components of the media campaign include billboards and busboards, television and radio spots, and other methods to reach the teenage target group.

Infrastructure Building Services

Adolescents

Needs Assessment/Planning/Policy Development

Staff of the MCH Adolescent School Health Initiative and the Family Planning Adolescent Program have been collecting data from state public and private agencies in order to publish data on the state's teen population in one comprehensive document for the first time. This Adolescent Data Book includes physical and mental health data; poverty and social welfare data; violence and crime data; and education and school data. It is expected that this publication will be a useful resource for planners and policy makers, state and local officials, grant writers, teachers, community leaders, activists, parents, and all others who are working to improve the health of Louisiana adolescents. Since publication in November 1999, Family Planning has distributed 349 data books by request and plans to send out another 500 to be mailed out by the end of June. Additionally, the data book will be put on the Internet and updated annually.

The Adolescent Health Initiative also produced the Louisiana Teen Pregnancy Prevention Directory. This Directory includes a listing of statewide programs that provide counseling and medical services to help teens prevent pregnancy and stay in school if they are teen parents. It is expected that the information in this Directory will help keep adolescents and health professionals who work with adolescents informed of the existing teen pregnancy prevention services in Louisiana. Of the 300 printed, all have been distributed statewide. Another 300 are being printed in June 2000. The Directory will also be put on the Internet and updated regularly.

Coordination/Systems of Care/Policy Development

The State law creating the school-based health center program included a provision for the establishment of an Intergovernmental Coordinating Council, composed of departments of government that serve adolescents. In the five years this council has met, under the leadership of MCH, it has 1) served as the policy making body for the Robert Wood Johnson Foundation Making the Grade Louisiana grant; 2) collaborated on such issues as welfare reform and Medicaid/LaCHIP; 3) established pooled funding among OPH, the Office of Mental Health (OMH), and the Office of Addictive Disorders (OAD) to secure mental health staff at SBHCs; and 4) collaborated with the Department of Education to hire a health professional in the State education agency. Pooled funding has been successfully piloted in one region by supporting provision of preventive mental health services in a school-based health center. School-based health center staff have been trained by Medicaid to become official CHIP application centers. Since all SBHCs are also required to bill Medicaid for reimbursable services that they provide, more children enrolled in LaCHIP can mean more Medicaid revenue for the centers' expansion. Guidelines of the SBHC program require local level collaboration among sponsors and funding sources. A local level collaborative model has been developed whereby the school board, sponsoring hospital or community health center, parish health unit, community mental health, and alcohol and drug abuse agency staff work together to bring resources and services to SBHCs which meet the physical and mental health needs of the students.

Priority Need 3: Decrease intentional and unintentional injury in the MCH and CSHCN populations.

Related National Performance Measures (NPM) and State Performance Measures (SPM):

NPM-Rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

NPM-Rate (per 100,000) of suicide deaths among youths 15-19.

SPM-Rate of children (per 1,000) under 18 who have been abused or neglected.

SPM-Percent of women who have had a baby who report physical abuse either during their last pregnancy or in the 12 months prior to becoming pregnant.

Direct Health Care Services

Infants and Children

MCH has an interagency agreement with the Office of Community Services (Child Protection Agency) to utilize public health nurses to assist child protection workers in investigating suspected cases of medical neglect, malnutrition, and failure to thrive. Nurses either conduct a home visit with the child protection worker or see the child in the clinic. These activities are intended to reduce both intentional and unintentional injuries among the many children seen at the parish health units statewide. Meetings will be held with both agencies in order to keep this collaborative effort strong.

Enabling Services

Pregnant Women, Mothers, Infants, and Children

Case Management/Family Support Services/Outreach

MCH funds nurse home visitors in four regions of the state. This nurse home visiting program is based on the David Olds Nurse Home Visitation Model, and one of its objectives is to reduce family violence and number of childhood injuries. This model was chosen by MCH because of its proven effectiveness in preventing child abuse and neglect; clinical trials and longitudinal studies have shown that this program significantly reduced by 79% the verified reports of child abuse and neglect.

Also, MCH funds four paraprofessional home visiting programs in four different regions of the state which follow the Healthy Families America model developed in Hawaii. These programs seek to prevent child abuse and neglect by focusing interventions on promoting healthy pregnancies and child growth and development; modeling and fostering positive parenting skills and parent-child interactions; assuring provision of needed health care; and developing support systems for families.

The CSHS Program is developing a care coordination model that will incorporate a proactive approach directed at primary, secondary, and tertiary prevention efforts through teaching and risk appraisal/symptom management activities.

Population-Based Services

Pregnant Women and Women of Reproductive Age

Outreach/Public Education

Region specific domestic violence emergency referral/safety cards were developed and distributed for all parish health unit and State Office of Public Health female bathrooms, as well as to private providers. These cards will continue to be available statewide.

Infants and Children

Public Education

The MCH funded Louisiana SAFE KIDS Program Coalition is a comprehensive public information injury prevention program which organizes local chapters throughout the state, distributes newsletters and pamphlets, conducts special events, and participates in health fairs. Interventions address car, gun and fire safety, child-proofing homes, bicycle helmet use, and sports injury prevention. A citizen surveillance program continues to recruit citizens who mail postcards to SAFE KIDS when a child is seen riding unrestrained in a safety seat or seat belts, indicating the license plate number and other information about the event. The State Department of Motor Vehicles provides the name and address of the registered owner of that car and SAFE KIDS sends information about the child safety seat law to the vehicle owner. Information and discount coupons for car safety seats are sent as well. SAFE KIDS collaborates with numerous organizations including Children's Hospital, Fire Departments, Motor Vehicle Safety agencies, the Louisiana Highway Safety Commission, and the Department of Education. The City of New Orleans Health Department will partner with SAFE KIDS to target reduction of preventable injuries.

MCH funds a child abuse prevention public information campaign in conjunction with Prevent Child Abuse Louisiana, the State chapter of Prevent Child Abuse America. Radio commercials, billboards, and speakers bureaus promote healthy parenting, positive discipline, and the toll free counseling hot-line for parents. A flyer is included with the mailing of all birth certificates in the state and is distributed to all WIC clients informing new parents about this counseling hot-line.

Infrastructure Building Services

Infants and Children

Assessment

A Child Health patient record used in the parish health units has been revised to be more comprehensive in gathering information on social and familial factors that place an infant or child at higher risk of poor outcomes. The new record includes screening for environmental and safety risk factors in infants and children. Counseling specific to the identified safety risk factors are addressed in the clinic visits. Information on injury prevention for specific injuries or risk situations will be distributed as they are developed.

Coordination/Surveillance/Monitoring

The Child Death Review Panel, established by the State Legislature in 1993, reviews all unexpected deaths in children under the age of 15. This panel includes representatives from MCH, Child Protection Agency (Office of Community Services), Coroners Association, Attorney General, American Academy of Pediatrics, State Medical Society,

Vital Registrar, State Police, Fire Marshall, the Legislature, and the general public. The MCH Program has staffed the review panel, in conjunction with the Tulane Child Death Review and the SIDS Counseling and Risk Reduction Program. Plans for next year include establishing a full-time position within the Office of Public Health to staff the panel and to continue with the development of local review panels.

Children

Assessment/Training

The MCH Oral Health Program has initiated the P.A.N.D.A Program (Prevention of Abuse and Neglect through Dental Awareness) in conjunction with the Louisiana Dental Association. This program provides training and educational materials to dentists and dental hygienists on recognizing child abuse and neglect and encourages them to report suspected cases.

Priority Need 4: Increase care coordination among children with special health care needs.

Related National Performance Measures (NPM) and State Performance Measures (SPM):

NPM-The degree to which the State CSHS Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

NPM-The degree to which the State assures family participation in program and policy activities in the State CSHS Program. SPM-The percent of CSHS patients with case management from a nurse, social worker, or nutritionist.

Direct and Enabling Services

Children with Special Health Care Needs

The CSHS Program is developing a formalized care coordination model to be implemented after staff training is accomplished. Care coordination will meet the needs of children/adolescents and families through a proactive, family-centered, outcomes-focused collaborative process. This model is felt to be unique in that it will not only empower families to independently utilize and navigate systems of care, but it will also prepare the child/adolescent for transition into adult roles and responsibilities as appropriate for each individual child/adolescent and family. Other components of the model include medical home coordination as an integral component of the plan of care and promotion of health strategies that will include primary, secondary, and tertiary prevention of disabilities. The CSHS Care Coordination Program proposes to strengthen the service delivery system by promoting a framework that holistically works with the child and family to promote an enhanced continuum of care through each aspect: primary care (medical home/health promotion); family support; development/education/vocation; and speciality care.

CSHS Coordination will meet the needs of children/adolescents and families through a proactive, family-centered, outcomes-focused collaborative process:

- 1) providing core public health functions to include assessment of unmet needs, assurance of infrastructure development, and policy development to address the needs of this population;
- 2) providing a proactive approach directed at primary, secondary, and tertiary prevention efforts through teaching and risk appraisal/symptom management activities;
- 3) providing developmentally appropriate counseling according to the child's age and state of growth and development;
- 4) enhancing a seamless, comprehensive system of care through coordination that includes the medical home, tertiary centers, community-based services including schools, and other providers of care;
- 5) enhancing knowledge and understanding of the disease process/disability and health promotion and disease prevention strategies needed to promote optimum health;
- 6) reducing secondary disabilities and co-morbidities while maximizing health wellness and quality of life; and
- 7) preparing the child/adolescent for transition into adult roles and responsibilities as appropriate for each individual child/adolescent and family.

To assure that the CSHS Program, including its Care Coordination model, continues to be family-centered and advocacy-focused, parent participation in the program will continue. CSHS has had parent participation for over 14 years. Parent Liaisons attend CSHS clinics to offer emotional support and resources to families of CSHCN. Parent input into program policy and procedures occurs with three statewide parent coordinators who have collaborated with staff in the development of the Care Coordination model, continuous Quality Improvement, Universal Newborn Hearing Screening Systems, and the Medical Home project. In addition, parents were an integral part of outreach training to increase awareness of the program, as well as members of the committee established for eligibility expansion. Future proposed activities for parents are in the pilot project for diabetes and the development of the Birth Defects Monitoring Network.

Priority Need 5: Increase access to and utilization of comprehensive primary, preventive, and specialty care services for women of reproductive age, infants, children, adolescents, and children with special health care needs with particular emphasis on transportation and provider availability.

Related National Performance Measures (NPM) and State Performance Measures (SPM):

NPM-Percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program.

NPM-The degree to which the State Children with Special Health Care Needs Program provides or pays for specialty and sub-specialty services, including care coordination, not otherwise accessible or affordable to its clients.

NPM-Percent of Children with Special Health Care Needs in the State who have a "medical/health home."

NPM-Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.

NPM-Percentage of Children with Special Health Care Needs (CHSCN) in the State CHSCN Program with a source of insurance for primary and specialty care.

NPM-Percent of children without health insurance.

NPM-Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

SPM-Percent of all children and adolescents enrolled in public schools in Louisiana that have access to school based health center services.

SPM-Percent of women in need of family planning services who have received such services.

SPM-Percent of Children's Special Health Services patients with case management (follow up) visits from a nurse, social worker, or nutritionist.

Direct Health Care Services

MCH provides comprehensive health services to women of reproductive age, infants, children, and children with special health care needs who lack access to services due to financial or other barriers including the lack of providers. The CSHS clinics bring subspecialty providers to the rural areas of the state where these services are not available.

Women of Reproductive Age

The MCH Block Grant funds supplement the Title X Family Planning Program which delivers services in the same facilities and by the same staff as the MCH Program. Comprehensive medical, educational, and family planning services are provided to approximately 70,000 women each year. The Family Planning Program provides services via 79 of the State's parish health units and 12 delegate agencies. Their goal is to increase new users, targeting underserved populations with improved outreach, clinic efficiency evaluations, and the hiring of additional nurse practitioners in areas with provider shortages.

Infants and Children

Comprehensive preventive child health services, including physical examinations, laboratory and other screening procedures, immunizations, nutritional assessments and counseling, health education, and WIC services are provided in all the parish health units to children whose families are uninsured or are Medicaid eligible and have no access to private care. WIC services, immunizations, and health and parenting education are also provided in the parish health units to patients referred by other health providers. MCH has a contract with Medicaid to conduct EPSDT screening in all parish health units. Although private provider participation has decreased the number of children screened by MCH, there are still areas of the state where access is a problem and EPSDT services in parish health units are still active. MCH funds provide support to community-based child health programs, including St. Thomas Health Services, Inc. in New Orleans and the Shreveport "Tots and Teens" program providing pediatric primary care.

A subprogram of MCH is the Hearing, Speech and Vision Program, which provides statewide diagnostic speech/language pathology and audiology services for infants and children; vision screening services; auditory brainstem response and otocoustic emissions testing; a family service plan with follow up; and preventive counseling and identification/evaluation/referral of children referred from preschool and school screening programs and parish health unit preventive health programs.

Children with Special Health Care Needs

CSHS provides pediatric subspecialty treatment to over 7,000 children through its regional and local clinics. Comprehensive services, including nursing, social work, nutrition, audiology, and speech-language pathology, are provided in a team approach. CSHS supports three High Risk Clinics throughout the state to identify and treat infants at risk. Transportation is a barrier to accessing these services. CSHS will continue to work with Medicaid and other community agencies to improve availability.

Direct and Enabling Services

Pregnant Women

All regions will be requested to develop their own comprehensive plan to improve prenatal care inclusive of access to providers and transportation assistance. However, three regions - Baton Rouge (region two), Alexandria (region six) and Shreveport (region seven) - will be the focus of MCH and regional collaboration due to particularly poor pregnancy outcomes and/or acute access issues in these regions. Statewide, regional and parish health unit staff and their community partners express the need to increase the number of prenatal care providers and improve transportation services as top priorities.

Environmental Scan Survey results will assist regional administrators and medical directors in identifying professional partners in each region. These partners will be potential collaborators to improve the primary care needs of the region's population. The survey collected information from each parish on the following types of services: primary care clinics, private primary care medical providers (specifically: general/family practice, OB/GYN, pediatricians and internal medicine), dentists (all subspecialties), hospitals, and community agencies.

Regions can use the results of this primary care survey initially to identify providers who currently serve their parishes. Regions will review which clinics, medical and dental providers, and agencies provide services to pregnant women (including direct medical services, dental services, smoking cessation, substance abuse, and psychosocial services) and if these providers and services accept current or new Medicaid clients or other forms of payment from low income women. This information will inform regional administrators of providers with whom they can negotiate service arrangements. Regional administrators will identify local or regional providers willing to take clients or will develop contracts with providers of prenatal medical care.

Additionally, regions are encouraged to work with other agencies to apply for federal and private grants, such as Healthy Start, to fund prenatal care and transportation services that would improve pregnancy outcomes. MCH will assist regions with MCH data analysis pertinent to their parishes for grant development.

Infants and Children

Although information is available on the barriers to accessing child health services created by shortages of child health providers and transportation services, local initiatives to address these access issues have been limited.

MCH will review data and provide a more in depth analysis to help identify true shortages and areas experiencing severe access problems. Such activities will include surveys of Medicaid providers in Orleans and Rapides parishes and in other regions to ascertain whether they are accepting new patients; mapping of available providers; and communication with the EPSDT Program (KIDMED).

Enabling Services

Pregnant Women, Infants, and Children

Transportation

To address the statewide transportation need, MCH will encourage each region that identified transportation as a top priority to develop an action plan - taking into account existing public and private resources. Regional administrators will work with local transportation providers as a way to seek transportation for clients to and from medical services. Other solutions might include providing gas vouchers for transportation or tapping into underutilized vans owned by community agencies.

Case Management/Care Coordination

Access to health care services is increased by Hospital Nurse Coordinators, who are positioned in each of the State-supported hospitals to facilitate referral of Office of Public Health patients through the health care system. Strong ties exist between the parish health units and the Head Start Programs. Accepting referrals, giving immunizations, and providing well child care and health education are the primary services provided by local MCH staff.

Coordination with Medicaid

There is consistent collaboration between MCH and Medicaid at the state and local levels to ensure accessibility to comprehensive health services. MCH staff worked closely with Medicaid to design the outreach measures for Louisiana's Child Health Insurance Program, and continue to work closely with Medicaid outreach staff to conduct outreach and enrollment for Medicaid/LaCHIP. MCH is the Lead Agency for Louisiana's Covering Kids Initiative, a three-year Robert Wood Johnson Foundation grant. The grant is composed of a statewide intervention and two pilot projects (in New Orleans and in Central Louisiana) that conduct strategies to improve the enrollment of eligible children into LaCHIP.

Covering Kids identifies and addresses particular burdens that prevent LaCHIP enrollment. It specifically targets hard-to-reach populations that have been bypassed by traditional outreach efforts. Covering Kids works towards institutionalizing LaCHIP into existing programs and services, such as the School Lunch Program, TANF and Food Stamp Programs, and child care centers, in order to provide sustainable, efficient ways to enroll eligible children. The Initiative's strategies are closely coordinated with Medicaid outreach activities to prevent the duplication of services, and to assure that enrollment gaps are being filled.

All parish health units provide presumptive eligibility determination for pregnant women and assist them with completing the recently shortened and simplified Medicaid application form. Parish health units identify and inform eligible families about LaCHIP. The MCH Program is working with the State EPSDT Program to increase the number of infants and children screened through increasing linkage of unlinked, unserved infants and children to an EPSDT provider or providing screening to infants and children in need of screening.

Children with Special Health Care Needs

Care Coordination

The CSHS care coordination model is designed to improve continuity of care across settings and providers, improve interdisciplinary and interagency communication, reduce duplication or fragmentation of services, improve access to services and resources, and improve cost effectiveness and resource utilization for families and systems of care.

Population-Based Services

Pregnant Women, Mothers, Infants, Children, and Children with Special Health Care Needs

Outreach

The MCH toll free hotline is operated through a contract with the Disabilities Information Access Line in the Department of Health and Hospitals. The phone lines are managed by skilled counselors who provide confidential information for individuals seeking referrals for pregnancy testing, prenatal care, primary and preventive services for children, including comprehensive information for children with special health care needs. The "Shots for Tots" public information program promoting immunizations uses this hot-line. The hot-line provides referrals to public and private physicians who provide Title V and Title XIX services, and works to improve callers' access to services.

The Birth Defects Monitoring Network will provide information to all families of children identified with birth defects as an early link to essential medical, social, and educational services.

Women of Reproductive Age

Outreach/Public Education

The Office of Public Health's Family Planning Program will revise its statewide Outreach and Education Plan by January 2001. Client and field staff input will be solicited and combined with research-based, proven outreach strategies.

Topics will include 1) Contraceptive Technology, 2) Unintended Pregnancy, 3) Teen Pregnancy, 4) Male Involvement, and 5) Comprehensive Reproductive Health.

Pregnant Women

Public Education

The MCH Program operates a statewide, social marketing campaign, *Partners for Healthy Babies*, promoting early prenatal care, healthy behaviors during pregnancy, and use of a toll-free help-line staffed by skilled counselors who provide information and referrals for medical and social services. MCH supports a statewide network of local Perinatal Substance Abuse Coordinators who provide education and referral for prenatal patients and the community at large. This program also includes a clearinghouse of educational materials on alcohol, tobacco, and other drug use during pregnancy for distribution to private providers, health units, and schools.

Children

Public Education

As the Lead Agency for Louisiana's Covering Kids Initiative, MCH conducts public education on LaCHIP. Specifically, MCH will develop and distribute promotional materials, work with coalition members to educate families, and coordinate with the eligibility processes of other government and social programs. Covering Kids is in the process of sending LaCHIP promotional brochures to every schoolchild in Louisiana with the applications for Free and Reduced School Lunch. This is the second year that this activity will be done, and two major changes were made for the upcoming year's materials: pamphlets are geared toward adolescents and the need for recertification after one year is stressed. Covering Kids is also sending information to principals and school coaches detailing ways that they can promote LaCHIP in their schools. This is also the second year for this activity, which was first undertaken with the mailing of a principals packet last Fall. Postcards are being mailed to Food Stamp recipients in each region of the state in an attempt to educate families about LaCHIP and encourage them to apply. New promotional materials will be developed to target Spanish speaking and Hispanic eligible children throughout the state, using an already developed Hispanic Outreach Kit.

Orleans Parish will continue Medicaid/LaCHIP enrollment activities in child care centers, New Orleans Recreation Department camps, health fairs, clinics, and at other city events.

Infrastructure Building Services

Pregnant Women, Mothers, Infants, and Children

MCH offers expertise in the development and updating of health standards, health plan benefits, and quality assurance measures for Medicaid programs (EPSDT and managed care). The MCH Pediatric Medical Director continues to be a member of the American Academy of Pediatrics Liaison to State Government Committee, which serves as an advisory committee to the Medicaid/EPSDT Program.

MCH medical and nursing consultants update maternity and child health manuals and protocols and provide training on these changes to MCH/Family Planning regional nurses who in turn provide training to parish public health staff. An integration of clinical manuals has been undertaken which will include a revision of the Child Health Manual. MCH monitors Continuous Quality Improvement (CQI) systems at the OPH local, regional, and state levels in accordance with approved CQI protocols. CQI performance measures and statistics will continue to be monitored by the State Nursing Consultant. The MCH Pediatric Medical Director serves as the co-facilitator for the Louisiana Chapter of the American Academy of Pediatrics (AAP) CATCH (Community Access to Child Health) Program.

Policy Development

The MCH Needs Assessment results showed that 66% of all parishes identified transportation as their top priority need. Parish health unit patients reported that the number one reason they missed appointments was a lack of transportation. Both of these findings help to document the need for transportation services in Louisiana, and enable MCH to use hard data to help create policy change. MCH staff will meet with State Medicaid officials to share the results of data that clearly demonstrate the need to improve mechanisms at the regional level that fund travel for Medicaid clients.

Children with Special Health Care Needs

Coordination/Provider Training

The CSHS Program will increase capacity for a medical home for all children with SHCN in Louisiana by its leadership and participation in the Medical Home project and training. The Louisiana committee is developing training for primary care physicians to provide primary and preventative care to CSHCN. The CSHS Program has participated in a Transportation Summit sponsored by the Advocacy Center for the Elderly and Disabled that will continue and is hoped will increase access and build infrastructure for the service.

Priority Need 6: Assure that all children, especially those with special health care needs, have a medical home for comprehensive primary and preventive health care, with coordination of all health and support services.

Related National Performance Measures (NPM) and State Performance Measures (SPM):

NPM-The percent of children with special health care needs in the State who have a “medical/health home”.

NPM-The degree to which the State Children with Special Health Care Needs Program provides or pays for specialty and sub-specialty services, including care coordination, not otherwise accessible or affordable to its clients.

NPM-Percentage of Children with Special Health Care Needs in the State CSHS Program with a source of insurance for primary and specialty care.

NPM-Percent of children without health insurance.

NPM-Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

Direct and Enabling Services

Infants and Children

Screening services for Medicaid infants and children are provided in the parish health units through contracts with community physicians in some of the 20 Community Care parishes in the state. The Community Care Program provides physician primary care case management for Medicaid clients in those parishes. Parish health units in these areas provide information on their findings to the primary care case management physician and provide follow-up and other requested services as needed. In other areas of the state, the source of the child's primary medical care is routinely requested from clients and referrals to the primary care physician named by the client is done for problems found.

Children with Special Health Care Needs

CSHS care coordination includes medical home coordination as an integral component of the plan of care, and program staff will work with families and primary care physicians to make a medical home a reality for children and families.

Population-Based Services

Infants

Newborn Screening

The state mandated Newborn Screening Program ensures that all newborns are screened before discharge from the hospital for PKU, congenital hypothyroidism, hemoglobinopathies (sickle cell disease) and biotinidase deficiency. For infants with abnormal tests, contact is made with the primary care physician to assure further testing for confirmation. If disease is detected, results are relayed to the primary care physician and assistance for referral for specialized care is provided. Contracts with the three Louisiana medical schools provide laboratory testing and specialized clinical services for these patients.

Infrastructure Building Services

Infants and Children

At the present time, there is little documentation of the number of infants and children who lack a medical home that provides comprehensive primary and preventive care. In fiscal year 2001, MCH, in conjunction with the CSHS Medical Home for Children with Special Health Care Needs Initiative, will undertake the development of a process to document the current status related to medical homes for all infants and children. This will include an assessment of provider accessibility and availability as well as financial, cultural, and other barriers on a local and regional basis. In addition, a working group of child advocates and other public and private agencies and organizations will be established to determine the needs that must be addressed to establish a medical home for all children in the state. The ultimate goal is to develop a plan for the state to improve access to a medical home for all children.

Children with Special Health Care Needs

Coordination/Provider Training

The CSHS Program has taken a leadership role in the Medical Home Project for Louisiana. A statewide committee has been formed with the goal of educating pediatricians and other primary health care providers, office staff, child health advocates, families, and allied health professionals about the medical home concept and how they can work collaboratively to provide accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent care to children with special health care needs. The American Academy of Pediatrics, Medical Home Facilitation is assisting the group with planning several training sessions to be held around the state. Shriners' Hospital is also a major partner in planning the training for the northern part of the state. Representatives from the Louisiana Chapter of the AAP, local hospitals, three medical schools, parent advocacy organizations, the Office of Mental Health, the Office of Public Health, the Education Department, the legislator's office, and physicians in private practice have participated in the planning. Training sessions are still in the planning stages, but should serve as a meaningful catalyst for improving access to a Medical Home for CSHCN.

Priority Need 7: Assure the oral health needs of the MCH and CSHCN populations are met.

Related National Performance Measures (NPM) and State Performance Measures (SPM):

NPM-Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Direct Health Care Services

Children with Special Health Care Needs

CSHS funds a speciality Dental Clinic for children with special health care needs. Services are provided by LSU Dental School and are specially designed to be readily accessible to this population, known to have barriers to accessing regular dental care.

Population-Based Services

Children

Fluoridation

The Office of Public Health (OPH) has reestablished the State Community Fluoridation Program through the establishment of a full time Fluoridation Program Coordinator position to manage Program activities and the Fluoridation Program Legislation. The Legislation 1) encourages water systems with 5,000 or more connections to fluoridate, 2) reestablishes the Fluoridation Program through the Office of Public Health, and 3) creates a Fluoridation Advisory Board of 14 members from various organizations to seek additional funding for the implementation of fluoridation for the targeted

water systems. The Fluoridation Program Coordinator and the Fluoridation Advisory Board will work together in the coming year to promote water fluoridation efforts in the targeted water systems throughout the state.

Sealants

MCH has contracted with the David Raines Community Health Center (DRCHC) in a collaborative effort to provide dental sealants to children in 10 schools in the Shreveport area. MCH provided portable dental equipment which will be used at the various school sites by DRCHC dental staff. DRCHC will provide the dental professional staff to provide sealants to the children and will provide materials and supplies. This will be a pilot program which will be considered for replication in other areas of the state in conjunction with other community health centers or school-based health clinics.

Public Education

The Oral Health Program will distribute information on sealants, dental hygiene, and baby bottle tooth decay to school and public health nurses for dissemination to families statewide.

Infrastructure Building Services

Pregnant Women and Women of Reproductive Age

Assessment and Surveillance

The MCH-administered Pregnancy Risk Assessment System (PRAMS) survey added questions on oral health that will provide information on oral health among pregnant and postnatal women. The Behavioral Risk Factor Surveillance Survey (BRFSS) administered by OPH has incorporated an oral health module that will provide information on access to dental care and urgency of dental need. These data will be analyzed and reports will be disseminated.

Children

Assessment/Surveillance

The oral health needs assessment included surveys of dentists participating in the Medicaid Program. Medicaid claims data is being analyzed to evaluate utilization rates, sealant prevalence, and the number of children receiving dental exams during a specific time period. Medicaid data includes claims information since 1994, and data availability will be ongoing. Reports of this data will be prepared and shared with the Medicaid Program, the Louisiana Dental Association, and other interested stakeholders.

A school-based oral health screening program was initiated with school nurses and will be instituted periodically for surveillance purposes. This activity will continue to yield information on untreated caries, sealant prevalence, and the urgency of treatment need for 3rd grade schoolchildren.

Evaluation/Coordination/Provider Training

An evaluation of the partnership between the David Raines Community Health Center in Shreveport and the Office

of Public Health, whereby OPH provided portable dental equipment for the health center's sealant program, will be conducted. An attempt will be made to use this partnership as a blueprint for enacting similar sealant programs throughout the state.

The PANDA (Prevent Abuse and Neglect through Dental Awareness) Initiative will continue in conjunction with the PANDA Coalition, which includes the Louisiana Children's Trust Fund, Louisiana Dental Association and its Alliance, Louisiana Academy of Pediatric Dentistry, Louisiana Dental Hygienists Association, Office of Community Services, Louisiana Council on Child Abuse, and the American Society of Dentistry for Children. PANDA materials will be distributed to all dentists and hygienists in the state. Educational offerings will target dentists and hygienists so that they will be able to recognize and report signs of child abuse and neglect. Regional and state level trainings will be held.

The oral health screening and surveillance program will again be presented at the Louisiana School Nurse Association's annual meeting. Nurses who participated in the program will receive an updated training, and new nurses will be invited to be part of this program.

Priority Need 8: Address the social, emotional, and psychological needs of the MCH and CSHCN populations.

Related National Performance Measures (NPM) and State Performance Measures (SPM):

SPM-Percent of all children and adolescents enrolled in public schools in Louisiana that have access to school-based health center services.

SPM-Rate of children under 18 who have been abused or neglected.

SPM-Percent of CSHS patients with case management from a nurse, social worker, or nutritionist.

SPM-Percent of women who have had a baby who report physical abuse either during their last pregnancy or in the 12 months prior to becoming pregnant.

Direct and Enabling Services

Pregnant Women, Mothers, Infants, and Children

Prenatal care services are directed at assuring maternal and fetal optimal health, healthy behaviors, minimization of risk factors, and early recognition, treatment, and referral of problems that may put mothers and infants at risk of morbidity directly related to infant mortality.

A Prenatal Risk Assessment tool focusing on psychosocial risk factors will be developed and piloted in Louisiana. These risk factors include substance use, domestic violence, financial/social service needs, and mental health problems. The pilot in Louisiana health department clinics will include referral and follow up for women identified as needing intervention to address these risk factors.

MCH funds nurse home visiting programs in four regions of the State based on the David Olds Nurse Home Visitation Model. This is a program for first time mothers of low socio-economic status. Nurses follow a very strict program protocol which calls for regular visits to the family starting prior to twenty-eight weeks gestation until the infant is 2 years of age. MCH Program Staff have been collaborating with the Louisiana Office of Mental Health (OMH) to provide mental health support and services to the Nurse Home Visiting Program. An OMH assigned mental health worker will complete specialized training at Tulane University's School of Medicine in infant mental health before starting work with the team of nurse home visitors. This training was initiated by MCH due to the lack of such resources in most regions of the state. The purpose of this training is to enhance mental health professionals' expertise in extending their services to children from birth to three years of age. This project will provide training regarding infant and child development and psychopathology. Training components will include normal and abnormal development in infancy, assessment and treatment of psychosocial and psychological difficulties presented by infants and their caregivers, and working with family systems which include very young infants and toddlers. The training program will consist of a four-month block which involves 2.5 days of training in New Orleans per week. At the completion of this 4 month period, an 8-month follow-up period will be provided to supervise the trainee in his/her clinical setting. This mental health worker's role with the team of nurse visitors is to support psychosocial and mental health aspects of the program, provide case consultation to the nurses, and to provide direct clinical mental health services when appropriate. OMH plans to dedicate 1-2 mental health workers per nurse home visiting team.

MCH funds four para-professional home visiting programs in four different regions of the state. These programs follow the Healthy Families America model developed in Hawaii that utilized paraprofessional home visitors supervised by social workers or nurses. These programs seek to prevent child abuse and neglect by focusing interventions on promoting healthy pregnancies and child growth and development, modeling and fostering positive parenting skills and parent-child interactions, assuring provision of needed health care, and developing support systems for families.

Infants and Children

The revised child health record has been expanded to be comprehensive in gathering information on social and familial factors that place the infant or child at a higher risk of poor outcomes. Current services provided to those found to be at risk include counseling and education, as well as follow-up including referral to other agencies, will be continued.

Children with Special Health Care Needs

The CSHS Program provides parent support through all clinic team members including nurses, social workers, clerical staff, physicians, nutritionists, audiologists, other allied health staff, and Parent Liaisons. The Parent Liaisons also organize and participate in support groups for families of CSHCN. Since the need for support groups was reported as the top need of CSHS families, these will be increased during the next five years.

CSHS care coordination will be family-centered and the ultimate support of the child and caregiver needs in a plan that will improve the quality of life by providing family support and enhancing family well being. The inclusion of

transition services into care coordination will also support the self determination and independence of adolescents with SHCN. This will include increasing competence in children and adolescents to enable them to manage their health condition, negotiate the service delivery system, increase their self-esteem, and transition to adult independence and self-sufficiency to the greatest extent possible.

Population-Based Services

Mothers, Infants, and Children

The Pierre the Pelican pamphlet series sent to all new parents in Louisiana focuses on child growth and development and mental health concerns. This pamphlet series is mailed monthly to parents of infants, every other month during the second year, and continues to be sent quarterly until age four, and semi-annually until age six. MCH is planning to update the Pierre the Pelican program operation and is currently evaluating alternative newsletters to be sent to new parents. The revised program will additionally emphasize developing healthy infant-caregiver relationships, healthy social and emotional development, parent and parenting issues, and mental health concerns including maternal depression and family stress.

Infrastructure Building Services

Mothers, Infants, and Children

Provider Training

An Infant Mental Health Educational Series (25-hours) was developed by an Infant Mental Health Specialist in cooperation with MCH. This series emphasizes attachment theory and current knowledge of infant social and emotional development as the basis for recognizing the importance of the infant-parent relationship to later health and developmental outcomes. This Infant Mental Health Training is being provided to public health staff, including CSHS staff, across the state. Training will be completed in two additional regions of the state in the upcoming year, and six of the nine regions of the state will have been trained by the end of next year. Infant mental health also is being integrated into the training of Child Care Health Consultants. An introductory workshop was provided at the annual conference in 1999, and further trainings are planned. In addition, a screening protocol for behavior and emotional problems which can be identified in day care settings has been incorporated into the Child Care Health Consultant protocols. When implemented, staff will obtain training in use of the protocol assessment and procedures. MCH is also working with the Office of Mental Health and Tulane University Medical Center Department of Psychiatry for additional OPH and OMH staff to receive the four month intensive infant mental health training.

Training in the *Keys to Caregiving* Program, a parenting education program (developed by Georgina Sumner, with NCAST at the School of Nursing at the University of Washington) which focuses on infant states, behaviors, and cues to assist mothers and caregivers to better understand and enjoy their babies, will begin in at least three regions of the state. The content of this program can be presented in a group format, or with individual mothers/caregivers at the time of the well-baby visits. It currently is used in the Nurse Home Visitation program and has been well-received by parents in that

program. It builds on the content of the Infant Mental Health training, and will provide additional tools, techniques, and strategies for public health nurses in their work with infants and their caregivers. In order to facilitate this training, MCH has collaborated with the Southwest Area Health Education Consortium (SWAHEC) in requesting a grant from the Louisiana Children's Trust Fund to obtain funds for supplies and materials for the *Keys to Caregiving* training.

A follow-up training in *Bright Futures Guidelines for Health Supervision* will also be conducted for new staff. Staff training will be developed in areas that were identified by OPH's Psychosocial Task Force. The areas identified as needs were suicide ideation, child/adolescent/maternal depression, child sexual abuse, child emotional abuse, behavioral problems in preschool children, and caregiver mental illness.

Coordination

The New Orleans Health Department, the Mental Health Association, and other mental health providers in New Orleans will collaborate to increase detection of mental health problems.

Evaluation

The effectiveness of the Nurse Home Visiting Program is being evaluated through a randomized controlled trial. The mental health component will be evaluated to determine the added benefit of this component to the standard home visiting intervention and will look at outcomes of depression, partner violence, substance abuse, and parent/infant relationship.

Assessment/Evaluation

A screening tool to assess mental health, family violence, family and social support, and other risk factors included on the child health record will be evaluated. In addition, collaboration with the New Orleans MCH Medical Director will focus on identifying assessment tools for detecting mental health problems in primary care and child health clinics. Training will be provided to public health staff on the use of these tools, as well as on how to make appropriate referrals for mental health services.

Children with Special Health Care Needs

Coordination

CSHS will continue collaboration with the Office of Mental Health for technical assistance in providing services to CSHCN. A partnership has been formed to investigate additional areas of funding for direct services to this population.

Priority Need 9: Assure early identification and referral of substance abuse, domestic violence, and child abuse and neglect.

Related National Performance Measures (NPM) and State Performance Measures (SPM):

SPM-Percent of all children and adolescents enrolled in public schools in Louisiana that have access to school-based health center services.

SPM-Rate of children under 18 who have been abused or neglected.

SPM-Percent of CSHS patients with case management from a nurse, social worker, or nutritionist.

SPM-Percent of women who have had a baby who report physical abuse either during their last pregnancy or in the 12 months prior to becoming pregnant.

SPM-Percent of women who use substances during pregnancy.

Direct Health Care Services

Pregnant Women

Prenatal care services are directed at assuring maternal and fetal optimal health, healthy behaviors, minimization of risk factors, and early recognition, treatment, and referral of problems that may put mothers and infants at risk of morbidity. A risk assessment is conducted on all patients receiving comprehensive prenatal care in the parish health units and includes questions about substance abuse and domestic violence. Referrals are made to local substance abuse treatment facilities and battered women shelters.

Infants and Children

The revised child health record is used to identify infants and children at risk for child abuse and neglect by looking at factors that have been associated with child abuse and neglect, such as maternal age, previous history of child abuse, the parent being abused as a child, domestic violence, and substance use and abuse.

MCH has an interagency agreement with the Office of Community Services (Child Protection Agency) to utilize public health nurses to assist child protection workers in investigating suspected cases of medical neglect, malnutrition, and failure to thrive. Nurses either conduct a home visit with the child protection worker or examine the child in the clinic. An interagency meeting with Office of Community Services and Office of Public Health staff will be held to enhance collaboration and insure the continued success of this program. A refresher course on identifying child abuse and neglect will be conducted for public health staff statewide.

Enabling Services

Pregnant Women, Mothers, Infants, and Children

Case Management

MCH funds the Teen Advocacy Program in Baton Rouge, a community-based case management program for pregnant and parenting teens and pregnant women at risk for HIV infection and substance abuse.

MCH funds four para-professional home visiting programs in four different regions of the state. These programs follow the Healthy Families America model developed in Hawaii that utilized paraprofessional home visitors supervised

by social workers or nurses. These programs seek to prevent child abuse and neglect by focusing interventions on promoting healthy pregnancies and child growth and development, modeling and fostering positive parenting skills and parent-child interactions, assuring provision of needed health care, and developing support systems for families.

MCH funds nurse home visiting programs in four regions of the state, based on the David Olds Nurse Home Visitation Model. This is a program for first time mothers of low socio-economic status. Nurses follow a very strict program protocol which calls for regular visits to the family starting prior to twenty-eight weeks gestation until the infant is 2 years of age. The objectives of the program are improving women's health behaviors during pregnancy, including nutrition and prevention of substance use; improving family caregiving for infants and toddlers, including reducing childhood injuries and family violence; and improving maternal life-course development, including reducing subsequent pregnancy and increasing educational achievement and workforce participation.

A Prenatal Risk Assessment tool focusing on psycho-social risk factors will be developed and piloted in Louisiana. Women who receive prenatal care from the private sector but receive WIC services in the parish health units will be targeted for this risk assessment. These risk factors include substance use, domestic violence, financial/social service needs, and mental health problems.

Infrastructure Building Services

Pregnant Women, Mothers, and Infants

Coordination

Interventions proposed in the community needs assessment included the initiation of smoking cessation programs, and collaborating with other community agencies to address the need for substance abuse prevention and treatment services. Orleans Parish will partner with the Mental Health Association, the Office of Mental Health, and local mental health providers to develop a plan to increase detection of mental health problems in New Orleans clinics and to increase utilization of existing services in the Orleans area.

Children

Coordination

MCH staff participate on a planning committee for a statewide conference on child abuse, sponsored by Prevent Child Abuse Louisiana. This conference will provide information and training to private and community-based providers to better equip them to recognize and report child abuse and neglect in the children they see.

Provider Training

MCH's Oral Health Program conducts the PANDA (Prevent Abuse and Neglect through Dental Awareness) Initiative. Training is provided to dentists and dental hygienists to instruct them on recognizing and reporting signs of child abuse and neglect in their patients.

Priority Need 10: Reduce unhealthy and risk taking behaviors of adolescents, pregnant women, and parents through public, professional, and patient education.

Related National Performance Measures (NPM) and State Performance Measures (SPM):

NPM-The birth rate for teenagers aged 15 through 17 years.

NPM-The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

NPM-Rate of suicide deaths among youths 15-19.

SPM-Percent of all children and adolescents enrolled in public schools in Louisiana that have access to school-based health center services.

SPM-Rate of children under 18 who have been abused or neglected.

SPM-Percent of women who use substances during pregnancy.

SPM-Percent of infant deaths due to Sudden Infant Death Syndrome (SIDS) that have a complete autopsy and death scene investigation.

SPM-Percent of licensed day care centers with a health consultant contact.

Direct Health Care Services

Pregnant Women

At the parish health units, all women seeking prenatal care receive extensive counseling and education on prenatal risks and how to keep healthy. Topics include substance abuse, nutrition, exercise, signs of early labor, prevention of sexually transmitted diseases, breastfeeding, and others. Pamphlets and videos are additional methods used in patient education.

Infants and Children

Families of children receiving preventive services at the health unit are screened for environmental factors related to safety and injury prevention and lead poisoning. Counseling on preventive measures to address identifies areas of risk is provided. Material on injury prevention and risk reduction for SIDS is provided to families.

Enabling Services

Pregnant Women

The Nurse Home Visiting Program being implemented in four regions of the state addresses substance use during pregnancy and provides education, counseling, and referral for women in need of these services.

Pregnant Women and Mothers

Health Education

In November 1997, five parenting cards became available for distribution to the public by all parish health units. These cards were created from over 4,000 ideas generated from surveys completed by 786 parents in parish health unit waiting rooms across the state. The topics of the cards are: how to deal with baby's crying; getting your child to listen and cooperate; boosting your child's self-esteem; potty training; and what works better than spanking. These cards continue to be popular with the nurses in the health units as informational materials to provide to clients. The cards will continue to be available to all public health units during the next fiscal year.

Population-Based Services

Pregnant Women, Mothers, and Infants

Through the social marketing campaign, *Partners for Healthy Babies*, several communication and education strategies are utilized to reach both the MCH public and professionals concerning prenatal health issues. Healthy behaviors during pregnancy and early prenatal care are the main messages of this campaign. Population-based communication channels including multi-media (advertising, public relations), educational materials (brochures, flyers, pamphlets, posters), and group communication (speeches, health fairs) are part of ongoing campaign efforts. *Partners'* newest outreach effort to secure the attention of teen audiences consists of a music entertainment piece by a local rap artist. A website for the project is under construction. New messages scheduled for the upcoming year will address SIDS and folic acid intake before pregnancy. Special events include raffles for infant car seats for women who received early and regular prenatal care. These events include radio remote broadcasts, are co-sponsored by a retailer and The Louisiana Highway Safety Commission, and are held in high trafficked areas such as malls.

Outreach activities to private physicians in the form of direct mail, brochures, posters, and one-to-one communication are a component of campaign efforts as well. *Partners For Healthy Babies* is continuing to develop its community outreach component, where local gatekeeper agencies are visited (i.e. Head Start Centers, Neighborhood Centers, etc.) and materials are distributed and presentations are given to patients and staff. Because of staffing and funding issues, this component is currently limited to the Greater New Orleans area.

A clearinghouse of resources and materials including audiovisuals and print material on perinatal substance abuse is maintained by MCH. These materials are made available and distributed to both public and private sectors, community organizations, and individuals.

Pregnant Women and Mothers

Public Education

Pierre the Pelican is a pamphlet series promoting mental and physical health and child health and development, mailed monthly to pregnant women throughout the state and to all Louisiana first-time mothers during their child's first five years. MCH is in the process of updating and revising the Pierre the Pelican materials.

Through a contract with the Pediatric AIDS Program at Children's Hospital, now the FACES Program, MCH educates women in New Orleans about AZT therapy for HIV-infected pregnant women.

Infants

Sudden Infant Death Syndrome (SIDS)

The MCH Program coordinates the SIDS Case Management and Risk Reduction Program. The counseling component is administered in conjunction with the Tulane University School of Medicine, Pediatric Pulmonary Section and public health nurses and social workers statewide. Staff provide information and crisis counseling to bereaved family members of SIDS victims. The SIDS Program is also coordinating with Children's Bureau to provide grief counseling for families of SIDS victims and ongoing support through the formation of a SIDS support group. All SIDS occurrences are monitored and followed up. The MCH Program provides a SIDS Program Coordinator who supports the statewide SIDS Program in establishing community-based education on SIDS risk reduction in areas with infants who are at high risk of death from SIDS. This position will develop, implement, and evaluate a statewide SIDS community risk reduction education program to provide public education and awareness on SIDS. The public information campaign will be implemented within high risk target population areas of the state through interagency collaboration with existing community-based agencies and organizations including family day care/child care providers, senior citizen organizations, infant mortality reduction initiatives, and the faith-based community. SIDS informational kits will be developed to assist community-based agencies.

Children

Childhood Lead Poisoning Prevention

A plan for education on risk reduction for childhood lead poisoning has been developed and will be implemented. This plan addresses risk factors and preventive interventions for lead poisoning in children and will be targeted to community groups and individuals in high-risk areas as well as to health care providers.

Infrastructure Building Services

Pregnant Women

Policy Development/Training/Systems of Care

The Office of Public Health and Office of Addictive Disorders (OAD) signed an interagency agreement to expand the pilot project which jointly provides pregnancy testing in the OAD treatment facilities statewide. OAD staff administer the pregnancy tests and provide counseling and referrals for medical care. OPH provides the pregnancy tests, establishes standard protocol for pre and post test counseling, and provides patient educational materials. OPH also provides all necessary training to OAD staff and accepts all referrals for prenatal care. The initial two region pilot was completed in June 1999, and an agreement has been signed which covers three years, to include phasing in all regions of the state in that three year period.

Provider Training

Through a contract with the Pediatric AIDS Program (now FACES) at Children's Hospital, MCH educates primary care providers in New Orleans about the benefits of and protocols for AZT therapy for HIV-infected pregnant women. The FACES contract is also sponsoring a campaign to heighten the awareness of medical students to public health issues. The approach is multi-faceted, and includes regular email communications to students, a bulletin board at the school highlighting public health issues, and presentations to special interest groups of Tulane Medical School students.

Infants

Sudden Infant Death Syndrome Training/Standards/Systems of Care/Monitoring

In conjunction with Tulane Medical School, Pediatric Pulmonary Section, MCH provides SIDS related educational programs to public health nurses, coroners, law enforcement, social workers, and the general public. Standardization of information reported in the autopsy and death scene investigation has been implemented through regionalization of forensic examinations. Analysis of data obtained through these reports has been expanded and is providing improved information about the relationship between the risk factors and unexpected infant death.

Infants and Children

Coordination/Standards Development/ Training/ Systems of Care

The MCH Program has expanded its existing Child Care Health Consultant Initiative through the Community Integrated Services System (CISS) Initiative, Health Systems Development in Child Care grant. By combining professional health experience with knowledge and training in child care, consultants work to support, assist, and problem solve with child care providers in order to achieve safer child care. MCH has trained 150 health consultants who serve as a source of education, guidance, and support to child care facilities. They provide technical assistance, act as health resource and referral persons, and provide access to health care information. The program brings together a multi-disciplinary network of public and private health professionals from variety of settings to address local community needs. These health consultants are certified by the Department of Health and Hospitals, Office of Public Health, and the Department of Social Services, Bureau of Licensing after participating in an intensive training conference. The training conference is offered every other year, and Child Care Health Consultants are required to attend in order to renew their certification. A training activity focusing on mental health and behavioral issues will be conducted this coming year.

Child Care Health Consultants in turn conduct training for child care providers statewide on health and safety issues, in accordance with licensing regulations and the National Health and Safety Performance Standards Guidelines for out-of-home child care providers. Child Care Health Consultants visit centers to ensure that the surroundings are safe. They also provide assistance by telephone to child care providers whenever providers have health or safety related questions. This initiative is coordinated with the Department of Social Services, the agency that administers the State's Child Care Block Grant and is responsible for licensing day care centers. The State's primary child care advocacy organization, Agenda for Children, coordinates with MCH to reach day care providers and promotes the use of the health consultants through its statewide network of child care resource and referral coordinators. Committee meetings will continue for

coordinating and directing the Child Care Health Consultants Program to promote health and safety in child care centers.

MCH coordinates a state level advisory council on child care health and safety including the State Chapter of the American Academy of Pediatrics, Agenda for Children, and the Department of Social Services' Child Care Assistance Program and Bureau of Licensing. This council will meet twice in the coming year to continue working towards cohesive systems of services.

4.2 Other Program Activities

Direct and Enabling Services MCH's Genetics and Newborn Screening Program diagnoses, counsels, and educates children and families with genetic diseases; follows up suspected cases and specialized medical management; and follows up diagnosed cases identified through mandatory state newborn screening.

Obesity in children remains a problem in Louisiana. Revised CDC growth charts will soon be available for clinical use and will be implemented statewide. The revised charts include the body mass index, which is an indicator of body fat and will allow health care providers to detect children who are showing signs of being at risk for obesity. Utilizing these charts will provide at risk children earlier preventive interventions and could potentially contribute to decreasing the incidence of obesity.

Population-Based Services The Reach Out and Read Program in six New Orleans Health Department child health clinics will continue in order to encourage children to develop pre-literary skills prior to school entry.

Infrastructure Building Services

Epidemiology and Surveillance

MCH has a Centers for Disease Control and Prevention (CDC) MCH Epidemiology grant to develop the overall epidemiology capacity of the MCH and CSHCN Programs. This grant funds an MCH epidemiologist from the CDC who has improved MCH Program capacity to assess and monitor maternal and child health status. MCH analyzes vital statistics, census information, and health services utilization data on an ongoing basis. In addition to the CDC assignee, epidemiological staff include a Division of Health Services Epidemiologist and two SSDI-funded epidemiologists.

MCH, in collaboration with Tulane School of Public Health and Tropical Medicine, was awarded a CDC lead surveillance and prevention grant to establish a statewide population-based childhood lead surveillance system. Other information systems to monitor health include development of a statewide immunization registry, ongoing pediatric nutrition surveillance of children, and a Child Death Review.

An expanded pregnancy related mortality review was completed by MCH for 1995 -1997. Using CDC guidelines for defining pregnancy-related and pregnancy-associated mortality, this surveillance program identified 79 additional deaths (49 deaths were pregnancy related; 30 deaths were pregnancy associated). MCH plans to conduct this expanded review annually.

Evaluation/Quality Assurance

The Newborn Screening Subcommittee of the Genetics Program Advisory Committee will meet during FY 2001

to evaluate the use of tandem mass spectrometry, which has the capability of detecting 20 different metabolic disorders in the newborn.

The newborn screening program is participating in an evaluation of the impact of newborn screening on the health status of sickle cell disease patients. Three other states in the Southeastern Regional Genetics Group Network are participating in this project directed by James Eckman, M.D. of Emory University. This project will continue for a total three year period and will now focus more on screening and the follow-up system.

The Genetic Diseases Program continues to evaluate and improve on the quality assurance requirements of the Newborn Screening Rule. This effort has reduced the number of private labs performing newborn screening from six down to two. To further strengthen the quality assurance aspect of the Rule, plans are underway to add new requirements to the rule this year.

Coordination/Policy Development

The MCH Nutritionist coordinates a Childhood Obesity Committee within the Office of Public Health, and has developed a plan to establish a statewide advisory committee of agencies who work with young children. Initially, a telephone survey will be conducted to determine what policies and interventions exist to address childhood obesity.

Consumer Involvement within the MCH Program

MCH solicits public input on its services each year, via ongoing patient satisfaction surveys and an annual advertisement of program specifics and goals. Extensive public input is obtained in needs assessment years, and results are continuously reviewed and consulted as MCH programs are developed and shaped. Ongoing MCH programs also incorporate consumer input into their daily operations.

Patient feedback on MCH services is gathered using patient satisfaction surveys in the parish health units. Surveys are completed by clients as they wait for their appointments or after they are seen. The results are shared with clinic staff, and patient comments are incorporated into regional audit reports with a focus on continuous quality improvement of health care services. Results are also forwarded from the Regions to the MCH Central Office, where they are reviewed and considered in program planning. This process assists local clinics in providing efficient, quality services to their patients and assures that clients have a voice in MCH programs. Results usually indicate a general satisfaction with services received.

MCH advertises its program and goals annually in several ways. The priority needs of the MCH Program and the major activities are published yearly in the Louisiana MCH Coalition newsletter. MCH also requests feedback on its priority needs and activities in an annual mailing to key stakeholders - representatives of governmental, professional and voluntary agencies, universities, hospitals, advocacy organizations, and parent groups.

An extensive process to gain consumer input is undertaken in preparation for each MCH five-year needs assessment, and results continue to contribute to programming decisions in interim years. For the Year 2000 Needs Assessment, the MCH Program solicited input from stakeholders, parish health unit users, CSHS clinic users, providers, and public health nurses and their community partners statewide via surveys, focus groups, and a community assessment tool and health planning process. Methodology for this year's needs assessment is discussed in detail in Section 3.1.1,

Needs Assessment Process. Results were used to revisit and update the existing list of Priority Needs for the Louisiana Title V Program (See Form 14 in Section 5.8) , and to create the Annual Plan for the Title V Program (See Section 4.1).

MCH programs also rely on consumer input in their daily operations. The *Partners For Healthy Babies* media campaign relies on focus groups to shape concepts and messages for the campaign. The MCH program aimed at reducing the rate of perinatal HIV transmission in New Orleans engages an HIV-positive individual as their Client Involvement Coordinator. This individual works with the program to encourage and facilitate client participation in program services and to coordinate client events. Another activity that relied heavily on consumer input is the MCH parent education series. Materials were developed through key informant interviews with parents suggesting topics for which they needed more information. A survey was then sent to parents in four regions of the state, asking for parenting tips on these issues. The pamphlets were developed using direct quotes from these parents.

A contract was written and submitted for a Family Representative to the MCH Program. This individual will work closely with the CSHS Parent Coordinator and MCH Program staff to provide feedback into program activities and to organize parent involvement and feedback. A parent has been identified, and her contract has been submitted and is pending approval from the State Contract Office.

CSHS employs parents as Family Liaisons in all nine Regional Offices. In addition to providing one to one family support and information, the Family Liaisons promote the issues critical to families with children with special needs in local communities and at a state level. The CSHS Statewide Parent Coordinator has been instrumental in providing input to policy and establishing links with other consumer organizations at the state and national level. A Parent Coordinator for the Hearing, Speech, and Vision Program has been added to the staff, as well as a Statewide Parent Training Coordinator for CSHS.

Toll Free Hotline - The Maternal and Child Health Toll-free 1-800 number, entitled *Partners For Healthy Babies* (1-800-251-BABY), is operated through a contract with D.I.A.L. (Disabilities Information and Access Line) of the Louisiana Department of Health and Hospitals. The phone lines are handled by skilled counselors of D.I.A.L who provide confidential information for women who call seeking referrals for prenatal care and pregnancy testing. Also provided is information regarding primary and preventive services for children, including services for children with special health care needs, as well as referrals for immunizations and information about LaCHIP and Medicaid. The Louisiana Office of Public Health "Shots for Tots" initiative, in coordination with the *Partners for Healthy Babies* Project, utilizes the helpline number. Family Planning referrals are also available to callers. The helpline provides referrals to the public and private physicians who provide Title V and XIX services. The *Partners For Healthy Babies* services are communicated to the public through television, radio, billboards and bus placard advertising. In addition, promotional/incentive campaigns, newspaper articles and public relations meetings with community leaders are also utilized to make the public aware of this information and referral service.

MCH and EPSDT - There is consistent collaboration between MCH and Medicaid at the state and local levels. An Agreement between the two agencies outlines both the standard setting and direct service delivery role of the MCH Program on behalf of Medicaid recipients and services. At the state level the Child Health Medical Director has been a

member of the AAP Liaison to State Government Committee which acts as an advisory committee to the state Medicaid/EPSDT Program. Issues of number and content of the visits, personnel to provide services, reimbursement for services, and quality of care are addressed.

MCH has a contract with the State Medicaid Agency to conduct EPSDT screenings in parish health units statewide. The MCH Program continues to be a major provider of EPSDT screenings in the state. EPSDT screening visits have been coordinated with the basic Child Health and WIC services visits. Once EPSDT eligible children reach school age, they are referred to the school system in those parishes with EPSDT screening. In other parishes they are rescheduled for their next screening in the public health unit.

Coordination between the CSHS and the Medicaid Agency has taken a new direction with the OBRA '89 legislation. There is a focus on providing EPSDT children all needed medical services, including the purchase of durable medical equipment. The CSHS Program must assure that all children receiving diagnostic and treatment services receive regular, ongoing periodic screening. As mentioned previously, CSHS and KIDMED have formed a partnership as a result of the MCHB Tri-Regional meetings.

MCH and Other Federal Grant Programs

Supplemental Food Program for Women, Infants, and Children (WIC) and MCH -

These programs are closely integrated at the State and local levels. State level WIC and Title V coordination occurs on a regular basis. The MCH and WIC Programs are jointly conducting a media campaign to promote early prenatal care and healthy nutrition and other behaviors during pregnancy. At the local level, pregnant women and children receive WIC benefits at the same time they receive preventive/primary care. Families who receive their health services from private providers and use parish health units only for WIC services can also receive any additional MCH services from parish health unit staff.

Family Planning and MCH - The MCH Block Grant funds a portion of the Family Planning Program operating budget. The State level staff meet at least weekly. At the local level, MCH and Family Planning services are provided in the same parish health units by the same staff. The regional MCH/Family Planning nurse specialists are responsible for education and providing technical assistance and integrating MCH and family planning at the parish level.

Developmental Disabilities - The CSHS Program participates with the Louisiana State Planning Council on Developmental Disabilities for the development of a Community and Family Support System relative to services for children and adults with disabilities and their families. The system will assure that both children and adults with disabilities will have the option to live with their family or live in homes in the community rather than institutional placement. The development of service delivery will be at the community level.

Both MCH and CSHS are represented on the statewide Inter-agency Coordination Council. The Director of Social Services is secretary of the council to plan and implement Part C of IDEA (Infants and Toddlers with Disabilities). The CSHS Program Administrator is on the Finance and Case Management Committees. The Department of Education is the lead agency in this state. Representatives also participate on the Regional level councils. The MCH Program works with the Department of Education in referral of children for evaluation and for early intervention services. Infants and children

found to have delays in their development or have conditions which place them at high risk for these delays are referred to appropriate Department of Education services in accordance with guidelines and procedures developed by the Department of Education and MCH. Information is exchanged in the referral to prevent duplication of services.

Head Start - Strong ties exist between parish health units and Head Start programs in most parishes. Accepting referrals, giving immunizations, providing well-child care and health education are the main services provided by the local MCH staff.

MCH and Healthy Start/Great Expectations (HS/GE) - MCH staff has been very involved in the New Orleans Healthy Start Program from its planning stages, and maintains ongoing communications with both the New Orleans Healthy Start and the Northeast Louisiana Healthy Start. MCH staff participate on a Healthy Start coalition in Concordia Parish, where the Area Health Education Center had received a planning grant in 1999.

MCH and Providers to Identify Title XIX Eligibles

MCH is working closely with Medicaid to enroll newly eligible children in Louisiana's Child Health Insurance Program, as well as those who were already eligible and unenrolled in Medicaid. Parish health units, CSHS clinics, and school-based health centers distribute information and applications, answer questions regarding the application process, and assist with applications when necessary. MCH is the Lead Agency for the Robert Wood Johnson Foundation's Covering Kids Initiative for Louisiana, and activities complement Medicaid's plans to identify eligibles. The State Medicaid Agency shortened its application form for pregnant women, eliminated the need for a face to face interview, and reduced some of the verification documentation that was previously required. MCH has distributed the new application form to parish health unit staff and has explained the changes in the process. MCH will work closely with Medicaid to help identify pregnant women who are Medicaid eligible. Parish health unit staff will assist their patients in completing the application process; the application form will be mailed out by *Partners for Healthy Babies* helpline operators; and other outreach efforts will be made.

4.3 Public Input

Administrative Procedure Code of the State of Louisiana requires that applications for federal funds receive review and comment from the public by printing notification in the Louisiana Register notifying the public where and when copies of the grant application can be reviewed. A notice of OPH's intent to apply for Title V funds appeared in the June State Register, and explained how the public could obtain copies of the grant to review. The Block Grant Application was reviewed by the CSHS Parent Coordinator. As discussed above in Section 4.2, Consumer Involvement within the MCH Program, regular steps are taken to obtain feedback on MCH priorities and interventions, including patient satisfaction surveys, a mailing to stakeholders, and regular participation of consumers in MCH activities. In addition to these ongoing efforts, additional strategies were undertaken this year in preparing the Year 2000 Needs Assessment. Methodology for obtaining public input into the needs assessment process is described in detail in Section 3.1.1, Needs Assessment Process.

4.4 Technical Assistance

See Supporting Documents, Section 5.8 for Form 15.

V. Supporting Documents

5.1 Glossary

GLOSSARY

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

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see “Needs Assessment”)

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, “What does the State need to achieve the results we want?”

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for CSHCN - Those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)]*

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous year's MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *[Title V Sec. 501(b)(4)]*

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - *(For budgetary purposes)* Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. *(For planning and systems development)* Those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations

States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities

State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development, to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems

A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level

A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - Authorized persons to be served with Title V funds. See individual definitions under "Pregnant Women," "Infants," "Children with Special Health Care Needs," "Children," and "Others."

Community - A group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - Services provided within the context of a defined community.

Community-based Service System - An organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - The recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - The ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - Women who received a medical care procedure associated with the delivery or expulsion of a live birth or fetal death (gestation of 20 weeks or greater).

Direct Health Services - Those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care: inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, WIC and education. These services are especially required for the low-income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment - a program for medical assistance recipients under the

age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems.

Family-centered Care - A system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - The entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions - As used in the Maternal and Child Health block grant program: the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Palau.

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

Local Funding (as used in Forms 2 and 3)-Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low-income - An individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. [*Title V, Sec. 501 (b)(2)*]

MCH Pyramid of Health Services - (see "Types of Services")

Measures - (see "Performance Measures")

Needs Assessment - A study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining:

- 1) What is essential in terms of the provision of health services;
- 2) What is available, and

3) What is missing.

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMS, Healthy Start, SPRANS, AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, “Why does the State do our program?”

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - A narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: “The rate of women in [State] who receive early prenatal care in 19__.” This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

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

experiences prior to, during, and immediately following pregnancy.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - The provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - As used in this guidance, includes the 50 States and the 9 jurisdictions of the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Belau.

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - Activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - The process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition

building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration, and identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block Grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the State), *Other* Federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by State MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building," "Population Based Services," "Enabling Services," and "Direct Medical Services."

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

5.2 Assurances and Certifications

ASSURANCES – NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain Federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse

or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems
13. Will assist the awarding agency in assuring compliance with Section 106 of the National

Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. Sects. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed

after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about-
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace,
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
 - (1) Taking appropriate personnel action against such an employee, up to and including

termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or

- (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)
The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE
Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities

where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

5.3 Other Supporting Documents

None

5.4 Core Health Status Indicator Forms

5.5 Core Health Status Indicator Detail Sheets

5.6 Developmental Health Status Indicator Forms

5.7 Developmental Health Status Indicator Detail Sheets

5.8 All Other Forms

National “Core” Performance Measure Detail Sheets

State “Negotiated” Performance Measure Detail Sheets

Outcome Measure Detail Sheets

APPENDIX A

APPENDIX B

APPENDIX C

APPENDIX D

APPENDIX E