



## 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

According to the U.S. Census, Maryland was home to an estimated 5.2 million residents in 1999. It is comprised of 23 counties and the City of Baltimore and is characterized by mountainous rural area in the Western part of the State, densely populated urban and suburban areas in the central and southern regions and flat rural areas on the Eastern Shore. Maryland borders West Virginia on the west, Pennsylvania on the north, Washington, D. C., the nation's capital, in the central part and Delaware as well as the Atlantic Ocean on the east. Maryland has 9,837 square miles of land area, 623 square miles of inland waters and 1,726 square miles that constitute the Chesapeake Bay, the world's largest estuary. Maryland's Eastern Shore embraces the Chesapeake Bay, and its many estuaries and rivers create one of the longest waterfronts of any state. The Bay produces more seafood than any comparable body of water. Maryland is also home to the Maryland blue crab, the Baltimore Orioles baseball team, two football teams, and the Preakness.

In 1999, Maryland ranked 19th in population and 6th in population density among states (including the District of Columbia) with 529.1 persons per square land mile. From 1990 to 1999, Maryland's population grew by 8%. Montgomery and Prince George's counties, both part of the Washington D.C. suburbs, accounted for the majority of this population growth. Conversely, the population of Baltimore City decreased by 14% during this same time period. The majority of Maryland residents (79%) live in the major metropolitan areas that surround either Baltimore City or Washington D.C. The Baltimore-Washington D.C. combined Metropolitan Statistical Area constitutes the nation's fourth largest retail market.

Age and Sex: According to the 1998 Maryland Vital Statistics report, children and adolescents (1.4 million) under the age of 20 represented 27.6% of Maryland's population. Pre-teens and teens, between the ages of 10 and 19 represented one-half of the child population. Senior citizens, aged 65 and over, represented 11.5% of the population. An estimated 1.2 million women of childbearing age (ages 15-45) lived in Maryland in 1998. Between 1995 and 1998, an average of 71,000 babies were born each year.

Race/Ethnicity: With the exception of Western Maryland, the State's racial and ethnic population is rapidly increasing and comprises a significant portion of each geographic area. Racial/ethnic minorities comprised an estimated 32% of Maryland's population in 1998, up from

28% in 1990. Of the 1.6 million racial minorities in Maryland, African Americans represent 87%; Hispanics, the fastest growing ethnic minority in Maryland, represented 3.7%. Compared to the national average, Maryland has a greater proportion of African-Americans and a lower percentage of Hispanics.

Economic Well-Being: According to the U.S. Census, with a poverty rate of 7.2% in 1998, Maryland had one of the lowest overall poverty rates in the nation. However, there are pockets of poverty throughout the State. In 1989, child poverty rates ranged from a low of 3.2% in Howard County to a high of 32.2% in Baltimore City. Poverty rates also varied by race/ethnicity. For example, the poverty rate for African Americans was twice the rate for Caucasian Americans. While the majority of regions in Maryland experienced an economic boom during the 1990's, the Eastern Shore and Western Maryland experienced a decrease in their economic prosperity. Still, Maryland hosts some of the wealthiest communities and jurisdictions in the nation. U.S. Census data for 1998 show that the State had the nation's 5th highest per capita income and the 3<sup>rd</sup> highest median household income.

Among all states, Maryland's workforce is the best educated. A third of Maryland's population aged 25 and older holds a bachelor's degree or higher. More than 146,455 businesses employ 2.29 million workers who earn an annual payroll of \$76 billion. Some 3,494 of these businesses employ 100 or more workers. Most Marylanders (86%) work in the widely defined service-producing sector. This category ranges from government to transportation-related professions, from wholesale trade to the finance and insurance industry. Service careers top this list with 32% of the workforce in the health, legal and education fields. One in five residents work in retail trade or for the government. Major private sector employers include Bethlehem Steel, General Motors, Lockheed Martin, and Marriott International. Health care represents a \$17.0 billion industry in Maryland with per capita spending on health care reaching nearly \$3,316 in 1998.

Health Care Environment: The Urban Institute Monograph, titled "Health Policy for Low-Income People in Maryland, Highlights, MD Health", April 1999, stated "a unique combination of bold innovation and strong regulatory involvement, characterizes health care policy in Maryland. The State had used Medicaid rather than a separate state designed program to pursue coverage expansions, including the recent Children's Health Insurance Program (CHIP), and had been

aggressive in enrolling beneficiaries under capitated managed care. Maryland's group insurance market reforms were compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) before the federal law was enacted, and the State has arguably the strongest hospital market regulatory system and managed care consumer protections in the United States."

Health Status: In spite of Maryland's affluence and many positive attributes, health indicators for the State are mixed. Maryland's infant mortality rate stood at 8.6 in 1998, one of the highest in the nation. The Center for Disease Control and Prevention (CDC) conducts the Behavioral Risk Factor Surveillance System (BRFSS), a telephone survey that tracks health risks among adults (aged 18 and over) in the United States. According to the BRFSS, in 1998, the majority (86%) of adult Marylanders self-reported their health as good or excellent. The 1998 survey also found that one in three adult Marylanders was classified as overweight; slightly more than one in five was a smoker and most (72%) had visited a dentist within the past year. BRFSS data for 1997 indicated that three-quarters of adult Marylanders used seat belts on a regular basis; and 1.2% were identified as chronic drinkers (i.e., an average of two or more drinks per day).

The State's rate for heart disease deaths and alcohol-related deaths are lower than the national rate. There were 41,970 deaths among Marylanders in 1998. The leading causes of death for Marylanders were heart disease, cancer, and cerebrovascular disease. However, the AIDS case rate, infant mortality and incidence of violent crimes is higher than the national rates. This has resulted in Maryland's premature death rate (53.8 years of life lost before age 65 per 1,000 population) being 15% higher than the national rate (46.7) in 1995.

Maryland's 1.4 million children and adolescents are its most important and precious resource. Several recent reports have documented improvements in the health of Maryland's children such as declining teen pregnancy rates and increasing immunization rates. There is every reason to expect that most of Maryland's children will grow up to become healthy and productive members of society. However, the available data also suggest that there are troubling trends and challenges that could block the attainment of a healthy future for many of Maryland's children and adolescents. Most at risk are children who grow up in poor, minority, and disadvantaged families and communities. In the 1999 Kids Count Data Book published by the Annie E. Casey Foundation, Maryland, one of the nation's wealthiest states, ranked 24<sup>th</sup> on 10 indicators of child well-being. At least 12% of Maryland's children were defined to be at high risk for future failure

as measured by six indicators including poverty, and lack of health insurance coverage. According to the U.S. Census Bureau 13.2% of Maryland children and adolescents ages 0-17 lived in poor families in 1995. Poverty among Maryland children and adolescents increased by 17% between 1989 and 1995. The poverty rate among African-American and Hispanic children in Maryland was two to three times the rate for Caucasian children. The consequences of child poverty are severe. Poor children are known to have higher death rates, increased chronic diseases such as asthma, and less access to health care services.

Maryland's infant mortality rate stood at 8.6 in 1998, one of the highest in the nation. Infant mortality disproportionately affects African American babies. (Maryland has identified the elimination of health disparities to be a priority). More than 200 Maryland children ages 1-14 died that same year. Injuries, many of them preventable, were the leading cause of death for this age group followed by cancer. There were 267 deaths to Maryland adolescents ages 15-19 in 1998. Injuries, homicide, suicide and motor vehicle accidents, were the primary causes of these adolescent deaths.

Two major environmentally linked health conditions - asthma and lead poisoning - are major causes of childhood morbidity. An estimated 95,000 Maryland children and adolescents have asthma. The asthma hospitalization rate for African American children (60 per 10,000) in 1997 was more than three times the rate for Caucasian children (18 per 10,000). Childhood lead poisoning (defined as a venous or capillary blood lead level  $\geq 20$  ug/dL) is a serious, but preventable health problem that affected 772 Maryland children in 1998 alone. An additional 4,300 children were diagnosed with elevated blood lead levels (defined as a venous or capillary blood lead level  $\geq 10$  ug/dL).

Obesity and obesity related illnesses such as type 2 diabetes are documented to be increasing among children and adolescents. Anecdotally, school health personnel and primary care providers are increasingly identifying depression and mental health disorders as problems among adolescents. More detailed MCH related health status indicators are reported in the Needs Assessment Section (D.3.1) and/or the Health Status Indicator Section (D.3.2, 5.4 and 5.5). In addition, other emerging health trends, problems, gaps, and barriers are identified in the Needs Assessment section (D.3.1).

Access to Health Care: As of June 28, 2000, 15 of Maryland's 24 jurisdictions were either entirely or partially federally designated as medically underserved areas for primary care services. This occurs even though the ratio of primary care physicians to the population is higher in Maryland than the national average. Part of this higher representation is based on the number of physicians employed by government research facilities, military and medical schools, who are not available to the general public for traditional health care. Four of twenty-four Maryland jurisdictions are currently classified as being underserved for dental health services/manpower and 6 jurisdictions are classified as underserved for mental health services.

The Maryland Health Care Commission (using pooled data from the Current Population Survey for 1995-97) estimates that 15% of Maryland's non-elderly population is uninsured. Young adults ages 19-35 comprise the largest segment of the uninsured, 41%, followed by adults 35-49 (24%), children 0-18 (22%) and older adults 50-64 (14%). The Commission estimated that 11% of children and adolescents under the age of 19 were uninsured during this same time period. According to the U.S. Census Bureau, an estimated 7.2% (93,000) of Maryland children and adolescents under age 19 were uninsured and living in families with incomes below 200% of the poverty level in 1996-1998. Approximately one in ten of all Marylanders and almost one in five children were enrolled in the Medicaid Program in June 1999.

The Medicaid Program, known in Maryland as the Medical Assistance Program, serves as the major source of publicly sponsored health insurance coverage for children and adolescents in Maryland. The Maryland Children's Health Program (MCHP) began operating as a Medicaid expansion program on July 1, 1998. The MCHP program expanded coverage for comprehensive health insurance for children up to the age of 19 and for pregnant women of all ages in families with income at/or below 200 percent of the federal poverty level. This program substantially increased access to comprehensive health care services for uninsured children and pregnant women in Maryland.

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

185% and 200% of the Federal Poverty Level (FPL). Within the first nine months of the Program, approximately 45,000 children and 200 pregnant women had enrolled in MCHP.

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

Most children and adolescents enrolled in the Medical Assistance Program and all MCHP enrollees receive services through HealthChoice, Medicaid's managed care program, which became operational on July 1, 1998. All HealthChoice recipients are enrolled in managed care organizations (MCOs). Under HealthChoice, both mental health services and rare and expensive case management services (REM) for the children with special health care needs are 'carved out'. Medical care for REM children is paid by Medicaid on a fee for service basis. Maryland Health Partners is the core organization that manages the Mental Health payment system. Within this system, child and adolescent mental health care needs are addressed. The actual monitoring of mental health services including quality assurance, planning and identifying providers at the local level is done through regional Mental Health Core Service Agencies. Beginning in November 1999, physical and occupational therapy, speech and audiology services which had previously paid for through Title V funds, became the responsibility of Medicaid on a fee for service basis. Currently, all children up to 200% of FPL who are eligible for MCHP receive these services through Medicaid.

More detailed MCH-related health status indicators are reported in the Needs Assessment Section (D.3.1) and/or the Health Status Indicator Section (D.3.2, 5.4 and 5.5). In addition, other emerging health trends, problems, gaps and barriers are identified in the Needs Assessment Section (D.3.1).

## State Health Agency Priorities

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

1. *Implementation of a comprehensive anti-cancer/anti-tobacco program using funds from the National Tobacco Settlement.*

The first installment of funds received from the national tobacco settlement will be used by DHMH to implement a comprehensive anti-cancer/anti-tobacco program. This program, proposed by Governor Parris N. Glendening, is designed to help people currently addicted to tobacco products, as well as those who have developed cancer. The tobacco funds will support a myriad of projects to combat cancer; ranging from creating tobacco cessation and educational programs to funding cancer-related research in Maryland hospitals and institutes of learning. Outreach efforts and greater access to cancer screening and treatment will be implemented. During FY 2001, approximately \$40 million is allocated to this effort and beginning in FY 2002, approximately \$80 million will be assigned to DHMH to administer. It is anticipated that this allocation will continue for an additional 18 years. The Title V program will collaborate in the development of smoking cessation programs for children, adolescents, and pregnant women; and asthma outreach and education initiatives.

2. *Expansion of the Maryland Children's Health Program*

The Legislature recently approved the Department's proposal to expand MCHP eligibility income requirements from 200% to 300% of the Federal Poverty level (\$51,150 for a family of four). In addition, pregnant women with incomes up to 2.5 times the

poverty level (\$42,625 for a family of four) will be covered. This expansion will administered through employer sponsored insurance plans (when available) and through the current HealthChoice Program. Families will pay a monthly premium of \$37-45 per month per family. This expansion will begin in July 2001 and is expected to provide health care to an additional 19,600 children and 600 pregnant women from working families. Children receiving services through the expanded MCHP program will not receive as comprehensive a package of benefits as the initial MCHP enrollees.

To ensure continuity of care and reduce barriers to care, the CSHCN Program expanded its financial eligibility requirements to reflect expanded MCHP eligibility requirements. This was done through emergency regulatory changes during the 1999 Legislative Session. It is anticipated that during the 2001 Legislative Session, these regulations will be further revised to reflect the MCHP changes that occurred during the 2000 Legislative Session.

3. *Development and Implementation of the Healthy Maryland Project 2010 Initiative*

Healthy Maryland – Project 2010 is a statewide public health initiative that is laying the groundwork to meet the public health needs of Marylanders during the first decade of the new millennium. Linked to the national Healthy People 2010 Objectives, Project 2010 aims to identify statewide health priorities, foster public and private partnerships, and develop a Health Improvement Plan for the State. A Steering Committee and an Advisory Council have provided guidance for this process. A two day Health Summit in May 1999 provided the impetus for the development of the Health Improvement Plan (HIP). The HIP will address up to 18 priority health areas including infant mortality, child and adolescent health, and family planning. (See the Needs Assessment Section for further information about the HIP). The Plan is scheduled to be completed by October 2000.

4. *Prevention of Lead Poisoning Among Children*

In January 2000 Governor Glendening declared that the State of Maryland must aggressively expand its efforts to protect children from the tragedy of lead poisoning. He announced a comprehensive plan to significantly reduce the likelihood that children in low-income neighborhoods, particularly in Baltimore City, will be exposed to toxic lead. The

State's comprehensive plan includes the implementation of a Statewide Lead Targeting Plan, which was recently developed by the MCH Program and an Interdepartmental Strategic Plan for preventing lead poisoning. Legislation passed during 2000 requires that children living in areas identified as high risk for lead poisoning are to receive blood lead testing at certain age intervals. The MCH Program plans to work closely with State agency and community partners to assure that high risk children are screened.

5. *Reduction of Maternal Mortality*

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

Maternal and Child Health Program Priorities

The MCH Program's goals for FY 2001 are as follows:

1. To complete needs assessment activities and to develop a five to ten year MCH strategic plan with input from local health departments, health providers, family groups, community based organizations, advocacy groups and other MCH stakeholders.
2. To reduce maternal, infant and child mortality rate and improve health outcomes through the implementation of maternal mortality, fetal and infant mortality and child fatality review processes; the implementation of the Pregnancy Risk Assessment Monitoring System (PRAMS), and the continuation of local health department based home visiting and care coordination programs.
3. To implement the statewide lead targeting plan.

4. To enhance the epidemiological capacity of the MCH Program (A senior level MCH epidemiologist is to be hired in FY 2001. This position will be partially funded by a grant from CSTE ).
5. To continue to administer the Maryland Childhood Asthma Program. A media campaign, begun in FY 2000, will be expanded during FY 2001.
6. To continue to provide direct medical services pregnant women, children and CSHCN who are not eligible for MCHP.
7. To continue to administer the Universal Newborn Hearing Screening Program.
8. To continue to develop a statewide system of care for children with special health care needs, including enabling services such as respite care.

## **1.5 The State Title V Agency**

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

### **1.5.1 State Agency Capacity**

#### **1.5.1.1 Organizational Structure**

Administrative oversight for the Maternal and Child Health Block Grant is the responsibility of the Community and Public Health Administration (CPHA) under the Deputy Secretariat for Public Health Services. On June 1, 2000, Secretary Benjamin selected Dr. Russell Moy, who had been previously appointed to the position of Associate Director of CPHA in October 1999, to serve as the Acting Director of CPHA. Dr. Moy directed the Maryland Office of Maternal Health and Family Planning for ten years. Concurrently, Ms. Joan Salim, the current Director of the WIC Program was appointed as the Acting Associate Director for CPHA.

On February 25, 2000, CPHA leadership announced the reorganization of the MCH Offices within CPHA. This was done to bring MCH programs in closer alignment to maximize resources and improve communication and coordination at the State level. This reorganization included the formation of two new MCH units: the Center for Maternal and Child Health, and the

Office for Genetics and Children with Special Health Care Needs. These two new units are composed of programs and staff from the former three MCH offices: (1) Maternal Health and Family Planning, (2) Children's Health (which included the Specialty Care Program), and (3) Hereditary Disorders.

The Center for Maternal and Child Health was established as a result of the merger of the Office for Maternal Health and Family Planning, and preventive health programs under the Office of Children's Health. The Center includes five divisions: Family Planning and Reproductive Health, Maternal and Perinatal Health, Child and Adolescent Health, Community Initiatives and Partnerships, and Planning, Coordination and Evaluation. Ms. Bonnie Birkel, CRNP, MPH has been appointed director of the new Center. Ms Birkel was previously the Acting Director for the Office of Maternal Health and Family Planning. The new Office for Genetics and Children with Special Health Care Needs merges hereditary disorders and children's specialty care programs. Dr. Susan Panny has been appointed the Director of this new office. Dr. Panny, a Board Certified Geneticist was previously the Director for Hereditary Disorders.

CPHA will continue to be comprised of two associate directors and four non-supervisory functional tiers. The tiers are comprised of 4-5 offices and are grouped according to similar functions. The Family Health Services and Primary Care Team includes the Center for Maternal and Child Health, the Office for Genetics and Children with Special Health Care Needs, the Office of Primary Care and WIC Office. Other offices within the Department closely linked with the core MCH offices are Oral Health, Health Promotion, Education and Tobacco Control, Injury Prevention, Epidemiology and Disease Control, Health Policy and Public Health Assessment. Department organization charts identifying the programs at the Secretariat and CPHA levels are contained in Section V, Supporting Documents. The tier's mission and vision statements are also included in this section

#### **1.5.1.2 Program Capacity**

Two offices within CPHA: the Center for Maternal and Child Health and the Office for Genetics and Children with Special Health Care Needs are responsible for administering Federal Title V and State funds. The Office of Health Policy administers a portion of Title V State matching dollars that are allocated to the local health departments through targeted funding. Maryland's 24 local health departments provide the core public health functions of assessment,

policy development and assurance to citizens at the local level. The 24 local health departments receive annual basic public health funding (including Title V funds) from the DHMH through a Unified Grant Award. Local health departments provide MCH services such as school health, family planning, home visiting and care coordination, immunizations, lead screening, fetal and infant mortality review, child fatality review, oral health services and maternal health services for the uninsured.

The mission of the newly instituted Center for Maternal and Child Health (CMCH), is to improve the health and well being of women of reproductive age, newborns, children and adolescents. As the attached organization chart shows, the Center is comprised of five divisions: Family Planning and Reproductive Health; Maternal Health; Child and Adolescent Health; Community Based Initiatives and Planning, Coordination and Evaluation. A medical director has recently been selected and will join the Center on August 23, 2000. She is a neonatologist and will be responsible for (1) developing liaison relationships with various providers and community organizations, (2) providing the medical expertise on various legislative matters and overall quality assurance and best practice models for the various MCH programs. The Federal Abstinence Education and Service System Development Initiative (SSDI) grants are also administered by CMCH.

The Division of Family Planning and Reproductive Health assures that comprehensive, quality maternal health, family planning, colposcopy, and teen pregnancy prevention programs are available in the State. The Division of Maternal and Perinatal Health supports perinatal systems building through public outreach and provider education. This Division administers the Improved Pregnancy Outcome Program, the Crenshaw Perinatal Health Initiative, and oversees Fetal and Infant Mortality (FIMR), Maternal Mortality Review (MMR) and the PRAMS survey.

Through the newly restructured Title V Improved Pregnancy Outcome Program and the Crenshaw Perinatal Health Initiative, perinatal systems building is integrated at each of the State's 24 jurisdictions and in broader geographic regions, respectively. Activities in both of these programs incorporate community-based multi-disciplinary efforts directed at the county and regional levels. The Maryland Perinatal Health Initiative is a hospital-based program designed to improve birth outcomes in each perinatal health center in Maryland. Examples of strategies used by these three programs include fetal and infant mortality review, provider education, linkages

with perinatal health organizations, data collection and analysis, public awareness and outreach, development of guidelines for levels of perinatal care, establishment of maternal-neonatal transport standards, and hospital site visits to assist hospitals in their adherence to perinatal standards.

The Division of Child and Adolescent Health is responsible for developing, implementing and evaluating preventive strategies and programs to protect and promote the health and well being of all Maryland infants, children and adolescents. Programs administered by this Division include the Home Visiting and Care Coordination Program, the School Health Program; the Childhood Asthma Program; the Childhood Lead Screening Program; the Childhood Obesity Program; and the Adolescent Health Program.

The Division of Community Initiatives and Partnerships is responsible for Child Fatality Review, Male Involvement, Teen Pregnancy Prevention and Abstinence Education activities. This Division also shares some responsibility with the other programs where community involvement and outreach are a part of the effort. The Division of Planning, Coordination and Evaluation is responsible for (1) statewide and community needs assessments, (2) programmatic evaluations, (3) review and analysis of legislation, (4) program planning and analysis, (4) fiscal and administrative activities, and (5) inter- and intra-agency coordination.

The mission of the newly created Office for Genetics and Children with Special Health Care Needs (OGCSHCN) is two-fold: a) to reduce death, illness and disability from genetic disorders, birth defects and chronic diseases and injuries and to improve the quality of life for these individuals, and b) to protect and promote the health of Maryland's children with special health care needs by assuring a family-centered, community-based, comprehensive, coordinated and culturally appropriate system of specialty health care. As the attached organizational chart shows, the OGCSHCN is comprised of three divisions: Newborn Screening and Follow-Up, Clinical Genetic Services and Specialty Care and Regional Resource Development. Administration of the Universal Newborn Hearing Screening Program is another responsibility of this Office.

The Division of Newborn Screening and Follow-Up screens babies for eight disorders, Biotinidase Deficiency, Branched Chain Ketoaciduria, Galactosemia, Homocystinuria, Hypothyroidism, Phenylketonuria, Tyrosinemia and Sickle Cell Disease. All babies born in Maryland, 70,000 per year, are eligible for service. The Division also includes Carrier Screening

for sickle cell disease , thalassemia and Tay-Sachs Disease as well as AFP/triple Marker Screening to detect neural tube defects.

The Division of Clinical Genetic Services includes the Metabolic Disease Program which follows patients with genetic metabolic disorders like PKU or MSUD and provides case management and dietary therapy. The Hemoglobin Disorders Program follows children with sickle cell disease and other hemoglobin disorders and provides case management, home visiting, annual pediatric hematology evaluations, genetic counseling, parent education, support groups and summer camp. This Division also includes the Birth Defects Reporting and Information System which collects data on the number of babies born with any of 12 common birth defects and provides information on the defects and services available. Finally, the clinical Services Program coordinates a statewide network of clinical genetic services at 4 centers, 14 general genetics outreach clinics, 6 sickle cell disease outreach clinics, and 2 hemophilia outreach clinics.

The Division of Specialty Care includes the Children's Medical Services Program (CMS) which historically served as the payer of specialty services for a large population of children with special health care needs in the state. This program has undergone major changes in the last few years as a result of Medicaid expansion and the resulting redesign of the program. The community linkages component funds 14 local health departments for a variety of services including the provision of specialty clinics for uninsured and underinsured children, care coordination, assessment of family and community needs and service capacity building. Two Medical Child Care Centers are funded to serve children ages 6 weeks to three years of age with complex medical conditions and medical needs that cannot be met in traditional child/day care programs. As part of the interagency collaboration with Maryland's Early Intervention System, staff is involved in interagency coordination and liaison activities. A respite initiative has recently been developed as well as a plan for strengthening regional resources for families and providers.

Both the Center for Maternal and Child Health and the Office for Genetics and Children with Special Health Care Needs, hereafter referred to as the MCH Offices, share responsibility for MCH Block Grant development and implementation.

### **1.5.1.3 Other Capacity**

The organization charts contained in Section V, Supporting Documents, identifies the functions and staff that work on Title V Programs. In addition, strong working relationships exist

among a number of entities who support the planning and delivery of maternal and child health services in Maryland. The Office of Primary Care and Rural Health administers the AHEC through the University of Maryland and provides a variety of collaborative activities that are maximized with the inclusion of this office with the MCH Offices in the tier matrix. The Office of Communicable Disease, Center of Immunization has developed a strong collaborative relationship with the Office of Children's Health to improve childhood immunization rates.

Previously, the Office of Public Health Assessment (OPHA) provided programmatic data analysis as requested by the MCH Offices. However, since receiving Title V funding for a FTE biostatistician assigned to OPHA, an organized plan for addressing each Office's concerns has been developed. The Office of Oral Health (OOH) has developed a strong collaborative relationship with the MCH Offices. This is exemplified by the Office of Children's Health being requested to be an active consultant in the Statewide Oral Health Advisory Committee. This Committee is currently addressing access issues and developing a statewide child dental health assessment. The CMCH through the SSDI Grant is currently funding the Head Start Study. This Study includes a pilot component for determining how to evaluate and identify dental evaluation needs that are unique to CSHCN. The OOH is charged with the responsibility of conducting the oral health evaluation for the medical assistance program.

All of the Offices within CPHA are actively participating in the development of an INPHO II. Initial efforts will focus on the development of a MCH database. Phase one, which included identifying all sources of data and the offices and agencies providing or receiving data from the MCH offices has been developed. Having recently completed the pilot phase, it is anticipated that the project will be fully operational by the fall of 2000.

Maryland's Medical Assistance Program provides all the resources and personnel necessary to implement the HeathChoice and MCHP. A collegial and collaborative relationship exists between this Program and the MCH Offices. This is particularly evident in the policy discussions, sharing of client data bases between each unit, and access to information on Medicaid eligibility status. The Department's Alcohol and Drug Abuse, Mental Hygiene and AIDS Administrations provide additional specialized support in the form of technical assistance, consultation, and results of their needs assessments/data collection.

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

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

### **1.5.2 State Agency Coordination**

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

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

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

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

## **II. REQUIREMENTS FOR THE ANNUAL REPORT**

This section describes Maryland's program activities for FY 1999, the extent to which National and State performance measures and objectives were met in the FY 1999 program year and the extent to which funds were expended consistent with the application.

### **2.1 Annual Expenditures**

Please refer to Forms 3, (State MCH Funding Profile), 4 (Budget Details by types of Individuals Served) and 5 (State Title V Programs Budget and Expenditures by Types of Services ) under V. Supporting Documents, Section 5.4. The variation between budgeted and expended funds is attributed to the impact of MCHP which enabled the MCH Program to modify budgets and redirect funds from direct services to enabling services and population based services. In FY 2000, a higher percentage of these funds were redirected from both direct service and population-based services to enabling services to meet the increasing need for care coordination and home visiting services. In addition, in November 1999, the Medical Assistance Program began to pay for all therapies (OT, PT, speech and audiology services) for children enrolled in

Medicaid/MCHP. These services had previously been paid for the Children's Medical Services. This policy decision alone enabled several hundreds of thousands of Title V dollars to be reallocated for other purposes.

## **2.2 Annual Number of Individuals Served**

In FY 1999, Maryland's Title V Program served a total of 202,743 pregnant women, infants, and children including those with special health care needs. Please refer to Forms 6 (Number and Percentage of Newborns and Others Screened, Confirmed and Treated), 7 (Number of Individuals Served [Unduplicated] Under Title V) and 8 (Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX and Form 9 (MCH Toll-fee Telephone Line Reporting Form )under V. Supporting Documents, Section 5.4. for more detailed information. Additional information about Maryland's MCH Program is provided under Section 1.5 (State Agency Capacity)

## **2.3 State Summary Profile**

Please refer to Form 10 (Title V Maternal and Child Health Block Grant services Profile) under V. Supporting Documents, Section 5.4.

## **2.4 Progress on Annual Performance Measures**

Please refer to Form 11 (Tracking Performance Measures by Service Levels for National and State performance measures) under V. Supporting Documents, Section 5.4. Through the use of Title V, State and other Federal resources, Maryland is pleased to report the following accomplishments of the Title V program by each level of the pyramid (see Figure 2) and by required populations groups.

In many cases, the most current data is for calendar or fiscal year 1998, therefore, for many of these performance measures; we were unable to report on progress for FY 1999. Using FY 1999 data as a benchmark, therefore, as in the past, we must use the most recent available data which will continue to cause a disconnect between intervention strategies and performance measures. What is most notable is that with the exception of the CSHCN Redesign begun in the later part of FY 1999, most of the activities and programs cited in 1998 continued into 1999. In many cases, the 1999 data will not be available until June 2001 or later. As this data becomes available, it will be incorporated into subsequent applications. In the interim, as additional data becomes available throughout the year, it will be analyzed in conjunction with programmatic

activities and funding allocations to determine their appropriateness. These activities will be reported in next year's application.

As this year's annual report will show, Maryland was able to meet the majority of target goals for the 33 required performance and outcome measures. During FY 2001, the Title V Program will review the appropriateness of the performance objectives. Programs and activities which are not directly related to either the State or National performance measures are also included under the appropriate sections of the report by each level of the pyramid.

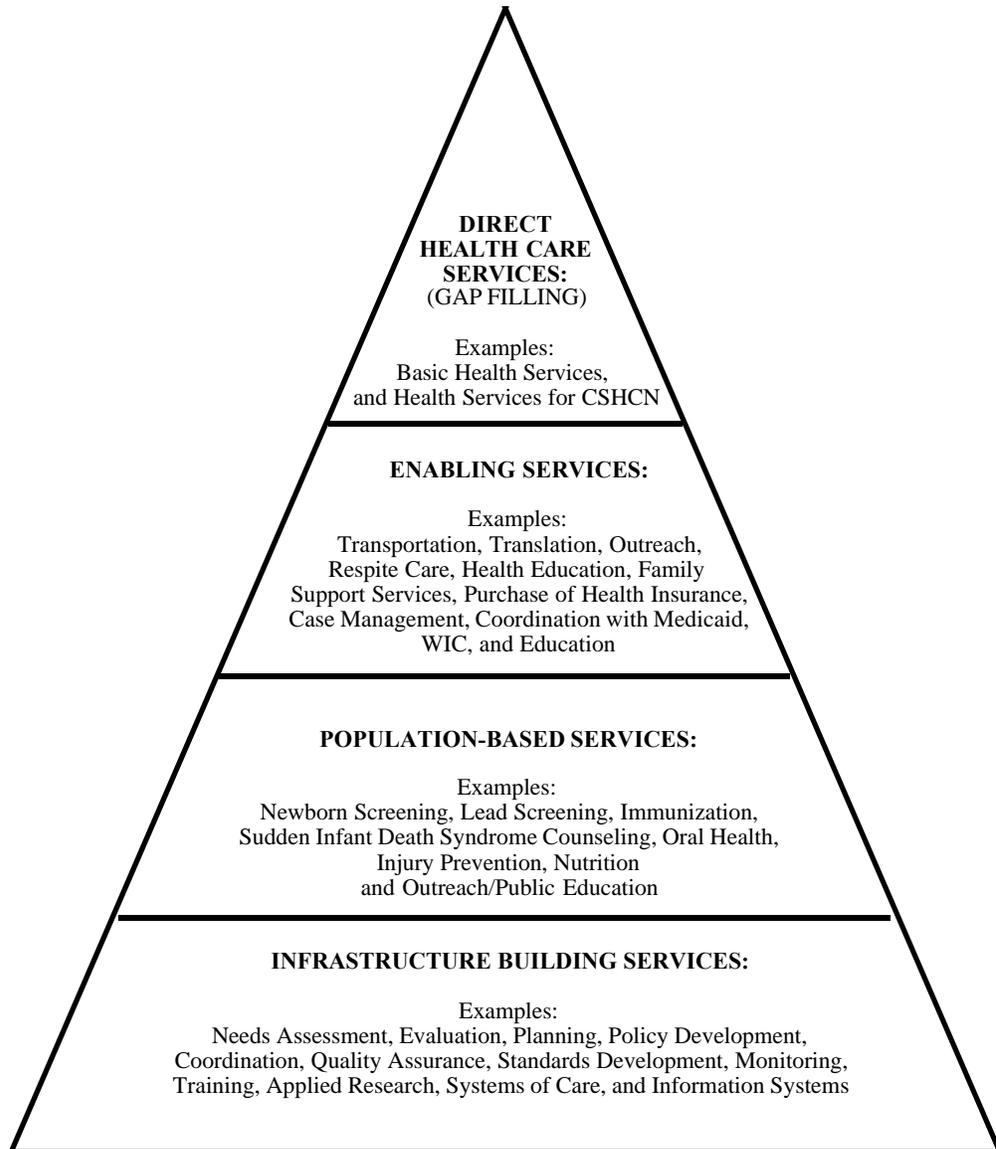
#### **2.4.1a. Direct Services for Pregnant Women, Mothers and Infants**

Prior to FY 1998, Title V funds through the *Improved Pregnancy Outcome (IPO) Program* actively supported the provision of prenatal care services to pregnant women in targeted high risk areas of the State. In FY 1998, the IPO Program was restructured into a statewide perinatal systems building program that seeks to improve pregnancy outcomes for all women in the State (see Infrastructure Building section for further information). Limited direct prenatal care services continued to be provided to women who lacked access to health care because of their ineligibility for Medical Assistance. These direct clinical services are primarily directed to undocumented persons living on the Eastern Shore and in the State's major metropolitan areas.

*Family Planning Program* -- In FY 1999, direct health care services for pregnant women and infants continued to include family planning/reproductive health services. The mission of the *Family Planning/Reproductive Health Program* is to reduce unintended pregnancy and improve birth and health outcomes for women by assuring that comprehensive family planning, preconception health care, teen pregnancy prevention, and colposcopy services are available and accessible. In FY 1999, the Family Planning Program served 72,089 clients through a network of ninety three clinic sites located in local health departments and other sites throughout Maryland. Colposcopy services were provided to 2,482 women in FY 1999. The

Figure 2

## CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



MCHB/DSCH 10/20/97

Title X Program emphasizes service to the most indigent population and two-thirds of clients served had incomes below 100% of the poverty level in FY 1999.

***Preconception Health Program*** -- Promoting and providing preconception health services is an important strategy for improving pregnancy outcomes and reducing unintended pregnancy in Maryland. The ***Preconception Health Program*** is an educational and clinical outreach program which emphasizes good health in all women of reproductive age. Clinical and administrative guidelines for preconception health risk assessment, extensive instructional materials, and information resources have been developed by the Program and distributed to all family planning and public health clinics. In FY 1999, more than 5,000 preconception visits were conducted at these sites. Women who receive preconception services are more likely to enter care in the first trimester.

The importance of folic acid as a means of preventing neural tube defects is stressed in Maryland as part of preconception health services. The Maryland Folic Acid Council (chaired by OMHFP) was established in January 1999 to promote the intake of folic acid before conception and during pregnancy to prevent neural tube defects. Activities included a Mass Transit Administration campaign and the creation of many promotional items for distribution at community and local events.

#### **2.4.1b. Enabling Services for Pregnant Women, Mothers and Infants**

Enabling services for pregnant women, mothers and infants include home visiting programs, the Maternal and Child Health Hotline, outreach and education services and activities to prevent congenital syphilis and HIV/AIDS. ***The Maternal and Child Health Hotline***, a cooperative activity between the Title V and Medical Assistance Program, is housed in Medical Assistance Program. Public health nurses under Title V provide consultation on MCH issues to families. The Hotline also refers pregnant women to prenatal care resources and provides information about eligibility for Medicaid/MCHP programs. Hotline staff responded to over 46,000 calls in FY 1999.

***Home Visiting Programs*** -- Local health departments continued to collaborate with the Medical Assistance Program in FY 1999 to improve health outcomes for pregnant women and infants by providing home visiting and care coordination services through the Healthy Start program. The Healthy Start Program seeks to ensure that low income pregnant women, infants

and children have access to a network of quality medical care. Healthy Start nurses in each LHD provide case management and home visiting services to high risk, low income pregnant women as identified by the *Maryland Prenatal Risk Assessment* form which is completed at the first prenatal visit. Emphasis on early and regular prenatal care and screening for risk factors for premature delivery are major components of Healthy Start. Home visits are continued postpartum if needed to support breastfeeding. In FY 1999, local health department Healthy Start nursing staff made approximately 18,400 home visits to pregnant women.

As of July 1998, MCHP expanded prenatal services to women to 200% of the FPL. All women enrolled in HealthChoice must be provided an appointment and be seen within 10 days of their request for this service. In 1998, more than 87% of all pregnant women in Maryland received prenatal care in the first trimester. LHDs helped to ensure that pregnant women enrolled in HealthChoice received access to early prenatal care.

***Congenital Syphilis Prevention.*** In 1996, the number of congenital syphilis cases in Maryland hit an all time high of 60. Between 1996 and 1997 Maryland's congenital syphilis rate increased 57% from 54.6 to 85.5 cases per 100,000 live births. This increase was largely attributable to a rise in the primary and secondary syphilis rate in Baltimore City in both 1996 and 1997. This rapid rise in syphilis rates made the eradication of congenital syphilis a MCH public health priority in 1998. Between 1997 and 1998, the congenital syphilis rate decreased by 23% from 85.0 to 65.5 cases per 100,000 live births and enabled the Title V Program to exceed its target goal of 85.0. However, the 1998 congenital syphilis rate for Maryland was still far higher than that for the U.S. (26.9) and the year 2000 objective (40.0). Data for 1999 show that number of congenital syphilis cases has declined even further from 60 in 1996 to 27 in 1999. This decrease was largely attributed to increased provider education and outreach to at risk populations.

Since January 1998, Maryland's prenatal care providers have been required to screen for syphilis at the first prenatal visit, at 28 gestational weeks (and at time of delivery in Baltimore City by Health Commissioner's order). The law emphasizes to providers the importance of early third trimester screening of all prenatal patients in order to treat women in time to prevent congenital syphilis in their babies. Representatives of the OMHFP, Baltimore City Health Department, the CDC, and the Maryland Epidemiology and Disease Control Program held monthly meetings to

track the numbers of cases, monitor systems of care, and develop new standards for decreasing the number of cases during FY 1999.

This past year, the State Health Department continued to partner with the Baltimore City Health Department and the CDC to reduce the high rate of syphilis in Baltimore City. Aggressive preconceptional/ prenatal outreach and screening methods were used in an attempt to reduce the rate of congenital syphilis in newborns. Population groups at highest risk such as drug addicts and inmates of correctional facilities continued to be targeted for syphilis screening, treatment and aggressive follow-up. (In FY 1998, the data showed that at least 20% of persons in the City with syphilis had a history of being detained at a correctional facility).

During FY 1999, several actions were taken to improve the infrastructure for preventing congenital syphilis. The OMHFP and the STD Control Program jointly presented six statewide trainings to promote better collaboration between local perinatal health coordinators and STD investigators and improve case identification, follow-up and treatment. The OMHFP and the Office for Epidemiology and Disease Control jointly developed two charts, *Important Reminders About Managing Infections During Pregnancy*, and *Procedures for Preventing Perinatal Infections*, that were mailed to all OB/GYNs and certified nurse midwives in the State. These educational materials included current screening and treatment guidelines for all perinatal infections. Quality assurance efforts were expanded by establishing congenital syphilis cases as a priority for Fetal and Infant Mortality Review Teams.

**HIV/AIDS Prevention** -- Approximately 0.5% of pregnant women test positive for HIV each year in Maryland. The Maryland AIDS Administration administers the Maryland Title IV Program. This Program helps to reduce perinatal transmission of HIV by providing the most current treatments and care for women and children with HIV. Women of childbearing age are targeted and provided one-on-one education sessions on how to protect them and their infants from HIV. All pregnant women are advised to be voluntarily tested for HIV. Refusal to participate in the screening does not influence the quality of care. The project facilitates access to a range of health care and case management services for women, children, teens, and families with HIV/AIDS. The Title V Program began participating on an advisory group for this initiative in FY 2000.

***Outreach to Hispanic Populations*** -- Between 1990 and 1999, Maryland's Hispanic population increased by 50%. The Spanish Outreach Initiative is a special project in 3 jurisdictions to provide outreach to Spanish speaking clients to increase their access to reproductive health services. Components of the initiative include the hiring of Hispanic male outreach workers, health promoters/educators and bilingual translators to educate Hispanic communities about reproductive health issues. During FY 1999, the OMHFP continued to promote and update its Spanish website. Written for an 8th grade reading level, the web site provides detailed information about preconception health, prenatal care and family planning and how to access these services. The translation of the web page to Spanish has improved access to reproductive health information for the Hispanic population as evidenced by the increased number of e-mails received by OMHFP in FY 1999.

#### **2.4.2b. Enabling Services for Children and Adolescents**

Enabling services, which promote access to care for preventive and primary care, services for children were provided by each of Maryland's 24 local health departments in FY 1999. Enabling services include care coordination, home visiting, health education, outreach, eligibility determination, enrollment into MCHP and inter-agency coordination. In FY 1999, MCH Block Grant funds supported local health department efforts in identifying and assisting families in accessing health and health related services, reducing child abuse and neglect, and improving immunization rates and screening for lead exposure/poisoning. These funds also supported local efforts to develop linkages with medical and health related providers to effectively meet the health needs of children.

Local health departments continued to play a key role in the implementation of HealthChoice and MCHP. As ombudsmen, they received referrals from Medical Assistance and provided necessary interventions to resolve complaints, including educating both recipients and MCOs and mediate disputes between recipients and MCOs. Community outreach was also done to identify children eligible for HealthChoice and MCHP. Once eligible children were identified, local health departments assisted with the application and enrollment processes. Community outreach, patient education and care coordination were provided to recipients referred by the MCOs for not adhering to their health care plan.

Local health departments also continued to provide home visiting and care coordination to reduce factors that place children at risk for child abuse and neglect and other undesirable outcomes. These services were delivered by paraprofessionals, public health nurses and social workers who were supported by the Healthy Generations (HGEN) Program. In FY 1999, OCH administered HGEN (Healthy Generations), a computer based information system that supports public health nursing and medical social work prevention-focused and family-centered services, including care coordination for at-risk pregnant women, infants and children (0-21). The program includes components for tracking, in cooperation with the primary health care provider, the health status of children 0-3 years; capturing client and population based immunization data; care coordination statistics; and outcome information. In FY 1999, HGEN continued to operate in 15 of the State's 24 jurisdictions. Approximately 6% of newborns in the State were enrolled in the program. During FY 1999, OCH also provided technical assistance, consultation and training to home visiting programs based in local health departments and served as a participant on a statewide planning committee to implement *Healthy Families America*, a nationally recognized home visiting model in each jurisdiction.

#### **2.4.2c. Enabling Services for Children with Special Health Care Needs**

As a result of the Medicaid expansion and a decrease in the payment and provision of direct care services through the CMS program, the need for enabling services, especially respite services has emerged. Information gathered during the CMS redesign process stressed the need for additional enabling services for CSHCN including respite care, transportation and translation services. Plans for shifting direct care dollars into enabling services were developed in FY 1999 for implementation in FY 2000 at both the State and local levels.

**Choices Program** -- CMS continued its partnership with the Shriner's Hospital through the MCHB funded "Choices Program" in FY 1999. The CMS staff worked with the Shriner's Network to identify children eligible for CMS or MCHP. Under this arrangement, CMS staff also referred families and children to services available within the Shriner's network. The staff has a collaborative arrangement in which CMS staff attend Maryland Shriner's clinics to conduct outreach activities to CSHCN and their families for CMS and Medicaid eligible services.

**SSI** -- In FY 1999, the three jurisdictions with the largest SSI caseloads: Baltimore City, Baltimore County and Prince George's County continued to receive funding to provide care

coordination for SSI beneficiaries. FY 1999 was the last year of this funding for this initiative because all SSI children began receiving care coordination through the Medical Assistance Program.

***Genetics Services*** --Enabling services for children with genetic disorders and birth defects included care coordination for approximately 242 children with sickle cell disease, 251 children with PKU and other metabolic diseases and 57 patients with hemophilia. Assistance with transportation to medical appointments, social services consultations, home visiting, parent and patient education, and annual health status reevaluations/care plan refinement services were provided to these populations as needed. The case management programs have been successful. Maryland has the lowest mortality rate among young children with sickle cell disease in the nation (0.8 deaths per 1,000 patient years in Maryland vs. 6.8 deaths per 1,000 patient years for the U.S.).

***Campership Programs*** -- During FY 1999, Maryland continued to fund special camps and supportive activities for children with sickle cell disease and PKU. Monies were awarded to the Maryland Alliance of PKU families to hold a PKU camp for children with PKU and their families. Last year, 104 persons attended the PKU camp and picnic. The sickle cell camp includes academic skill building activities and sickle cell disease related health education. In 1999, fifty two children attended the summer camp and 70 persons attended the sickle cell support group picnic.

#### **2.4.3a. Population Based Services for Pregnant Women, Mothers, and Infants**

In FY 1999, population based services for pregnant women and mothers focused on preventing teen pregnancy; promoting abstinence education; and improving birth outcomes by reducing smoking during pregnancy. Population based strategies for infants addressed the promotion of breastfeeding, and counseling for sudden infant death syndrome.

***Adolescent Pregnancy Prevention Program*** -- Similar to the rest of the country, adolescent birth rates in Maryland have been declining. This decline is being attributed to increases in education, including abstinence education; and improved access to all contraceptive methods. Maryland's Title V and Title X Program seek to reduce teen pregnancies by discouraging premature childbearing, promoting preconception health, preventing poor pregnancy outcomes and improving the health of teens. Teens represented 25,066 or 35% of clients served in

family planning clinics located at 93 sites (including 11 in school based health clinics) across the State in FY 1999. Over 57% of these teen clients were under the age of 18. Most adolescents were seen free of charge and any necessary screenings or contraceptive supplies were included with the visit. Counseling regarding responsible sexual decision making and abstinence was offered to teen clients. Family participation and parental involvement were strongly encouraged. In many counties, significant efforts were made to provide education, counseling and medical services to young men.

The ***Healthy Teens and Young Adults Program***, a model program which offers a holistic approach to preventing adolescent pregnancy, continued to operate in three jurisdictions with high rates of teen pregnancy - - Baltimore City, Prince George's County and Anne Arundel County. The Program provided comprehensive care to address both the psychosocial and physical health needs of 6,163 teens in FY 1999. Outreach to both males and females has been successful largely due to a popular peer program whereby teens help other teens. Other Title V supported teen pregnancy prevention activities include the Teen-Tot Program, Three for Free, and Adams House. The Teen-Tot Program seeks to decrease repeat teen births by offering comprehensive and holistic preventive services to parenting teens, their babies and extended family members in Baltimore City. Three for Free, a popular condom distribution program is offered at over 700 sites across the State. The Title V Program initiated funding of Adams House in FY 1999. This Prince George's County program targets teen males at risk for unplanned fatherhood and young fathers to promote planned, healthy fatherhood and community responsibility. Services include family planning, abstinence education, counseling, physical fitness, and career development.

The ***Maryland Abstinence Education and Coordination Program (MACEP)***, a federally funded program, promotes abstinence education by supporting community-based after school programs which promote self-esteem and alternatives to risky behavior while providing an abstinence only message. These programs target pre-teens and teens between the ages of 9 and 18 living in 12 jurisdictions with adolescent pregnancy rates higher than the statewide average. In FY 1999, the 16 funded after school programs served a total of 350 youth. In August 1999, over 400 teens, parents, and youth focused professionals attended Maryland's first Title V sponsored abstinence education conference, "*Winning Choices*". The Conference's goal was to showcase educational and entertainment programs that promote abstinence as the best option for teens.

MAECP partnered with the Maryland Governor's Council on Adolescent Pregnancy to implement abstinence activities. GCAP's goals are reduce Maryland's teen birth rate and improve health outcomes for pregnant adolescents. MAECP funds helped to support *Campaign for Our Children*, a nationally recognized media campaign promoting abstinence through public service announcements and advertisements. The Maryland MCH Programs also continued to partner with the Council in planning the 16<sup>th</sup> Annual State Conference on Teen Pregnancy.

***Smoking Cessation in Pregnancy (SCIP) Program*** -- Maryland birth certificate data for calendar year 1998 indicate that only 10% of pregnant women in Maryland were cigarette smokers during pregnancy. The Maryland Office of Health Promotion, Education, and Tobacco Use Prevention, a sister CPHA agency, administers the Smoking Cessation in Pregnancy (SCIP) Program. SCIP is a multi-component program designed to help pregnant women stop smoking. It is a low-intensity nurse driven intervention for patients receiving prenatal care service from Maryland's local health departments or Medicaid managed care health providers. Pregnant smokers meet with public health nurses who counsel them and help them quit or reduce their cigarette consumption. Along with one-on-one counseling, participants receive self-help materials in the form of a manual and a "Quit Kit." Local health department based public health nursing home visiting programs also counseled women on the need to quit or reduce cigarette smoking during pregnancy.

***Breastfeeding Promotion Activities*** -- More Maryland mothers are breastfeeding their newborns at hospital discharge, both within the general and WIC populations. Almost 48% of WIC mothers initiated breastfeeding in FY 1999, up from 13% in FY 1991. During FY 1999, each Maryland local health department promoted breastfeeding by (1) distributing educational materials to preconceptional and pregnant women and (2) supporting educational programs to improve the knowledge of health providers about breastfeeding. For example, the Eastern Shore Perinatal Advisory Council sponsored two days of training for over 100 nurses and social workers to encourage promotion of breastfeeding. Breastfeeding was also discussed and encouraged during home visits by public health nurses with pregnant and postpartum women and during WIC nutritional site visits. Local health departments also sponsored and held free breastfeeding classes. Some local counties also offered breastfeeding pump loaner programs for nursing moms.

The WIC program employs a nutritionist who devotes one half of her time to promoting breastfeeding among WIC recipients. WIC enrolls between 22,000-23,000 pregnant women each year. During FY 1999, the WIC program conducted 4 free regional conferences to give health providers (OB/Gins, Pediatricians, Family Practitioners, and nurse practitioners and their staffs) the information needed to effectively market breastfeeding. WIC also distributed "Breastfeeding Support Cards" which identify breastfeeding resources in each region of Maryland. Both providers and clients use these cards. In FY 1999, WIC also sponsored a peer counseling program in which experienced breastfeeding moms offered guidance and support to new breastfeeding moms.

***Sudden Infant Death (SIDS) Program*** -- During FY 1999, the Office of Children's Health continued to support the activities of the Center for Infant and Child Loss located at the University of Maryland, School of Medicine. The Center provides crisis intervention, grief counseling, consultation and referral, training, education, and information services to address SIDS and other causes of infant and child death. In FY 1999, Title V funds were used to offer more than 750 contacts with bereaved families for counseling and other services, made 225 referrals to Center trained public health nurses for follow-up services, provided training to over 200 individuals, and distributed 400 information packets. SIDS disproportionately affects African American infants. The Center targets the African American community in the dissemination of risk reduction messages including its "Back and Sleep" and "Safe Bedding" campaigns.

#### **2.4.3c. Population Based Services for Children with Special Health Care Needs**

***Newborn Screening and Follow-up Program*** -- The former Office for Hereditary Disorders administers the ***Maryland Newborn Screening and Follow-up Program***. In FY 1999, the Maryland Newborn Screening Program screened 100% of newborns. Maryland has one of the most extensive newborn screening programs in the nation. Screening is done on diseases that are treatable. Infants are screened for phenylketonuria (PKU), the branched chain ketoacidurias (BCK) also called maple syrup urine disease (MSUD), homocystinuria, tyrosinemia, galactosemia, hypothyroidism, sickle cell anemia (and its variants) and biotinidase deficiency. These disorders cause mental retardation and severe medical problems unless treated right away. All babies born in Maryland are eligible for service as well as Maryland residents whose children were born

outside of Maryland but elected to have their child screened in Maryland. Follow-up services including case management were provided to 797 infants requiring these services in 1999.

***Newborn Hearing Screening Program*** -- The Program to Identify Hearing Impaired Infants was established by the Department of Health and Mental Hygiene (DHMH) in 1985. The Program's mandate (Title 13, Subtitle 6, Sections 13-601 - 13-604) requires the early identification and follow-up of hearing-impaired infants and infants at risk for developing a hearing impairment. During FY 1999, only those children suspected as having a hearing impairment were screened.

During the 1999 Maryland General Assembly Session, legislation requiring Maryland to implement a Universal Newborn Hearing Screening Program passed. On July 1, 2000, all Maryland hospitals will be mandated to administer physiologic hearing screenings to all newborns. In the beginning of FY 1999, 8 of 37 hospitals in the State performed Universal Hearing Screening. By the end of FY 99, 12 out of 37 hospitals were performing universal screening. All other hospital screened high-risk babies physiologically before discharge or referred them for screening in the community. Under this Program, each hospital will be asked to follow the Model Program for Universal Newborn Hearing Screening established by a State Advisory Council. This Program will be administered by the Office for Genetics and Children with Special Health Care Needs.

#### **2.4.4a. Infrastructure Building Services for Pregnant Women, Mothers and Infants**

Maryland MCH infrastructure building services for improving birth outcomes for pregnant women and infants are broad based and multi-faceted in their approach. The Improved Pregnancy Outcome Program, the Crenshaw Perinatal Health Initiative, and the Maryland Perinatal Health Partnership are concerned with decreasing the percent of low and very low birth weight live births, increasing the percent of very low birth weight infants born at the appropriate tertiary facilities, improving use rates for early prenatal care, and ultimately reducing infant, neonatal, perinatal and postneonatal mortality. PRAMS, Maternal Mortality Review, and Fetal and Infant Mortality Review are data/information driven processes designed to improve birth and pregnancy outcomes.

***Improved Pregnancy Outcome Program*** -- In July 1997, the focus of the Title V Improved Pregnancy Outcome (IPO) program shifted from the provision of direct medical

services such as prenatal care to perinatal systems building. All 24 Maryland local health departments, as well as community-based organizations, receive IPO funds in order to address core public health functions that benefit all pregnant women and their newborns. Each Maryland jurisdiction has a perinatal coordinator. The goal of each jurisdiction is to establish a coordinated, interdisciplinary approach for assuring quality patient care services, educational activities, and community-based efforts directed at improving pregnancy and birth outcomes. In recognition of each community's differing demographics and health care environment, many different approaches were created and implemented. These approaches included outreach efforts to increase the accuracy of birth certificate data, fetal and infant mortality review, provider education, substance abuse education, and collaboration with non-medical services such as social services. In FY 1999, the OMHFP collected and analyzed data from over 10,000 Maryland Prenatal Risk Assessment forms completed by obstetrical providers participating in HealthChoice.

The *Crenshaw Perinatal Health Initiative* is part of a comprehensive strategy to promote coordinated, community based regional systems of health care for pregnant women and newborns in order to improve birth outcomes. Through a competitive process, local grantees are selected to develop regional perinatal plans and coordinate community-based perinatal services. During Phase III of this initiative in FY 1999, 11 Maryland organizations were funded. Funded activities included the following: (1) building on the findings of local fetal and infant mortality review committees to effect systems improvements; (2) promoting the collection and dissemination of perinatal outcomes data to hospitals for continuous quality improvement purposes; (3) collaborating with community organizations to improve maternal and infant health. Projects included outreach to minority groups, multi-pregnancy support and multi-media public education campaigns. In collaboration with the Southern Maryland Perinatal Partnership, the Crenshaw Initiative presented a major statewide conference, "New Directions in Perinatal Care" in FY 1999.

*Fetal and Infant Mortality Review* – In FY 1999, OMHFP completed the third year of a three year MCHB grant, Maryland Perinatal Outcome Review (MPOR). MPOR's purpose was to provide technical assistance and training to local jurisdictions to develop and support fetal and infant mortality review processes. The grant was conducted in conjunction with Med Chi, the State's Medical society. FIMR represents a quality improvement methodology that has at its core

the fundamental purpose of understanding the interface of community services and patient experience in order to empower communities to take action on behalf of mothers and infants. Fetal and infant deaths (or other adverse outcomes defined by the community) are studied as sentinel events that can illuminate problems or processes affecting the health of women and infants.

Seven new FIMR's were started in FY 1999 bringing the total number of FIMR's in the State to 17. (FIMR is an ongoing process in Maryland and by end of State fiscal year 2000, every jurisdiction was represented by an active FIMR committee). Approximately 161 cases were reviewed in FY 1999. Major findings from these reviews point to a need for improved communication between providers and agencies serving pregnant women and infants. FIMR activities are funded through the IPO Program and the Crenshaw Initiative.

The ***Maryland Perinatal Health Initiative*** is a partnership of the Commission on Infant Mortality Prevention, the Association of Maryland Hospitals and Health Systems, and the Department of Health and Mental Hygiene. This partnership was formed to lower neonatal mortality rates by ensuring that all very low birth weight infants are born at the appropriate subspecialty center - where their chance of survival is greatest. In an effort to ensure that very low birth weight babies are born at the appropriate subspecialty hospital, the Partnership has issued standards for perinatal care developed by a group of perinatal experts. Two of the major standards are: (1) All very low birthweight infants should be delivered in tertiary care centers (Level III, III+ and IV) and (2) The very low birthweight specific neonatal mortality rate for tertiary care centers should be lower than the average very low birthweight specific neonatal rate for all Maryland hospitals. Mortality data for each hospital's very low birth weight infants is supplied quarterly to perinatal providers by the Vital Statistics Administration.

***Maternal Mortality Review*** - In July 1998, the University of Maryland School of Medicine, under the auspices of the State Medical Society's subcommittee on maternal welfare, established a formal committee for Maryland Maternal Mortality Review. The Title V agency is represented on this committee. During FY 1999, the subcommittee reviewed maternal mortality data for Maryland. The data showed that the rate of maternal mortality in Maryland was higher than the national rate. The maternal mortality rate for African American women is four times the

Caucasian rate. Beginning in 2001, the Maryland death certificate will include information about current or recent pregnancies to aid in better identification of pregnancy related deaths.

#### **2.4.4b. Infrastructure Building Services for Children and Adolescents**

Infrastructure Building Services for children and adolescents focused on improving access to health care services, needs assessment and planning activities in light of the Medicaid expansions, policy development, coordination and training.

*Medicaid/Maryland Children's Health Program --* The lack of health insurance coverage can be an important barrier to the timely receipt of health care services. According to pooled Current Population Survey (CPS) data for the years 1997-1999 (developed by the Urban Institute), 12% of children under the age of 18 were uninsured. Data from the Maryland Health Care Commission for 1995-1997 estimates that 11% of children ages 18 and under were uninsured. CPS data for 1996-98 estimates that there are 93,000 uninsured children in Maryland living in families with incomes below 200% of the poverty level and potentially eligible for the Medicaid programs including MCHP. The CPS is the only source of data on health insurance coverage for Maryland children. There are concerns about its validity, particularly for a single year, since the Maryland data are based a very limited sample size.

On July 1, 1999, the DHMH launched the Maryland Children's Health Program (MCHP). MCHP provides comprehensive benefits through Medicaid's HealthChoice program to children up to 19 years of age whose parents work and earn up to twice the poverty level (\$34,100 for a family of 4) but cannot afford health insurance. The Program projected enrollment of 60,000 children within the first three years. Enrollment subsequently significantly surpassed the Program's expectation. By the end of the State FY 1999, almost 45,000 children had been enrolled and enrollment grew to 70,000 in less than two years. The success of the Program was attributed to outreach and education efforts in two broad areas. The first involved the simplification of the application process including the use of a streamlined three page application, and the ability to mail in the application. Secondly, there was extensive community outreach including use of report card mailers, sign-up days at McDonald's, visits to low income housing units, day care centers, and health fairs.

The Maryland Medical Assistance Program provides access to a broad range of health care services for eligible low income children. HealthChoice, the MA managed care program

developed under a Section 1115 waiver, completed its second year of State operation in FY 1999. In State fiscal year 1998, the most recent year for which data is available, 16% of Maryland children ages 0-19 were enrolled in the Medicaid Program. Baltimore City had the highest percentage (47%) of children enrolled in Medicaid of any jurisdiction in the State. The Program estimates 91.6% of potentially Medicaid eligible children received a service paid by the Medicaid Program in FY 1999.

Local health departments assist the Medicaid Program with outreach efforts to enroll eligible uninsured children and adolescents in HealthChoice and MCHP. Outreach strategies include a grassroots information dissemination campaign involving collaboration with State agencies, advocacy and community-based groups, and provider organizations; a general public media and advertising campaign; and streamlining of the application process. Eligibility information is distributed through schools, licensed day care centers, and Head Start programs.

***Adolescent Suicide Prevention*** -- The Maryland Mental Hygiene Administration (MHA) administers programs to prevent adolescent suicide. Maryland is nationally recognized a leader in reducing adolescent suicide rates among youth ages 15-24. According to the Centers for Disease control, the rate of suicide in Maryland's youth population, defined as ages 15-24, between 1989 to 1998 decreased more in Maryland than in any other state. For the past 12 years, October has been proclaimed as Youth Suicide Prevention Month in Maryland. During October, MHA sponsors an annual conference on youth suicide and other educational events.

In FY 1999, Title V funds helped to support the advertisement of the Maryland Youth Crisis Hotline. This innovative statewide 24 hour toll free, decentralized hotline provides telephone crisis intervention services to troubled youth and youth in crisis. It is the only decentralized hotline service for youth in the country. The Hotline uses a central number that automatically refers youth who call to one of the six local agencies across the State. Throughout its 12 year history, the hotline has been very successful in intervening with youth considering suicide. Maryland's Title V agency is represented on the Governor's Inter-Agency Workgroup on Youth Suicide Prevention. This workgroup plans the annual conference and Youth Suicide Prevention month activities, organizes public education activities, and develops special interest outreach programs for teens at high risk for suicide.

***Adolescent Health Initiative*** -- In FY 1999, OCH continued to develop the adolescent health initiative. Data and reports describing the health of adolescents in Maryland were compiled and summarized for use in planning and policy development. The OCH contracted with the University of Maryland Baltimore to facilitate the establishment of an adolescent health advisory group. This group, comprised of adolescent health experts across the state, will work with CMCH to develop a parenting curriculum for parents of teens, and to develop training materials to educate primary care providers on important adolescent issues and the availability of resources to address these issues through the provision of periodic regional in-service training for LHD staff.

#### **2.4.4c. Infrastructure Building Services for Children with Special Health Care Needs**

***CMS Redesign Initiative*** -- During FY 1999, the CMS Program continued a major redesign initiative to improve services for children with special health care needs, and shifted its focus from direct care services to an increased emphasis on the other MCH activities identified in the pyramid. This initiative involved the collaborative effort of numerous stakeholders and was facilitated by a consultant team from the Johns Hopkins School of Public Health, Women's and Children's Health Policy Center. Both internal and external advisory committees were formed. The internal workgroup included representation from the OCH, Mental Health Administration, the Office of Hereditary Disorders (OHD), and the Medical Assistance Program. The external committee included representatives from the State Department of Education, parent groups, local health departments, the Federal Maternal and Child Health Bureau, the Maryland Chapter of the American Academy of Pediatrics, the University of Maryland, Johns Hopkins Hospital, child advocacy groups, and several community-based organizations.

The CMS Redesign Initiative consists of four phases. Phases I-III were completed in FY 1998. The final phase, which was completed in FY 1999, focused on developing a strategic plan to address the following:

- 1) Promotion of partnerships and linkages with families and providers and community-based agencies and programs serving CSHCN.
- 2) Assurance and standards development
- 3) Assessment and Policy development
- 4) Enhancement and expansion of the health and health-related services network

5) Training and education

Key elements in the plan to address these issues included the designation and collaboration with four tertiary care centers serving CSHCN as Centers of Excellence, the planning for establishment of regional resource networks, and the development of formalized family involvement in the program. In FY 1999, the designation of the four COEs (The Kennedy Krieger Institute, Johns Hopkins Children's Center, University of Maryland, and Children's National Medical Center), and the establishment of regional family representatives was completed. COE work on selected institutional projects began in FY 1999 to be completed in FY 2001.

As part of the CMS redesign process, arrangements for the provision of "wrap around" services at two COEs were developed. These services will be provided by the University of Maryland Children's Center, and the John's Hopkins Children's Center. Services will include those services not covered by insurance but thought necessary for appropriate care of the child. These services include but not limited to non-case management social work services, nutritionist consultation, and nurse education and support services for families. Special rates were determined for each specialty provider based on the types of services they provide in their clinic.

***Maryland Childhood Asthma Program*** -- Asthma is a serious chronic disease; however, when managed properly no child should die from asthma. Since 1993, 17 Maryland children between the ages of 1-14 have died from asthma. In FY 1998, OCH began developing a plan to address asthma as a major public health problem for children and adolescents. During FY 1999, the Maryland Childhood Asthma Program was established with the goal of reducing asthma morbidity and mortality among children and adolescents in Maryland. A childhood asthma coordinator was appointed and given responsibility for developing statewide initiatives for asthma prevention, care and education. Program activities focused on compiling asthma morbidity and mortality data, and networking with asthma coalitions, advocacy groups and local agencies to identify key areas for coordination and collaboration. (This program was transferred from the CMS/Specialty Care Unit to the Center for Maternal and Child Health during the reorganization in FY 2000).

***Genetics Program*** -- The infrastructure for providing genetic services is partially supported by MCH funds and the cooperative network that staffs the genetics clinics, their supporting centers and laboratories is coordinated by the staff of the OHD. This coordinating and liaison role

is essential to the maintenance and improvement of the genetic services system. The OHD provides the medical support for the newborn metabolic and newborn hearing screening programs and the birth defects program. The OHD coordinates the carrier screening programs for Tay Sachs Disease, sickle cell disease and thalassemia and the prenatal AFP/Triple Marker Screening program, linking laboratory services, clinicians and community groups. The OHD links the Centers of Excellence providing outreach clinic services with local health departments and communities. The metabolic nutritionists providing the long term case management and dietary therapy for children with PKU and other metabolic disorders are in the OHD as the nurses providing home visiting and long term case management for children with sickle cell disease. MCH dollars are also used to support a consortium formed by the Maryland Chapter of the National Hemophilia Foundation, the Pediatric Hematology Unit at Johns Hopkins Hospital and St. Agnes Hospital. The consortium is an "affiliated program" with the Comprehensive Hemophilia Treatment Center at George Washington/Children's Hospital National Medical Center in Washington D.C.

***Birth Defects Reporting and Information System (BDRIS)*** -- Maryland law established the Birth Defects Reporting and Information System in 1982. Data collection began September 1, 1983. The purpose of the law was to establish a mechanism for the reporting of selected birth defects to establish their incidence in the Maryland population, to develop procedures to monitor birth defect trends especially in relationship to environmental hazards, and to provide information on birth defects and services to the parents and families of infants affected with these birth defects. The law requires the reporting of 12 "sentinel" birth defects. "Sentinel" defects are the defects chosen by the World Health Organization (WHO) for their international birth defects surveillance program. These include: Anencephaly, Spina Bifida, Hydrocephalus, Cleft Lip with or without Cleft Palate, Esophageal Atresia/Tracheo-Esophageal Fistula, Rectal/Anal Atresia, Hypospadias, Reduction Deformity (upper limb), Reduction Deformity (lower limb), Congenital Hip Dislocation, and Down Syndrome. Approximately 500 families are served each year.

### **Extent to Which National and State Performance Measures and Targets were Met**

Form 11 summarizes Maryland's tracking of performance measures by service levels. The following tables highlight Maryland's success in meeting performance measure targets for FY

1999 and identify related program activities. If the goals were not met, explanations are provided as well as strategies to improve the outcomes.

*Performance Measure 01*

**Level of Service**  
**Population: CSHCN**

<b>National Performance Measure</b>		<b>Progress Reported</b>			
<b>01</b>	<b>The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN program.</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>FY 1999 Goal/Status</b>
		5.4%	<1%	<1%	FY 1999 Goal <1%  Goal Met

Discussion of Progress

The Maryland Title V Program set < 1% as the target goal for performance measure 01 in FY 1999. This goal was met. A description of the activities and/or programs which assisted the Maryland Title V Program in achieving this goal follows.

Role of Title V/Activities and Programs

In FY 1999, 11,530 Maryland under the age of 16 received SSI benefits. All children receiving SSI in Maryland have the option of enrolling in HealthChoice, the Medicaid managed care program. HealthChoice pays for a comprehensive package of specialty care services including rehabilitation. Because Maryland's Medicaid Program provides such a comprehensive package of primary and specialty care services, the Maryland Title V Program had projected that less than 1% of SSI beneficiaries under the age of 16 would receive supplemental services through the State CSHCN Program in FY 1999. The MCH Program informed all SSI recipients of their eligibility for HealthChoice.

*Performance Measure 02*

**Level of Service: Direct Health Care**

**Population: CSHCN**

<b>National Performance Measure</b>		<b>Progress Reported</b>			
<b>02</b>	<b>The degree to which the State Children with Special Health Care Needs Program pays for specialty &amp; subspecialty services, including care coordination otherwise accessible or affordable to its clients.</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>FY 1999 Goal/Status</b>
		<b>8</b>	<b>8</b>	<b>8</b>	<b>FY 1999 Goal: 8</b>  <b>Goal Met</b>

Discussion of Progress

The Maryland Title V Program set 8 as the target for performance measure 02 in FY 1999. This goal was met. A description of the activities and/or programs that assisted the Maryland Title V Program in achieving this goal follows.

Role of Title V/Activities and Programs

During FY 1999, the State CSHCN program paid for specialty and subspecialty services for 5,163 uninsured and underinsured eligible children with specialty health care needs. These services were largely provided through hospitals, community based organizations, and local health department based clinics. Services included medical and surgical subspecialty services, OT, PT, speech, hearing and language services, respiratory services, durable medical equipment and supplies, nutrition services, care coordination, and early intervention services. Home health services are neither provided nor paid for by the State CSHCN program. These services are offered by other health providers in the State. Care coordination is provided by case managers and program staff at the State and local health departments.

In FY 1999, the State CSHCN Program began to see a decrease in numbers of children referred to the CMS program as well as an increase in the numbers of CMS children qualifying for HealthChoice either through MCHP or another Medical Assistance Program. FY 1999 was a transition year for CMS children most (approximately 85%) of whom became eligible for Medical Assistance Programs. Outreach efforts by local health departments to undocumented children and older adolescents began to serve as the basis for new CMS referrals.

*Performance Measure 03*

**Level of Service: Direct Health Care**

**Population: CSHCN**

<b>National Performance Measure</b>		<b>Progress Reported</b>			
<b>03</b>	<b>The percent of Children with Special Health Care Needs (CSHCN) in the State who have a “medical/health home.”</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>FY 1999 Goal/Status</b>
		<b>85.0%</b>	<b>85.0%</b>	<b>85.0%</b>	<b>1998 Target: 90%</b>  <b>Goal not met</b>

Discussion of Progress

Maryland Title V Program set 90% as the target goal for performance measure 03 in FY 1999. However, the Maryland Title V Program is unable to determine the precise number of children with a medical home since this information is not routinely collected. In Maryland, the medical/health home is defined as having access to health insurance coverage for primary and specialty care. Data from the Childhood Disability Supplement of the 1994-95 National Health Interview Survey estimated that 85% of the more than 183,000 children with special health care needs were insured. Given the date of the available data and the recent implementation of MCHP in FY 1999, it is quite possible that the State has met its objective. The Title V Program assumes that all insured children have a medical home and therefore 85% of CSHCN are assumed to have a medical home.

In FY 2000, the MCHP Program actively pursued participating in the CSHCN component of the SLATIS, a national survey, to assist in quantifying this measure. Unfortunately, Maryland's participation in this survey proved to be cost prohibitive (\$100,000+). In FY 2001, the Title V Program will work to develop a methodology to more accurately identify the percent of CSHCN that have a medical home.

**Role of Title V/Activities and Programs**

All referrals to the CMS program are screened for eligibility for other programs such as SSI and Medicaid. CMS also has a provision in its program regulations to pay for health insurance instead of just specialty care if the child’s family has access to a health insurance plan through the parent's place of employment. Although this provision is only utilized for a small number of children, it does serve as a source of providing for a medical home for CSHCN.

*Performance Measure 04*

**Level of Services: Population Based  
Population: Infants**

National Performance Measure		Progress Reported			
<b>04</b>	<b>Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies [(e.g. the sickle cell disease) (combined)]</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>FY 1999 Goal/Status</b>
		<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>1999 Target: 100% Goal met</b>

Discussion of Progress

The Maryland Title V Program set 100% as the target goal for performance measure 04 in FY 1999. The Newborn Screening Program screened 100% of Maryland newborns in 1999. Therefore, this goal was met. In 1999, the proportion of newborns with at least one screening (PKU, hypothyroidism, galactosemia, hemoglobinopathies) for Maryland as a whole met the year 2000 Objectives (100%). A description of the activities and/or programs that assisted the Maryland Title V Program in achieving this goal follows.

Role of Title V/Activities and Programs

Maryland has one of the most extensive newborn screening programs in the nation. Infants are screened for phenylketonuria (PKU), the branched chain ketoacidurias (BCK) also called maple syrup urine disease (MSUD), homocystinuria, tyrosinemia, galactosemia, hypothyroidism, sickle cell anemia (and its variants) and biotinidase deficiency. These disorders cause mental retardation and severe medical problems unless treated right away. All babies born in Maryland or who are residents born elsewhere are eligible for service. Follow-up services including case management were provided to 831 infants requiring these services in 1999.

*Performance Measure 05*

**Level of Service: Population Based  
Population: Children**

National Performance Measure		Progress Reported			
05	Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B	1996	1997	1998	FY 1999 Goal/Status
		78%	80%	80%	1998 Target: 82%  Goal Not Met

Discussion of Progress

The Maryland Title V Program set 82% as the target goal for performance measure 05 in FY 1999. Since there is currently no immunization registry in Maryland for accurately determining the immunization of two year olds, estimates are derived from the CDC's National Immunization Survey that is conducted every 6 months. This national survey indicated that 80% of 19-35 month olds in Maryland were fully immunized according to the 4:3:1:3 series in 1998/99. This survey excludes measurement of immunization levels for Hepatitis B. Maryland did not reach its target goal of an 82% immunization rate for FY 1999. It is believed that missed opportunities by physicians to provide immunizations and limited resources to adequately identify, track, monitor and refer all underimmunized children are two major reasons for why Maryland did not reach its Title V target goal of 82%. A description of the activities and/or programs that assisted the Maryland Title V Program in achieving this goal follows.

Role of Title V/Activities and Programs

The Center for Immunizations within the Epidemiology and Disease Control Program is largely responsible for statewide immunization activities in Maryland. These activities include the provision of immunization clinics through local health department clinic sites, the administration of the Maryland Vaccines for Children Program, provider education programs, community outreach and education, and surveillance and assessment activities. In FY 1999, the Maryland Center for Immunizations immunized more than 15,000 Maryland children through 500 local health department sponsored immunization clinics.

*Performance Measure 05 (Cont'd)*

The Maryland Vaccine for Children (VFC) Program has been in operation since 1994. The program supplies all routine childhood vaccines. Designed to remove cost as a barrier to vaccination, the VFC program allows physicians to provide vaccines, free of cost, to children 18 years and under who have Medicaid, are uninsured or are underinsured. During FY 1999, the VFC Program processed requests for 736,645 doses of vaccine for over 900 public and private providers.

The OCH continued to support LHD efforts to inform consumers, communities and providers about the importance of immunizations during FY 1999. OCH also continued to administer Healthy Generations (HGEN), a computer-based tracking system, used by LHDs in collaboration with the Center for Immunizations, to identify and track under-immunized children. The OCH collaborated with the Center for Immunizations and the Office of Public Health Assessment to plan for integration of existing data systems.

*Performance Measure 06*

**Level of Service: Population Based  
Population: Adolescents**

National Performance Measure		Progress Reported			
<b>06</b>	<b>The rate of births (per 1,000) for teenagers aged 15 through 17 years.</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>FY 1999 Goal/Status</b>
		<b>29.6</b>	<b>28.2</b>	<b>26.3</b>	<b>1998 Target: 29.1  Goal Met</b>

Discussion of Progress

The Maryland Title V Program set 29.1 as the target goal for performance measure 06 in 1998. This goal was met and surpassed. In 1998, the birth rate for Maryland teenager aged 15-17 stood at 26.3, a decline of 6.7% from the 1997 rate of 28.2. Maryland's teen birth rate has continued to decline since the early 1990's. This decline is being attributed to increased in education, including abstinence education, and improved access to all contraceptive methods. A description of the activities and/or programs that assisted the Maryland in achieving this goal follows.

Title V Role/Activities and Programs

Maryland's Title V and Title X Program seek to reduce teen pregnancies by discouraging premature childbearing, promoting preconception health, preventing poor pregnancy outcomes and improving the health of teens. Teens represented 25,066 or 35% of clients served in family planning clinics located at 93 sites across the State in FY 1999. Eleven of these sites were located in school based health clinics. Over 57% of these teen clients were under the age of 18. Counseling regarding responsible sexual decision making and abstinence was offered to teen clients. Family participation and parental involvement were strongly encouraged. In many counties, significant efforts were made to provide education, counseling and medical services to young men. Most adolescents were seen free of charge and any necessary screenings or contraceptive supplies were included with the visit.

### ***Performance Measure 06 (Cont'd)***

Healthy Teens and Young Adults Program, a model program which offers holistic approach to preventing adolescent pregnancy, continued to operate in three jurisdictions with high rates of teen pregnancy - - Baltimore City, Prince George's County and Anne Arundel County. The Project provided comprehensive care to address both the psychosocial and physical health needs of more than 6,000 teens in FY 1999. Outreach to both males and females has been successful largely due to a popular peer program whereby teens help other teens. Other Title V supported teen pregnancy prevention activities include the Teen-Tot Program and Adams House. The Teen-Tot Program seeks to decrease repeat teen births by offering comprehensive and holistic preventive services to parenting teens, their babies and extended family members in Baltimore City. Three for Free, a popular condom distribution program is offered at over 700 sites across the State. The Title V Program initiated funding of Adams House in FY 1999. This Prince George's County Program targets teen males at risk for unplanned fatherhood and young fathers to promote planned fatherhood and community responsibility.

The ***Maryland Abstinence Education and Coordination Program (MAECP)***, a Title V funded program, promotes abstinence education by supporting community-based after school programs which promote self-esteem and alternatives to risky behavior while providing an abstinence only message. These programs target pre-teens and teens between the ages of 9 and 18 living in 12 jurisdictions with adolescent pregnancy rates higher than the statewide average. In FY 1999, the 16 funded after school programs served a total of 350 youth. In August 1999, over 400 teens, parents, and youth focused professionals attended Maryland's first Title V sponsored abstinence education conference, "*Winning Choices*". The Conference's goal was to showcase educational and entertainment programs that promote abstinence as the best option for teens.

MAECP partnered with the Maryland Governor's Council on Adolescent Pregnancy to implement abstinence activities. GCAP's goals are reduce Maryland's teen birth rate and improve health outcomes for pregnant adolescents. MAECP funds helped to support *Campaign for Our Children*, a nationally recognized media campaign promoting abstinence through public service announcements and advertisements. The Maryland MCH Programs also continued to partner with the Council in planning the 16<sup>th</sup> Annual State Conference on Teen Pregnancy.

### ***Performance Measure 07***

**Level of Service: Direct**

**Population: Children**

<b>National Performance Measure</b>		<b>Progress Reported</b>			
<b>07</b>	<b>The percent of third grade children who have received protective sealants on at least one permanent molar tooth.</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>FY 1999 Goal/Status</b>
		<b>16.7%</b>	<b>16.7%</b>	<b>16.7%</b>	<b>1999 Goal: 28%</b> <b>Data not available</b>

Discussion of Progress

The Maryland Title V Program set 28% as the target goal for performance measure 07 in FY 1999. However, there is currently no database available on an annual basis which allows Maryland’s Title V Program to determine the percentage of third graders receiving dental sealants. The most recent data was gathered in 1995 from a survey of 3500 school children conducted by the University of Maryland Dental School. This study, which documented the extent and scope of oral health problems among school aged children in Maryland, was funded with SSDI monies under the auspices of the Office of Children’s Health . Approximately 17% of eight year olds (a proxy for third graders) reportedly received protective sealants on at least one permanent molar in 1995. Compared to children nationally, Maryland children were found to have higher rates of dental caries and dental decay. A second statewide oral health needs assessment of Maryland school children will be conducted by the University Dental School in FY 2001.

Role of Title V/Activities and Programs

In FY 1999, the Maryland Office of Children’s Health worked collaboratively with the Office of Oral Health (OOH) to improve the oral health of children. OOH uses State and Title V funds to target outreach and preventive oral health services to uninsured and Medicaid/MCHP children.

***Performance Measure 07 (Cont’d)***

During this past fiscal year, Title V funds administered by the OOH were used to support oral health prevention and treatment programs through three separate grants to local health departments in rural Eastern Shore counties. Maryland's Eastern Shore encompasses a nine county area that lacks fluoridated treatments. The Upper Shore Program operates a mobile dental clinic to provide outreach, education, preventive treatment services to schools, Head Start programs and WIC Program enrollees. Title V funds helped to provide oral health education and services to approximately 7,000 children aged 3-18 years in FY 1999.

Many low income, uninsured and Medicaid/MCHP children lack access to oral health services in Maryland. Maryland's Medical Assistance reimbursement rate for dental services ranks very low. As a result, the majority of dentists in the State have chosen not to participate as Medicaid dental providers and even fewer specialists participate in the Medicaid Program. Several jurisdictions are without Medicaid providers. In FY 1999, the University of Maryland Dental School was awarded a grant to conduct two demonstration projects, one in Prince George's County and on the Eastern Shore, to identify strategies to increase access to dental care for high risk children enrolled in Medicaid/MCHP.

All 24 local health departments receive funds to target dental health services to Medicaid and uninsured children and pregnant women. Ten of Maryland's 24 counties operated comprehensive oral health programs in FY 1999. A dental resource directory describing low cost and affordable dental services for children was distributed by OOH for families, health care providers and schools in FY 1999.

*Performance Measure 08*

**Level of Service: Direct**

**Population: Children and Adolescents**

<b>National Performance Measure</b>		<b>Progress Reported</b>			
<b>08</b>	<b>The rate of deaths to children aged 0-14 caused by motor vehicle crashes per 100,000 children</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>FY 1999 Goal/Status</b>
		3.6	3.5	3.6	<b>1998 Target: 3.3</b>  <b>Goal not met</b>

Discussion of Progress

In 1998, 38 Maryland children under the age of 15 died in motor vehicle crashes. The 1998 rate of 3.6 was higher than the Title V target goal of 3.3. Drunk drivers and unrestrained or improperly restrained children are two factors that significantly contribute to vehicle related fatalities among children.

Role of Title V/Activities and Programs

Child safety seats are very effective when installed and used correctly reducing the risk of injury by 71% for infants and by 54% for toddlers. Since the 1980's, Maryland's Kids in Safety Seats (KISS) Program has been the State's lead agency in child passenger safety. KISS is housed in the DHMH and funded by the Department of Transportation. KISS's mission is to help reduce the number of needless injuries and deaths by educating the public on child passenger safety. One objective of KISS is to help people use safety seats correctly each time a child rides in a car. In Maryland, it is estimated that 80% of population uses child safety seats; however, the misuse rate is approximately 90%. In FY 1999, KISS worked to achieve its goal by educating the public on the State's child passenger safety law, offering literature and program materials for Maryland residents, and providing training and technical assistance in child passenger safety throughout the State. The Title V program assists KISS in promoting the need of child passenger safety by distributing literature at community events and educating families during local health department home visits.

*Performance Measure 09*

**Level of Service: Population Based**

**Population: Infants**

National Performance Measure		Progress Reported			
09	Percentage of mothers who breastfeed their infants at hospital discharge.	1996	1997	1998	FY 1999 Goal/Status
		56.5%	58.1%	58.8%	Target Goal: 60%  Goal not met

Discussion of Progress

The Maryland Title V Program set 60% as the target goal for performance measure 09 in FY 1999. More Maryland mothers are breastfeeding their newborns at hospital discharge, both within the general and WIC populations. Almost 48% of WIC mothers initiated breastfeeding in FY 1999, up from 13% in FY 1991. The percentage of mothers breastfeeding in FY 1999 fell just short of Maryland's target goal of 60%. The newborn screening database currently serves as the source of data on breastfeeding in Maryland. Beginning in FY 2001, data for this performance measure will be derived from the PRAMS survey. A description of the activities and/or programs that assisted the Maryland Title V Program in achieving this goal follows.

Role of Title V/Activities and Programs

During FY 1999, each Maryland local health department promoted breastfeeding by (1) distributing educational materials to preconceptional and pregnant women and (2) supporting educational programs to improve the knowledge of health providers about breastfeeding. For example, the Eastern Shore Perinatal Advisory Council sponsored two days of training for over 100 nurses and social workers to encourage promotion of breastfeeding. Breastfeeding was also discussed and encouraged during home visits by public health nurses with pregnant and postpartum women and during WIC nutritional site visits. Local health departments also sponsored and held free breastfeeding classes. Some local counties also offered breastfeeding pump loaner programs for nursing moms.

*Performance Measure 09 (Cont'd)*

The WIC program employs a nutritionist who devotes one half of her time to promoting breastfeeding among WIC recipients. WIC enrolls between 22-23,000 pregnant women each year. During FY 1999, the WIC program conducted 4 free regional conferences to give health providers (OB/GYNs, Pediatricians, Family Practitioners, and nurse practitioners and their staffs) the information needed to effectively market breastfeeding. WIC also distributed "Breastfeeding Support Cards" which identify breastfeeding resources in each region of Maryland. Both providers and clients use these cards. In FY 1999, WIC also sponsored a peer counseling program in which experienced breastfeeding moms offered guidance and support to new breastfeeding moms. WIC also distributed educational materials and posters provided by the USDA's national campaign to increase breastfeeding. Finally, the WIC Program provided training to promote breastfeeding for WIC and local health department staff and others.

Governor Glendening has designated the month of August as Breastfeeding Month. Educational and promotional events during FY 1999 included the sponsoring of a walk to promote breastfeeding in Baltimore's Inner Harbor. The Worksite Lactation Support Project at DHMH also continued to promote breastfeeding for mothers who return to work.

*Performance Measure 10*

**Level of Service: Population Based**

**Population: Infants**

<b>National Performance Measure</b>		<b>Progress Reported</b>			
<b>10</b>	<b>Percentage of newborns who have been screened for hearing impairment before discharge.</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>FY 1999 Goal/Status</b>
		<b>3.7%</b>	<b>6.2%</b>	<b>19%</b>	<b>FY 1999 Target: 10%</b>  <b>Goal met</b>

Discussion of Progress

The Maryland Title V Program set 10% as the target goal for performance measure 10 in FY 1999. In FY 1999, the proportion of Maryland newborns with a hearing screen before hospital discharge was 19% and exceed the Title V target goal of 10%. A description of the activities and/or programs that assisted the Maryland Title V Program in achieving this goal follows.

Role of Title V/Activities and Programs

The Program to Identify Hearing Impaired Infants was established by the Department of Health and Mental Hygiene (DHMH) in 1985. The Program's mandate (Title 13, Subtitle 6, Sections 13-601 - 13-604) requires the early identification and follow-up of hearing-impaired infants and infants at risk for developing a hearing impairment. At the beginning FY 1999, 8 of 37 hospitals in the State performed Universal Newborn Hearing; by the end of the FY 99, 12 hospitals universal screening performed and all other screened high risk babies physiologically before discharge or referred high risk babies for screening in the community. On July 1, 2000, all Maryland hospitals will be mandated to administer physiologic hearing screenings to all newborns. Each hospital will be asked to follow the Model Program for Universal Newborn Hearing Screening established by a State Advisory Council.

*Performance Measure 11*

**Level of Service: Infrastructure Building**

**Population: CSHCN**

<b>National Performance Measure</b>		<b>Progress Reported</b>			
<b>11</b>	<b>Percentage of Children with Special Health Care Needs (CSHCN) in the State program with a source of insurance for primary and specialty care.</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>FY 1999 Goal/Status</b>
			<b>49%</b>	<b>45%</b>	<b>FY 1999 Target: 35%</b>  <b>Goal Met</b>

Discussion of Progress

The Maryland Title V Program set 35% as the target for performance measure 11 in FY 1999. This goal was met. A description of the activities and/or programs that assisted the Maryland Title V Program in achieving this goal follows.

Role of Title V/Activities and Programs

In FY 1999, 45% of all children seen through the CMS Program had some form of health coverage for primary and specialty care. This percentage does not reflect the number of children who transitioned into MCHP during the year. For statistical purposes, health insurance data on children is collected once every 12 months when eligibility is determined. This percentage also includes children who have primary and specialty care coverage but may not be underinsured for the type of specialty care needed.

*Performance Measure 12*

**Level of Service: Infrastructure Building**  
**Population: Infants, Children & Adolescents**

National Performance Measure		Progress Reported			
<b>12</b>	<b>Percentage of Children without health insurance</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>FY 1999 Goal/Status</b>
		<b>8.1%</b>	<b>10.1%</b>	<b>12.0%</b>	<b>Target: 8.6%</b>  <b>Goal not Met</b>

Discussion of Progress

An accurate count of the number of uninsured children and adolescents in Maryland is difficult to obtain. The annual March supplement of the U.S. Census Bureau's Current Population Survey (CPS) provides consistent data on the number of uninsured persons in the U.S. The sample sizes from this survey for most states are too small to provide reliable estimates of the number of uninsured children. However, because this is one of the few sources of data, Maryland like many states is forced to rely on this data for monitoring progress on Performance Measure 12. The 1998-CPS survey data for Maryland indicate that 17.5% of children were uninsured, 3.5% were enrolled in the Medicaid Program, and 78% were covered by private insurance. This survey does not take into account the full implementation of MCHP. This data underestimates the percentage covered by Medicaid and we suspect overestimates the percentage uninsured since the survey did not gather information about HealthChoice. According to data provided by the Maryland Medicaid Assistance Program, approximately 19% of Maryland children and adolescents under the age of 20 were covered by Medicaid as of August 31, 1999.

Using pooled data for the years 1996, 1998, and 1999, the Kaiser Commission on the uninsured estimates that 12% of Maryland children under age 19 were uninsured and 11.2% were covered by Medical Assistance. Data from the Maryland Health Care Commission estimates that 11.1% of children under the age of 19 in Maryland were uninsured in 1995-1997. These data indicate that Maryland was not able to achieve its Title V goal of 8.6%.

### *Performance Measure 12 (Cont'd)*

During FY 2001, Maryland plans to investigate additional methods for estimating the percentage of uninsured children in the State. This methodology will then be used, if possible, to reconfigure uninsured rates since FY 1996.

#### Role of Title V/Activities and Programs

The Maryland Medical Assistance Program serves as the major source of publicly sponsored health insurance coverage for children and adolescents lacking access to employer sponsored and private programs. On July 1, 1999, the DHMH launched the Maryland Children's Health Program (MCHP). MCHP provides comprehensive benefits through Medicaid's HealthChoice program to children up to 19 years of age whose parents work and earn up to twice the poverty level (\$34,100 for a family of 4) but cannot afford health insurance. The Program projected enrollment of 60,000 children within the first three years. Enrollment subsequently significantly surpassed the Program's expectation.

By the end of the State FY 1999, almost 45,000 children had been enrolled and enrollment grew to 70,000 in less than two years. The success of the Program was attributed to outreach and education efforts in two broad areas. The first involved the simplification of the application process including the use of a streamlined three page application, and the ability to mail in the application. Secondly, there was extensive community outreach including use of report card mailers, sign-up days at McDonald's, visits to low income housing units, day care centers, and health fairs.

In FY 1999, the Title V Program including local health department based MCH programs continued to support the Medicaid Program in enrolling eligible children and adolescents. The State continued to coordinate its outreach efforts with local health departments, community health centers, managed care organizations, and other public and private providers working with low income uninsured populations. Eligibility information is distributed through schools, licensed day care centers, and Head Start programs. Outreach strategies also included a grassroots information dissemination campaign involving collaboration with State agencies; advocacy and community based groups; a general public media and advertising campaign, promotion of the MCH Hotline for information and referral; and streamlining of the application process.

*Performance Measure 13*

**Level of Service: Infrastructure Building**

**Population: Infants, Children & Adolescents**

National Performance Measure		Progress Reported			
<b>13</b>	<b>Percentage of potentially Medicaid children who have received a service paid by the Medicaid Program.</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>FY 1999 Goal/Status</b>
		<b>82.3%</b>	<b>82.3%</b>	<b>91.6%</b>	<b>FY 1998 Goal: 84%</b>  <b>Goal Met</b>

Discussion of Progress

The Maryland Medical Assistance Program provides access to a broad range of health care services for eligible low income children. HealthChoice, the MA managed care program developed under a Section 1115 waiver, completed its second year of State operation in FY 1999. In State fiscal year 1999, approximately 19% of Maryland children and adolescent under age 19 were enrolled in the Medicaid Program. Baltimore City had the highest percentage (47%) of children enrolled in Medicaid of any jurisdiction in the State. The Program estimates 91.6% of potentially Medicaid eligible children received a service paid by the Medicaid Program in FY 1999. The state's target goal was met.

Role of Title V/Activities and Programs

Local health departments assist the Medicaid Program with outreach efforts to enroll eligible uninsured children and adolescents in HealthChoice and MCHP. Outreach strategies include a grassroots information dissemination campaign involving collaboration with State agencies, advocacy and community-based groups, and provider organizations; a general public media and advertising campaign; and streamlining of the application process. Eligibility information is distributed through schools, licensed day care centers, and Head Start programs.

*Performance Measure 14*

**Level of Service: Infrastructure Building**

**Population: CSHCN**

<b>National Performance Measure</b>		<b>Progress Reported</b>			
<b>14</b>	<b>The degree to which the State assures family participation in program and policy activities in the State CSHCN program.</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>FY 1999 Goal/Status</b>
		<b>2</b>	<b>2</b>	<b>11</b>	<b>Target: 12</b> <b>Goal not Met</b>

Discussion of Progress

The Title V program had projected a FY 1999 score of 12 for this performance measure. The State's indicator fell just shy of this indicator due to a need to improve family participation at the level of block grant application review. It is anticipated that even though invitations were sent to many family groups, a more personal approach will be implemented for next year's application process.

Role of the Title V/Activities and Programs

FY 1999 was the first year of a contract with Parent's Place of Maryland, the Maryland Chapter of Family Voices. One of the objectives under the contract is this performance measure. Although we have demonstrated the need for family participation, actual implementation of plans begun in FY 2000. Strategies have been developed to promote increased family participation at both the State and local levels.

*Performance Measure 15*

**Level of Service: Infrastructure Building**

**Population: Infants**

<b>National Performance Measure</b>		<b>Progress Reported</b>			
<b>15</b>	<b>Percent of very low birth weight.</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>FY 1999 Goal/Status</b>
		1.9%	2.0%	1.9%	<b>1998 Goal: 2.0%</b>  <b>Goal Met</b>

Discussion of Progress

In 1998, 1.9% of Maryland babies were born at very low birthweights. Maryland as a whole did not compare favorably to either the U.S. (1.5%) or the Year 2000 Objective (1.0%) for proportions of very low birth weight (VLBW) live births (weighing 1,499 grams or less). Maryland met the Title V target goal of 2% in 1998. This goal was primarily met because of the aggressive strategies implemented to assure (1) early access to prenatal health care, (2) screening and treatment of infections, (3) smoking cessation programs and (4) substance abuse referral and access.

Role of Title V/Activities and Programs

In July 1997, the focus of the Title V Improved Pregnancy Outcome (IPO) program shifted from provision of direct medical services such as prenatal care to perinatal systems building. All 24 Maryland local health departments, as well as community-based organizations, receive IPO funds in order to address core public health functions that benefit all pregnant women and their newborns. Each Maryland jurisdiction has a perinatal coordinator. The goal of each jurisdiction is to establish a coordinated, interdisciplinary approach for assuring quality patient care services, educational activities, and community-based efforts directed at improving pregnancy and birth outcomes. In recognition of each community's differing demographics and health care environment, many different approaches are being created and implemented. These have included outreach efforts to increase the accuracy of birth certificate data, fetal and infant

### *Performance Measure 15 (Cont'd)*

mortality review, provider education, substance abuse education, and collaboration with non-medical services such as social services.

The Crenshaw Perinatal Health Initiative is a part of a comprehensive strategy to promote coordinated, community based regional systems of health care for pregnant women and newborns in order to improve birth outcomes. Through a competitive process, local grantees are selected to develop regional perinatal plans and coordinate community-based perinatal services. In FY 1999, activities included the following: (1) building on the findings of local fetal and infant mortality review committees to effect systems improvements; (2) promoting the collection and dissemination of perinatal outcomes data to hospitals for continuous quality improvement purposes; (3) collaboration with community organizations to improve maternal and infant health. Projects include outreach to minority groups, multi-pregnancy support and multi-media public education campaigns.

Fetal and Infant Mortality Review (FIMR) is another methodology used in Maryland to improve birth outcomes including reducing the number of low birth weight births. In FY 1999, OMHFP completed the third year of a 3 year MCHB grant, Maryland Perinatal Outcome Review (MPOR). MPOR's purpose was to provide technical assistance and training to local jurisdictions to develop and support fetal and infant mortality review processes. The grant was conducted in conjunction with Med Chi, the State's Medical society. FIMR represents a quality improvement methodology, which has at its core the fundamental purpose of understanding the interface of community services and patient experience in order to empower communities to take action on behalf of mothers and infants

Seven new FIMR's were started in FY 1999 bringing the total number of FIMR's in the State to 17. (FIMR is an ongoing process in Maryland and by end of State fiscal year 2000, every jurisdiction was represented by an active FIMR committee). Approximately 161 cases were reviewed in FY 1999. Major findings from these reviews point to a need for improved communication between providers and agencies serving pregnant women and infants. FIMR activities are funded through the IPO Program and the Crenshaw Initiative.

*Performance Measure 16*

**Level of Service: Infrastructure Building**

**Population: Adolescents**

National Performance Measure		Progress Reported			
<b>16</b>	<b>The rate (per 100,000) of suicide deaths among youths aged 15-19</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>FY 1999 Goal/Status</b>
		<b>5.6</b>	<b>6.4</b>	<b>5.6</b>	<b>1998 Goal: 5.4</b>  <b>Goal Not Met</b>

Discussion of Progress

Between 1997 and 1998, the rate of suicide deaths among youths aged 15-19 declined by 12.5% and returned to the 1996 rate. The 1998 rate of 5.6 was just shy of the Title V goal of 5.4. It is anticipated that as Maryland comes closer to its goal, it will become more difficult to reach the goal unless improved early identification of potential adolescents at risk is achieved. Mental health issues, particularly depression and loneliness were cited in the needs assessment as a statewide issue. The MCH Program will be evaluating this area and collaborating with MHA on intervention strategies.

Role of Title V/Activities and Programs

The Maryland Mental Hygiene Administration (MHA) administers programs to prevent adolescent suicide. Maryland is nationally recognized as a leader in reducing adolescent suicide rates among youth ages 15-24. According to the Centers for Disease Control, the rate of suicide in Maryland's youth (defined as ages 15-24), between 1989 to 1998 decreased more in Maryland than in any other state. For the past 12 years, October has been proclaimed as Youth Suicide Prevention Month in Maryland. During October, MHA sponsors an annual conference on youth suicide and other educational events.

In FY 1999, Title V funds helped to support the advertisement of the Maryland Youth Crisis Hotline. This innovative statewide 24 hour toll free, decentralized hotline provides telephone crisis intervention services to troubled youth and youth in crisis. It is the only decentralized hotline service for youth in the country.

*Performance Measure 16 (Cont'd)*

The Hotline uses a central number that automatically refers youth who call to one of the six local agencies across the State. Throughout its 12 year history, the hotline, has been very successful in intervening with youth considering suicide. Maryland's Title V agency is represented on the Governor's Inter-Agency Workgroup on Youth Suicide Prevention. This workgroup plans the annual conference and Youth Suicide Prevention month activities, organizes public education activities, and develops special interest outreach programs for teens at high risk for suicide.

*Performance Measure 17*

**Level of Service: Direct**

**Population: Infants**

National Performance Measure		Progress Reported			
<b>17</b>	<b>Percent of very low birth weight infants delivered at facilities for higher risk deliveries and neonates.</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>FY 1999 Goal/Status</b>
		<b>83.3%</b>	<b>84.6%</b>	<b>85.9%</b>	<b>1998 Goal: 86%</b>  <b>Goal Met</b>

Discussion of Progress

In 1998, 85.9% of very low birth weight infants born in Maryland were delivered at high-risk facilities. This percentage met the Title V target set for 1998. It should be noted that as Managed Care Program (private and public) develop contractual relationships with tertiary hospitals the ability to maintain this goal may be hampered. The MCH Program will continue to monitor this performance measure. A description of the Title V activities and programs which assisted Maryland in achieving this goal follows.

Role of Title V/Activities and Programs

The Maryland Perinatal Health Initiative is a partnership of the Commission on Infant Mortality Prevention, MHA: The Association of Maryland Hospitals and Health Systems, and the Department of Health and Mental Hygiene. This partnership was formed to lower neonatal mortality rates by ensuring that all very low birth weight infants are born at the appropriate subspecialty center - where their chance of survival is greatest. In an effort to ensure that very low birth weight babies are born at the appropriate subspecialty hospital, the Partnership has issued standards for perinatal care developed by a group of perinatal experts. These standards state that: (1) All very low birthweight infants should be delivered in tertiary care centers (Level III, III+ and IV) and (2) The very low birthweight specific neonatal mortality rate for tertiary care centers should be lower than the average very low birthweight specific neonatal rate for all Maryland hospitals. Mortality data for each hospital's very low birth weight infants is supplied quarterly to perinatal providers by the Vital Statistics Administration.

*Performance Measure 18*

**Level of Service: Direct**  
**Population: Pregnant Women**

National Performance Measure		Progress Reported			
18	Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.	1996	1997	1998	FY 1999 Goal/Status
		88.3%	88.9%	87.9%	1998 Goal: 89.3%  Goal not Met

Discussion of Progress

The FY 1998 target set for this performance measure was 89.3%. In 1998, 87.9% of Maryland infants were born to pregnant women receiving prenatal care in the first trimester. The Title V goal was not met. This is slightly higher than the percentage for the United States as a whole for the same year (82.8%). The percentages for the State of Maryland and for the U.S. were lower than the Year 2000 Objective of 90.0%.

Role of Title V/Activities and Programs

Promoting and providing preconception health services is an important strategy for improving pregnancy outcomes and reducing unintended pregnancy in Maryland. The Maryland Preconception Health Program is an educational and clinical outreach program which emphasizes good health in all women of reproductive age. This Program also promotes the need for early access to prenatal care services. Clinical and administrative guidelines for preconception health risk assessment, extensive instructional materials, and information resources have been issued to all public health clinics. In FY 1999, more than 5,000 preconception visits were conducted at these sites.

*State Performance Measure 01*

**Level of Service: Population Based  
Population: Children**

State Performance Measure		Progress Reported			
<b>01</b>	<b>Percent of children aged 0-72 months screened for lead poisoning/exposure by blood testing.</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>FY 1999 Goal/Status</b>
		13.9%	15.7%	14.1%	1998 Goal: 17%  Goal Not Met

Discussion of Progress

Lead poisoning is a serious, but preventable health problem that affects children in Maryland. In 1998, Maryland did not reach its goal of having 17% of children aged 0-72 months screened for lead exposure by blood testing. An estimated 14 percent of Maryland children aged 0-72 months were screened for lead poisoning/exposure by blood testing in FY1998. The Maryland Department of Environment's (MDE) Childhood Lead Registry (CLR) performs childhood blood lead surveillance for Maryland. The MDE's Lead Registry showed that blood lead testing dropped 12.7% statewide from testing 67,118 children under age 6 in 1997 to 58,585 in 1998.

Compared to 1997, blood lead testing in the population of children 0-6 years dropped statewide, from 67,118 children in 1997 to 58,585 in 1998. Four counties, Kent, Montgomery, Washington, and Wicomico had a modest increase in blood lead testing. The total number of children tested statewide in 1998 is similar to the statewide total of 1996. Testing in 1997 may have shown a temporary increase in response to the initiation of a 1997 law requiring evidence of lead screening within 30 days of a child's entry into daycare.

In 1998, blood lead testing among children 0 – 6 years for Baltimore City decreased, continuing a trend since 1995. The decrease is greater than the decrease expected due to population decrease in the 0 – 6 age group. Part of this decline may be due to improved methods beginning with the 1997 Annual Report, in the assignment of children to jurisdictions or to the county in unknown category. Other possible causes include a shift in health care provider.

### *State Performance Measure 01 (Cont'd)*

practice or family compliance with ordered testing. Other States also report a decrease in testing in recent years.

#### Role of Title V/Activities and Programs

The Maryland Department of the Environment is the lead state agency for enforcement of lead laws, case investigation and management, and maintenance of the childhood blood lead registry. DHMH is the lead state agency for childhood lead screening and testing and administers the legislatively mandated Childhood Lead Screening Program (CLSP). The mission of the CLSP is to reduce lead exposure in children under the age of six by promoting blood lead testing and raising lead awareness in communities. The Program was administered by OCH in FY 1999 and worked collaboratively with the Maryland Department of the Environment and others. CLSP served as a resource for families, child care providers, and health care providers.

The Program provided general information about lead poisoning including a risk assessment checklist, nutritional and other information to help reduce the effects of lead poisoning, and made referrals to obtain appropriate care for a lead poisoned child. In FY 1999, the CLSP conducted outreach visits to each local health department, provided in-service education to child care providers and hospital personnel, partnered with the American Academy of Pediatrics to conduct outreach at 150 pediatric practices, and exhibited and distributed outreach materials at community educational events.

During FY 1999, OCH continued to fund local health department based childhood lead poisoning prevention activities throughout the State and particularly in Baltimore City. Local health departments continued to provide outreach and health education activities to increase consumer and provider awareness of the need for lead screening by blood test. Baltimore City has the State's highest concentration of risk factors for lead poisoning. Title V funds were used by the Baltimore City Health Department to conduct lead outreach, lead screening, and medical case management. The Baltimore City Health Department provided lead poisoning prevention services to more than 2,000 children and families in FY 1999.

*State Performance Measure 02*

**Level of Service: Enabling**

**Population: Infants**

State Performance Measure		Progress Reported			
<b>02</b>	<b>Percent of at risk infants receiving one or more prevention focused home visits within the first eight weeks of life.</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>FY 1999 Goal/Status</b>
			<b>59%</b>	<b>59%</b>	<b>1998Goal: 60%</b>  <b>Goal Met</b>

Discussion of Progress

The Maryland Title V Program set 60% as the target goal for State performance measure 04 in FY 1999. This goal was met. A description of the activities and/or programs that assisted the Maryland Title V Program in achieving this goal follows.

Role of Title V/Activities and Programs

Home visiting and care coordination services are important enabling services for improving health outcomes for infants and children. The initiation of care coordination services for at risk infants and children in Maryland is facilitated by the use of referral tools developed by The MCH Program. These referral tools include the Maryland Prenatal Risk Assessment form, the Infant Identification and Referral form, and the Local Health Services request form. Public health Nurses and Medical Social Workers provide prevention-focused and family-centered services, including case management, for at-risk pregnant women, infants and children (0-21). Care coordination and home visiting services are supported by HGEN, a decision-based P.C. information system that includes components for tracking, in cooperation with the primary health care providers, the health status of children 0-3 years; capturing immunization data (client and population-based); and outcome producing data.

Local health departments voluntarily participate in HGEN and in 1999, 13 of 24 jurisdictions used HGEN for child ‘at-risk’ case management. HGEN is a ‘stand alone’ utility. The HGEN program is currently being re-written in a computer language that will offer network capability.

*State Performance Measure 03*

**Level of Service: Population Based  
Population: Children**

State Performance Measure		Progress Reported			
03	Asthma mortality rate (per 1,000,000) among children aged 1-14.	1996	1997	1998	FY 1999 Goal/Status
		3.9	5.0	2.0	FY 1999 Goal: 4.5  Goal Met

Discussion of Progress

The Maryland Title V Program set 4.5 as the FY 1999 performance objective for this measure. This goal was achieved. Asthma is a pervasive problem among children and adolescents in Maryland. This measure is currently being re-evaluated and any changes will be renegotiated prior to the FY 2002 application.

Role of Title V/Activities and Programs

Since 1993, 17 Maryland children between the ages of 1-14 have died from asthma. Asthma is a serious chronic disease; however, when managed properly no child should die from asthma. During FY 1999, the initial phases of childhood asthma awareness activities began. A childhood asthma coordinator was appointed. Plans were developed for a media campaign for FY 2000, and collaboration with local asthma coalitions to discuss the issue of asthma surveillance. Progress on these activities will be measured by the extent to which the media campaign is implemented and the surveillance system is in place. This formative evaluation will be part of the FY 2000 activities.

*State Performance Measure 04*

**Level of Service: Direct**

**Population: CSHCN**

State Performance Measure		Progress Reported			
<b>04</b>	<b>The degree to which the State CSHCN program implements key components of a strategic plan to redesign the program.</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>FY 1999 Goal/Status</b>
				<b>4</b>	<b>1999 Goal: 4</b>  <b>Goal met</b>

Discussion of Progress

The Maryland Title V Program set 4 as the target goal for State performance measure 04 in FY 1999. This goal was met. A description of the activities and/or programs that assisted the Maryland Title V Program in achieving this goal follows.

Title V Role/Activities and Programs

During FY 1999, the CMS Program continued a major redesign initiative to improve services for children with special health care needs, and shift its focus from direct care services to an increased emphasis on the other MCH activities identified in the pyramid. This initiative involved the collaborative effort of numerous stakeholders and was facilitated by a consultant team from the Johns Hopkins School of Public Health, Women’s and Children’s Health Policy Center. Both internal and external advisory committees were formed. The internal workgroup included representation from the OCH, Mental Health Administration, the Office of Hereditary Disorders (OHD), and the Medical Assistance Program. The external committee included representatives from the State Department of Education, parent groups, local health departments, the Federal Maternal and Child Health Bureau, the Maryland Chapter of the American Academy of Pediatrics, the University of Maryland, Johns Hopkins Hospital, child advocacy groups, and several community-based organizations.

The CMS Redesign Initiative consists of four phases. Phases I-III were completed in FY 1998.

### *State Performance Measure 04 (Cont'd)*

The final phase, which was completed in FY 1999, focused on developing a strategic plan to address the following:

- Promotion of partnerships and linkages with families and providers and community-based agencies and programs serving CSHCN.
- Assurance and standards development
- Assessment and Policy development
- Enhancement and expansion of the health and health-related services network
- Training and education

Key elements in the plan to address these plan areas included the designation and collaboration with four tertiary care centers servicing CSHCN as Centers of Excellence, the planning for establishment of regional resource networks, and the development of formalized family involvement in the program. In FY 1999, the designation of the four COEs (The Kennedy Krieger Institute, Johns Hopkins Children's Center, University of Maryland, and Children's National Medical Center), and the establishment of regional family representatives was completed. COE work on selected institutional projects began in FY 1999 to be completed in FY 2001.

As part of the CMS redesign process, arrangements for the provision of "wrap around" services at two COEs were developed. These services will be provided by the University of Maryland Children's Center, and the John's Hopkins Children's Center. Services will include those services not covered by insurance but thought necessary for appropriate care of the child. These services include but not limited to non-case management social work services, nutritionist consultation, and nurse education and support services for families. Special rates were determined for each specialty provider based on the types of services provided.

*State Performance Measure 05*

**Level of Service: Population Based**

**Population: Pregnant Women**

State Performance Measure		Progress Reported			
<b>05</b>	<b>Percent of women who do not smoke during pregnancy.</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>FY 1999 Goal/Status</b>
		<b>84.6%</b>	<b>88.9%</b>	<b>89.8%</b>	<b>1998 Goal: 88%</b>  <b>Goal Met</b>

Discussion of Progress

The Maryland Title V Program set 88% as the target goal for performance measure 05 in FY 1999. Maryland birth certificate data for calendar year 1998 indicate that almost 90% of pregnant women in Maryland did not smoke during pregnancy. Therefore, this goal was met. A description of the activities and/or programs that assisted the Maryland Title V Program in achieving this goal follows.

Role of Title V/Activities and Programs

The Maryland Office of Health Promotion, Education, and Tobacco Use Prevention administers the Smoking Cessation in Pregnancy (SCIP). SCIP is a multi-component program designed to help pregnant women stop smoking. It is a low-intensity nurse driven intervention for patients receiving prenatal care service from Maryland’s local health departments or Medicaid managed care health providers. Pregnant smokers meet with public health nurses who counsel them and help them quit or reduce their cigarette consumption. Along with one-on-one counseling, participants receive self-help materials in the form of a manual and a “Quit Kit.”

*State Performance Measure 06*

**Level of Service: Population Based**

**Population: Pregnant Women**

State Performance Measure		Progress Reported				
06	Congenital Syphilis Rate	1996	1997	1998	1999	FY 1999 Goal/Status
		54.6	85.5	65.5		FY 1998 Goal: 85.0  Goal Met

Discussion of Progress

The Maryland Title V Program set 85.0 as the target goal for performance measure 06 in FY 1998. This goal was met. In 1996, the number of congenital syphilis cases in Maryland hit an all time high of 60. Between 1996 and 1997 Maryland's congenital syphilis rate increased 57% from 54.6 to 85.5 cases per 100,000 live births. This increase was largely attributable to a rise in the primary and secondary syphilis rate in Baltimore City in both 1996 and 1997. This rapid rise in syphilis rates made the eradication of congenital syphilis rate a public health priority in 1998. Between 1997 and 1998, the congenital syphilis decreased by 23% from 85.0 to 65.5 cases per 100,000 live far higher than that for the U.S. (26.9) and the year 2000 objective (40.0).

Data for 1999 show that the number of congenital syphilis cases has declined even further from 60 in 1996 to 27 in 1999. This decrease was largely attributed to increased provider education and outreach to at risk populations. It should be noted that while the number of congenital syphilis cases for 1999 is available, the number of births for 1999 is currently unavailable. Therefore, 1998 is the most recent year for this indicator. A description of the activities and/or programs that assisted the Maryland Title V Program in dramatically reducing the congenital syphilis rate follows.

Title V Role/Activities and Programs

Since January 1998, Maryland's prenatal care providers have been required to screen for syphilis at the first prenatal visit, at 28 gestational weeks (and at time of delivery in Baltimore

### *State Performance Measure 06 (Cont'd)*

City by Health Commissioner's order). The law emphasizes to providers the importance of early third trimester screening of all prenatal patients in order to treat women in time to prevent congenital syphilis in their babies. Representatives of the OMHFP, Baltimore City Health Department, the CDC, and the Epidemiology and Disease Control Program held monthly meetings to track the numbers of cases, monitor systems of care, and develop new standards for decreasing the number of cases during FY 1999.

This past year, the State Health Department continued to partner with the Baltimore City Health Department and the CDC to reduce the high rate of syphilis in Baltimore City. Aggressive preconceptional/prenatal outreach and screening methods were used in an attempt to reduce the rate of congenital syphilis in newborns. Population groups at highest risk such as drug addicts and inmates of correctional facilities continued to be targeted for syphilis screening, treatment and aggressive follow-up. (In FY 1998, the data showed that at least 20% of persons in the City with syphilis had a history of being detained at a correctional facility).

During FY 1999, several actions were taken to improve the infrastructure for preventing congenital syphilis. The OMHFP and the STD Control Program jointly presented six statewide trainings to promote better collaboration between local perinatal health coordinators and STD investigators and improve case identification, follow-up and treatment. The OMHFP and the Office for Epidemiology and Disease Control jointly developed two charts, *Important reminders About Managing Infections During Pregnancy*, and *Procedures for Preventing Perinatal Infections*, that were mailed to all OB/GYNs and certified nurse midwives in the State. These educational materials included current screening and treatment guidelines for all perinatal infections. Quality assurance efforts were expanded by establishing congenital syphilis cases as a priority for Fetal and Infant Mortality Review Teams.

*State Performance Measure 07*

**Level of Service: Infrastructure Building**

**Population: Infants**

<b>State Performance Measure</b>		<b>Progress Reported</b>				
<b>07</b>	<b>The percent of perinatal health care organizations that participate in a statewide perinatal data system.</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>FY 1999 Goal/Status</b>
		<b>85%</b>	<b>92%</b>	<b>100%</b>	<b>100%</b>	<b>1999 Target: 100%</b>
						<b>Goal Met</b>

Discussion of Progress

The Maryland Title V Program set 100% as the target for performance measure MD 07 is FY 1999. The target goal was met.

Role of Title V/Activities and Programs

This performance measure will be discontinued in FY 2001 since the target goal of 100% participation has been reached.

*State Performance Measure 08*

**Level of Service:**

**Population: Infants**

State Performance Measure		Progress Reported				
<b>08</b>	<b>The percent of infants with abnormal newborn screening tests who are followed up.</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>FY 1999 Goal/Status</b>
		99.6%	98.9%	99.8	95.9	FY 1999: 100%  Goal not Met

Discussion of Progress

The Maryland Title V Program set 100% as the target for performance measure MD 08 is FY 1999. The target goal was not met.

Role of Title V/Activities and Programs

The newborn screening program has had to deal with constant changes in the health care delivery system and in laboratory methodology. The goal that was set was very idealistic but probably not consistently achievable in today’s world. Nevertheless, we will continue to strive to follow up all “not normal” results. The sensitivity of the newborn screening tests currently available is not 100% and the program has little control over this in the short term. However once a baby is identified, we can and will strive to be sure that each one is followed up.

In the early 1990s, newborn screening programs had to meet the challenge of adequately screening babies in a timely fashion, despite very short postpartum hospital stays. At that time up to 40% of the infants left the hospital too young for an adequate sample to be collected. This produced a massive increase in follow-up workload. Almost 40% of the infants had to be retested and cut off levels had to be lowered to compensate for the lower sensitivity of the tests that measure metabolite accumulation. In addition, screening too early produced a large number of false positive tests for hypothyroidism. The TSH surge accompanying birth resulted in numerous infants with elevated TSH levels on the first day of life which were normal for age and not due to hypothyroidism. Education of the MCOs about the consequences of short maternity stays failed to convince them to change their policy. Therefore, legislation was passed requiring insurers to cover a minimum 48 hour post partum stay, to use the American Academy of Pediatrics/American College of Obstetrics and Gynecology Guidelines for Perinatal Care as the criteria for utilization review and to provide home nursing visits when indicated. Maryland had the first law in the USA in 1995, however major improvement was not seen

*State Performance Measure 08 (continued)*

until the law was strengthened in 1996. Then the rate of inadequate samples because the baby was screened too early rapidly decreased to under 8%.

The next challenge came in 1997 when Medicaid clients were transitioned to managed care under the HealthChoice program. It became increasingly difficult to identify the primary care provider who would actually be following the infant. In addition, it became increasingly difficult to have follow-up testing performed. MCOs declined to authorize follow-up testing done at the hospital of birth, often did not yet have the infant in their computer system by the time a follow-up test was needed, and declined to refer infants with positive test to metabolic geneticists or other specialists at the Centers of Excellence. Primary care providers declined to follow-up minor abnormalities, almost certainly due to TSH surge, or liver problems in premature infants, in order to avoid MCO sanctions. (Maryland's newborn screening program is voluntary.) It also became more difficult to track homeless and highly mobile families because of the decrease in the numbers of public health nurses at local health departments, who had traditionally made home visits and helped find infants in the community.

In 1999, the laboratory initiated a policy of repeating all borderline Guthrie tests using high performance liquid chromatography (HPLC) and reporting any elevation at all (for example a phenylalanine of 2.1) for follow-up to clinically validate the HPLC technique. These developments have resulted in a few more minor abnormalities being lost to follow-up. The 34 lost to follow-up infants in 1999 included: 17 with slightly elevated TSH probably due to TSH surge or low T4 due to prematurity, 9 minimal abnormalities of either total galactose or GALT probably due to carrier status, 6 hemoglobin abnormalities in a very mobile population, and 2 minimally elevated amino acid levels probably due to liver disease/prematurely. The infants lost to follow-up are still a small number with minor abnormalities. The changes in the health care delivery system have made it more difficult to resolve borderline cases but not (yet) to track major abnormalities for which all resources are mobilized.

Attempts to improve follow-up include: an improved data management system; automatic computerized generation of certified letters to the family's last known address, next of kin/contacts and physician of record; and hiring additional follow-up personnel. A courier service to decrease transit time from the hospitals to the newborn screening laboratory is expected to begin sometime in FY 2000. (The difficulty of follow-up in a highly mobile population increases with each day after discharge from

*State Performance Measure 08 (Continued)*

the hospital.) The Advisory Council on Hereditary Disorders plans a major re-examination of the program for their FY 2000 term. Participants in the re-evaluation will include primary care providers, metabolic geneticists, other consultants, laboratory personnel, parents, patients and advocates. All aspects of the program will be discussed including adding several disorders (CAH, CF, MCADD) and exploring tandem mass spectrometry.

*State Performance Measure 09*

**Level of Service: Direct**

**Population: Children**

State Performance Measure		Progress Reported				
<b>09</b>	<b>The rate of deaths to children aged 1-4 caused by sickle cell disease.</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>FY 1999 Goal/Status</b>
		1.0	2.0	0	1.0	4.0  Goal Met

Discussion of Progress

The Maryland Title V Program set 4.0 as the target for performance measure MD 08 is FY 1999. The target goal was met.

Role of Title V/Activities and Programs

Maryland has had a very strong long-term follow-up program for infants identified with sickle cell disease since 1985. Each child receives a definitive diagnostic evaluation from a pediatric hematologist, is placed on prophylactic penicillin, receives conjugate HIB and pneumococcal immunizations, home visiting and nursing case management. An annual evaluation by the pediatric hematologist is also provided at one of 6 centers and 6 outreach clinics. Parent support group activities are facilitated; genetic counseling is provided; and prenatal education is emphasized. This program has resulted in the lowest mortality from sickle disease among young children in the U.S.

The increase in deaths in 1997 was because of an increase in penicillin resistant pneumococci in the community at a time when the only pneumococcal vaccine available was given at 2 years of age. Patients now receive the conjugate pneumococcal vaccine at 2, 4, and 6 months of age. (Our patients took part in the clinical trials of the new vaccine.) The conjugate pneumococcal vaccine seems to have overcome the problem of penicillin resistant pneumococci for the moment.

The goal is to maintain this low mortality rate even though the patients are now all in managed care. Special performance standards and practice guidelines were formulated. Focused chart reviews of children with sickle cell disease in managed care through the HealthChoice quality assurance program have identified some difficulties. These have been addressed by: two forums for HealthChoice and other MCO medical directors and special needs coordinators, the development of additional educational materials and child specific feedback letters to the MCOs and the primary care providers with suggestions for improving each child's care. This is an ongoing partnership.

## 2.5 Progress on Outcome Measures

Form 12, Tracking Health Outcome Measures, as well as the following narrative detail Maryland's progress on meeting the required outcome measures. The following narrative also describes the contributory positive impact of national and state performance measures on outcome measures for the Title V population.

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***Outcome Measure 01: The infant mortality rate per 1,000 live births.***

***1998 Target: 8.4***

***1998 Indicator: 8.6 Goal not met***

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In 1998, the infant mortality rate per 1,000 live births for Maryland (8.6) was substantially higher than that for the U.S. (7.2) and the year 2000 Objective (7.0). The 1998 rate was identical to the 1997 rate. The Caucasian American infant mortality rate rose from 5.3 in 1997 to 5.5 in 1998. The rate for African Americans fell from 16.1 in 1997 to 15.4 in 1998. The overall infant mortality rate in Maryland has historically been higher than the national rate. However, Maryland's infant mortality has been declining. Between 1989 and 1998, the rate declined by 17.3%. Factors which one thought to contribute to the higher infant mortality rate: The three leading causes of infant death in 1998 were disorders relating to short gestation and unspecified low birth weight (low birth weight), congenital anomalies and sudden infant death syndrome (SIDS). These three causes accounted for nearly 45% of all infants' deaths. The leading cause of death among Caucasians American infants was congenital anomalies, followed by low birth weight, respiratory distress syndrome and maternal complications. Low birth weight was the leading cause of death among African-American infants, followed by SIDS and congenital anomalies.

National Performance measures 4,8,15,17,18 and State Performance Measures 2,5,6 and 7 directly impact Maryland's infant mortality rate. The Maryland Governor's Commission on Infant Mortality Prevention analyzes factors contributing to infant mortality and works to reduce the number of infant deaths in Maryland. A major charge of the Commission is to reduce the racial difference in infant mortality. Reducing the percentage of low birth weight births in Maryland is another priority. Title V is represented on this Commission.

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***Outcome Measure 02: The ratio of the African-American infant mortality rate to the white infant mortality rate.***

***1998 Target: 2.5    1998 Indicator: 2.8    Goal not met***

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Maryland's African-American infant mortality rate has historically been twice the Caucasian American rate. In 1997, African-American rate was three times the Caucasian American rate. Infant mortality increased slightly among Caucasian Americans and declined slightly among African-Americans between 1997 and 1998. This caused the gap between Caucasian Americans and African-Americans infant mortality rates to narrow slightly. Although infant mortality rates for both Caucasian Americans and African-Americans have declined over the past decade, the decline has been much more rapid among Caucasian American infants. The average white infant mortality rate declined by 15.6% between the years 1989-93 and 1994-98, while the rate for African-Americans declined by only 6.4%. No one is sure of why African-American rates are so much higher than Caucasian American rates. Higher rates of low birth weight babies and less access to health care partially explain the difference.

In 1998, the African-American/Caucasian American ratio of infant mortality for Maryland as a whole (2.8) was higher than that for the US (2.4). Maryland's Caucasian American infant mortality rate of 5.5 was lower than the national rate of 6.0. In contrast, Maryland's African-American infant mortality rate of 15.3 was higher than the national rate of 14.1. While Maryland's Caucasian American infant mortality rate has not exceeded the national rate in the last decade, Maryland's African-American infant mortality which was lower than the national rate early in the decade, now exceeds the national rate. One explanation for the difference between African-American infant mortality rates in Maryland and nationally is that the proportion of very low birth weight infants (< 1500 grams) is higher among African Americans in Maryland (3.4%) than among African-Americans in the nation (3.1%). Maryland will be undertaking a study during the next fiscal year to determine why the gains experienced in the early nineties have not prevailed.

***Racial Disparities in Infant Mortality*** -- Due to an increase in the infant mortality rate among African American infants in CY 1997, a detailed medical chart review was completed of those infant deaths which occurred in the Baltimore metropolitan area. This was accomplished

with the cooperation of the OB/GYN and pediatric departments in all the major Baltimore area hospitals. Findings indicated that multiple births, chorioamnionitis, and sexually transmitted diseases were factors most strongly associated with the increase in neonatal deaths among the African American population in Baltimore. Steps are now being taken to deal more effectively with these issues. The final report, "Using a Consolidated Database to Assess Infant Mortality in the Baltimore Metropolitan Area" was distributed to perinatal centers, health providers, and community leaders. In addition, the OMHFP collaborated with the Maryland Commission on Infant Mortality Prevention to hold town meetings to explore the issue of racial disparities in infant mortality.

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***Outcome Measure 03: The neonatal mortality rate per 1,000 live births.***

***1998 Target: 5.2***

***1998 Indicator: 6.3 Goal not met***

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Maryland's neonatal mortality rate for 1998 was 6.3 per 1,000 live births for all infants, 2% higher than the rate in 1997. The 1998 neonatal mortality rate was 4.1 for whites, 14% higher than the prior year., and 11.1 for African Americans, 5% lower than the 1997 rate of 11.7. In 1998, the Neonatal Morality Rate per 1,000 live births for Maryland (6.3) was substantially higher than that for the US (4.8) and the Year 2000 Objective (4.5). The leading causes of neonatal death were low birth weight, congenital anomalies, and maternal complications of pregnancy, accounting for 52% of all neonatal deaths.

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***Outcome Measure 04: The postneonatal mortality rate per 1,000 live births.***

***1998 Target: 2.4***

***1998 Indicator: 2.3 Goal Met***

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Maryland's postneonatal rate was 2.3 per 1,000 live births in 1998, 4% lower than the 1997 rate of 2.4. The postneonatal mortality rate declined by 1.8% between 1997 and 1998 among whites (from 1.7 to 1.4) and decreased 2% among African Americans (from 4.4 to 4.3). The 1998 postneonatal mortality rate for Maryland was comparable to that of the US (2.4) and slightly

lower than the year 2000 Objective (2.5). The three leading causes of postneonatal deaths in 1998 were sudden infant death syndrome, congenital anomalies and respiratory conditions.

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***Outcome Measure 05: The perinatal mortality rate per 1,000 live births***  
***1998 Target: 14.1                      1998 Indicator: 15.6 Goal not Met***

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The Perinatal Morality Rate per 1,000 live births for Maryland as a whole (15.5 in 1997) was significantly higher than that for the US as a whole (7.4) in 1996) and the Year 2000 Objective (12.4).

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***Outcome Measure 06: The child death rate per 100,000 children aged 1-14.***  
***1998 Target: 23.5                      1998 Indicator: 20.0 Goal Met***

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In 1998, the leading causes of death for children aged 1-14 were injuries, including motor vehicle accidents and homicide. This was followed by cancer and congenital anomalies. Child deaths have been declining in Maryland. Analysis of single year data indicates the current rate of 19.8 deaths per 100,000 children 1-14 is the lowest it has been in the past two decades. Since 1990 this rate has fallen by 28% from 27.4 per 100,000, to the current rate of 19.8 per 100,000.

During FY 1999, the Maryland Legislature passed legislation creating State and local child fatality review teams. CPHA provides administrative support to the State team. The State team's purpose is to (1) develop an understanding of the causes and incidence of child deaths, (2) develop plans for implementing changes within the agencies represented on the team, and (3) advise the Governor, General Assembly and public on changes to law, policy and practice to prevent child deaths. The purpose of the local team is to (1) develop an understanding of the causes of child deaths, (2) promote cooperation among agencies, (3) develop plans and recommendations and (4) advise the State team. In November 1999, Maryland local health officers were surveyed to determine the extent to which child fatality review was being conducted throughout the State. At that time, about half of the jurisdictions had already initiated child fatality review processes. The remaining counties were in various stages of child fatality review implementation.

### **III. REQUIREMENTS FOR THE APPLICATION [Section 505]**

#### **3.1 Needs Assessment of the Maternal and Child Health Population**

During this past year, the MCH offices have completed multiple components of the Title V Needs Assessment. As stated in last year's application, a major component of the assessment was done through a contractual agreement with Johns Hopkins University, School of Hygiene and Public Health and the University of Maryland School of Nursing. In addition, the MCH Program funded community-based assessments in several jurisdictions, conducted programmatic evaluations and developed health plans which included a needs assessment (e.g., the lead targeting plan). These activities have enabled the MCH Program to (1) develop collaborative, working relationships with internal and external stakeholders, (2) develop a better understanding of the strengths and limitations of various data systems, (3) identify strengths and limitations of various methodologies used throughout the past two years and (4) most importantly, identify more precisely the epidemiological needs of Maryland's MCH Program.

### **3.1.1 Needs Assessment Process**

A major component of the needs assessment involved both a qualitative and quantitative analysis of the MCH population, including CSHCN. This portion of the needs assessment was completed by the University of Maryland School of Nursing in partnership with the Johns Hopkins School of Hygiene and Public Health. The objectives of this analysis were (1) to assess the health status of mothers, infants, children and adolescents including children with special health care needs in Maryland; (2) to assess the MCH preventive, primary, and specialty service needs in the twenty-four jurisdictions of Maryland; and (3) identify gaps in the acquisition of relevant data. The data were aggregated according to regions specified in the State's Health Improvement Plan:

Region	Jurisdiction
Baltimore City	Baltimore City
Montgomery County	Montgomery County
Prince George's County	Prince George's County
Western Maryland	Garrett, Allegany, Washington and Frederick Counties
Central Maryland	Baltimore, Howard, Harford, Carroll and Anne Arundel Counties
Southern Maryland	Charles, Calvert and St. Mary's Counties
Eastern Shore	Cecil, Kent, Queen Anne's, Caroline, Talbot, Dorchester, Worcester, Wicomico and Somerset Counties

Qualitative Methodology: The qualitative methods employed in the statewide assessment included the use of semi-structured in-person and telephone interviews and focus groups. Draft interview guides were developed by the investigators and were reviewed by DHMH program directors prior to implementation. A set of MCH indicators developed the MCH Program were used as a framework to guide the needs assessment process. Populations that were assessed included pregnant women, mothers, infants, children, adolescents and children with special health care needs. Content analysis was used in organizing and integrating all qualitative data according to emerging themes and concepts. The data were then categorized by the domains listed in the conceptual framework: (access, infrastructure, preventable diseases and disabilities, mental health and substance abuse, injury, education, risk factor and resilience and family support).

Face-to-face interviews were conducted with each jurisdiction's health officer or their designee. The interviews lasted between one to four hours and included the following topics: (1) the impact of HealthChoice and MCHP on health department services, (2) necessary resources to more effectively complete their job, (3) health problems for each population group, (4) access to

care, (5) strengths of programs and (6) strengths of the community. During this interview process, the health department staff identified a purposive sample of community-based health care professionals to be interviewed. The population selected included a variety of professionals and practices involving clients with a broad range of income and insurance coverage. A total of thirty-nine provider interviews were conducted lasting between thirty minutes and two and one-half hours in duration; thirty-eight were conducted in person while one was done by telephone. Twelve interviews were conducted on the Eastern Shore, four in Montgomery County, four in Southern Maryland, four in Prince George's County, four in Baltimore City, three in Western Maryland and eight in Central Maryland.

In addition, each county's health department's staff identified a purposive sample of community leaders. Criteria for selection included working with the MCH population in a non-health professional role. The interview included the following topics: (1) health problems for each population group, (2) impact of MCHP, (3) strengths of services provided, (4) strengths of the community and (5) suggestions for improving health services. Each semi-structured interview was conducted by telephone. The duration of the interviews ranged from thirty minutes to one hour. Three interviews were conducted on the Eastern Shore, one each in Montgomery County and Baltimore City, two in Prince George's County, five in Central Maryland, three in Southern Maryland and four in Western Maryland.

The MCH Program assisted the researchers in identifying possible focus group settings. The focus group participants included pregnant women, parents of infants and toddlers, teen parents with infants, parents of children and adolescents, and parents of CSHCN. The following topics were used to guide the focus group discussions: (1) benefits of health care, (2) barriers to health care, (3) major health problems for moms, babies, children and adolescents, (4) access to substance abuse or mental health treatment, (5) access to supportive services, (6) school readiness and (7) the role of the local health department.

Quantitative Methodology: Quantitative data are reported for each of the three populations—pregnant women and infants, children and adolescents, and children with special health care needs—and within those, for each of the domains (see above). Quantitative indicators were identified through several mechanisms. First, the federally mandated performance measures were identified. During the spring and summer of 1999, several meetings were held between

Johns Hopkins School of Hygiene and Public Health, University of Maryland, School of Nursing and DHMH, Community and Public Health Administration to identify indicators and data sources that would comprehensively describe the maternal and child health populations. The groups sought to identify indicators that would represent several of the domains that broadly characterized the populations of interest. Specifically, the Hopkins' Women's and Children's Health Policy Center (WCHPC) (1) identified the relevant data for monitoring the indicators, (2) analyzed the data, and (3) led discussions for the interpretation of the results.

The groups not only identified health-related indicators but also included measures of general risk and well being (e.g., domestic violence among women of childbearing age, school achievement). Because the groups were not limited to those measures for which appropriate data sources existed, we were able to generate information on gaps in the quantitative data. Available data for each of the indicators is reported for the State, region and county as well as the State's comparison to U.S. data and Year 2000 objectives. The Women and Children's Health Policy Center team took the lead in the quantitative part of the needs assessment.

Triangulation: Triangulation is the use of multiple methods or perspectives to collect and interpret data about some phenomenon in order to converge on an accurate representation of reality. Triangulation of quantitative epidemiological methods and qualitative methods was used to provide a comprehensive perspective on MCH needs in Maryland. The epidemiological data provide statistics related to MCH and the qualitative data provide insights on the nature of health problems from the perspective of health care professionals, community leaders, and consumers. These qualitative insights can be used to generate solutions and develop effective program that respond to State and regional needs.

### ***Supplemental Needs Assessment Materials***

As Exhibit 1 shows, the major statewide needs assessment was further supplemented with data, information, analyses and recommendations from several other sources. A brief overview of the various data sets and sources used follows.

Vital Statistics Data: Historically, birth, death and fetal death certificates have been the main source of information for MCH surveillance. The information includes birth outcomes, maternal socio-demographic characteristics, prenatal and intrapartum care. This information enables the State to determine by jurisdiction the infant mortality rate, birth weight percentages at different

intervals, percentages of prenatal care by trimester, adolescent pregnancy rate, fetal death rate, live births to pregnancy ratios, and maternal mortality, including causative factors. This information enables comparison of years, jurisdictions and racial and ethnic populations to determine trends and health disparities. In Maryland, Vital Statistics data is collected on the number of births by the ethnicity, but a breakdown by country of origin is not available. The Vital Statistics Administration also provides yearly population estimates for Maryland.

U.S. Census Data for Maryland: The decennial Census and its updates provide the basis for most socio-demographic data on Maryland's population. Much of this information is summarized for the State and each jurisdiction in the annual Kids Count reports prepared by the Casey Foundation and Maryland Advocates for Children and Youth. Various State socio-demographic profiles are available on the State's web site:

[www.mdarchives.state.md.us/msa/mdmanual/01glance/html](http://www.mdarchives.state.md.us/msa/mdmanual/01glance/html).

Surveillance Systems and Registries: Information is also available from DHMH's various registries including Birth Defects, Newborn Screening, Communicable Disease, Tuberculosis, Sexually Transmitted Diseases, and Immunization Registries.

Maryland Health Improvement Plan (HIP), 2010: On July 30, 1998, the DHMH Secretary launched the Healthy Maryland 2010 process and identified the development and implementation of the HIP as a top priority for the Department. All administrations are to be full participants in this project. This process has included:

- Establishing a steering committee, work groups and a Project 2010 Council to facilitate broad communication and input into the statewide process. Materials from the federal and other state governments were reviewed by these groups to benchmark and select 'best practices' as models for consideration and implementation.
- Providing information to local health departments and various State central offices in support of strategic planning activities.

## Exhibit 1

### Data and Information Sources Used in the Completion of Maryland's Title V Needs Assessment, FY 2001

#### All MCH Populations

- Maryland Vital Statistic Reports
- Surveillance System Reports
- U.S. Census Data for Maryland
- Medicaid Data and Annual Reports
- Hospital Discharge Data
- Program Evaluations
- MCH Program Data
- Various Surveillance Systems and Registries, (e.g., birth defects registry)
- Maryland Healthy People 2000 and 2010 Reports
- Maryland Health Improvement Plan Draft, 2010\*
- Maryland Local Health Department Core Funding Proposals\*
- Maryland Local Health Department Title V and State Grant Awards
- Local Health Department Priorities\*

#### Mothers, Infants, and Pregnant Women

- Maternal Mortality Review Analysis\*
- Fetal Infant Mortality Review Analysis\*

#### Children and Adolescents

- National and Maryland *Kids Count* Reports
- Maryland's Results for Child Well-Being Report
- Community Needs Assessments in five counties, one of which is pending\*
- Targeting Plan for Areas At Risk for Childhood Lead Poisoning

#### Children with Special Health Care Needs

- Survey of Health Care Experiences of Families of CSHCN
- Sickle Cell Disease Review Study
- Needs Assessment Survey of Individuals with Spina Bifida
- Cost Survey of the Care for Individuals with Cleft Lip and Cleft Palate

All sources listed with an asterisk [\*] extensively involved parents, providers and/or the community in their development.

- Identification of a “Consensus Set of Indicators” as the central methodology to support the State’s 2010 Project. This methodology ranks key health indicators based on analyses of local and State rates and trends. Results from this approach, known as the Diamond Methodology, were compiled in a pictorial display of health indicators categorized as: better than, the same as, or worse than the relevant State and national rates.
- Convening a two day summit in the summer of 1998 which led the ground work for the determination of 25 broad priority health areas to be included in the HIP. These priorities were further reduced to 16 by asking health professionals, advocates, business community and the general public to rank their top priorities. Various administrations were then charged with the responsibility of developing one of 16 modules for inclusion in the HIP. Each LHD was also asked to chose a priority area for module development.
- Each HIP module includes a problem statement, 2010 goals and objectives and actions steps for meeting the goals.
- The proposed priorities are currently being compiled. Public hearings on various aspects of the HIP will occur during the Fall of 2000. A final report will be prepared for the State Legislature prior before January 2001.
- The Title V Program was asked to develop modules concerned with child and adolescent health, infant mortality and family planning. Focus groups comprised of health professionals, business partners, advocates, and community representatives from various jurisdictions assisted with module development. The specific goals to be addressed are:
  - To reduce infant mortality.
  - To ensure that all pregnancies are intended pregnancy.
  - To reduce childhood morbidity and mortality by preventing asthma mortality and morbidity; preventing childhood lead poisoning; and promoting healthy behaviors-good nutrition and physical activity.
  - To improve access to health care for adolescents
  - To improve the service system for CSHCN

For the purpose of the Title V Needs Assessment, a review of the draft of the entire State HIP, which 16 modules and a priority plan for each of the twenty-four (24) jurisdictions, was

undertaken. The content was analyzed and categorized by the Block Grant population focus and the pyramid structure. Findings are presented in section 3.1.2. (Needs Assessment Content) of this application.

Local Health Department Core Funding: Core services funds, as mandated by the State Legislature (Health General Article sections 2.302-2.305), are provided to local health departments for specific programs approved by the secretary of DHMH. Local health departments are to use these funds for programs related to maternal health, child health, family planning, communicable disease, adult health, geriatric services, wellness promotion, environment and administration/infrastructure. The selection and the amount per selection is at the discretion of the LHD. MCH core funding for FY 2001 focuses on the following areas:

- Maternal health services for the underinsured and uninsured including the immigrant population
- Dental services for children, including the immigrant population
- Care Coordination/Home Visiting for Prenatal/Postpartum women and children 0-3
- Specialty Clinics for CSHCN
- Family Planning Services, including Pre-Conception Counseling
- School Health Programs, including mental health counseling and/or school based clinics.

Local Health Department Priorities: These priorities, revised yearly, are part of the core funding proposal submitted to CPHA. This yearly priority list, identifies community needs, irrespective of the funding source. The factor that hinders the quality of this list is the local health department's reluctance to identify a need when funding availability is limited to non-existent. The concern is being held accountable for programs and resolution of problems without the resources to assure a reasonable opportunity reduce morbidity and improve on the health and wellness of its citizens.

State and Title V Awards: These categorical grants are for specific purposes. The State Central Offices develop the criteria for each funding area. Each LHD receives an RFP-Condition of Award Packet in January of the preceding fiscal year. Each LHD has the option of applying for funds in any of the categories listed. Unfortunately, because of large budgetary cuts in the early 90's, these grants have been level funded. Inflation and fiscal shortfalls have resulted in either (1) local government increasing their support of LHD activity, (2) services being reduced or

eliminated and/or (3) LHD reorganizing to reflect core public health functions rather than direct or enabling services. Examples of categorical grants include the Improved Pregnancy Outcomes Program, family planning services, lead screening and case management, and specialty clinics for CSHCN, and care coordination.

### **Community Based Needs Assessments**

Throughout the past year, the MCH Program has used both Title V and SSDI grant monies to fund various community assessments. To date, four county assessments have been completed. It is anticipated that the final report for each jurisdiction will be submitted to the Center for Maternal and Child Health by September 2000. For the purpose for this application, the final drafts of the assessments have been reviewed and the conclusions incorporated into this application's needs assessment section.

- Tri-County Needs Assessment: Title V funded a telephone survey to determine the health status, behaviors and needs of adolescents and CSHCN in Somerset, Wicomico and Worcester Counties located on the Eastern Shore. The telephone survey covered 630 randomly selected households and contained modules on asthma, diabetes, and injury.
- Allegany County: A second community assessment funded through the SSDI grant examines the health status and health needs of children, adolescents and CSHCN in Allegany County in Western Maryland. The health assessment is just one component of a more comprehensive community assessment being conducted in partnership with the County's housing, employment, and education programs.
- Prince George's County: The third community assessment, funded through SSDI, local health department and county government monies, will include an assessment of the MCH population from birth through age 21. While this assessment is not completed in time for this application, it is anticipated that the results of the County's assessment will be included in next year's application and be used to determine subsequent programmatic development and funding allocations.

### **Central Office Program Assessments and Evaluations**

Fetal and Infant Mortality Review: The Maryland Perinatal Outcomes Project is a demonstration project being funded under the Title V set-aside program for Special Projects of Regional and national significance (SPRANS). The goals of the project are (1) to establish local

FIMRs as a key component of statewide perinatal systems development and quality improvement and (2) to integrate and coordinate perinatal outcome reviews with other related review processes including maternal mortality review, child fatality review, and maternal-neonatal transport outcomes. Through partnerships with professional and community organizations, including the Medical and Chirurgical Society of Maryland, the Project provides technical assistance and training with regard to the abstracting of medical records, interview of mothers, conduct of interdisciplinary meetings, analysis of FIMR funding and facilitation of system changes.

Maternal Mortality Review (MMR): The risk of maternal death has been cited as a serious public health concern by the Centers for Disease Control. The incidence of maternal mortality is particularly acute in Maryland. Under current law, there is no statutory body charged with investigating causes of maternal death. These deaths are significantly under reported due to concerns over civil litigation or medical liability. Through the passage of Senate Bill 459/House Bill 515, during the 2000 Legislative Session, Maryland becomes one of 25 states that have established or reestablished maternal mortality review committees, intended to document and address the causes of maternal mortality. The MMR process will identify maternal death cases, review records and data, consult with experts and make recommendations regarding prevention of maternal death.

Child Fatality Review (CFR): During the 1999 Legislative Session, the passage of Senate Bill 464 established the State Council on Child Abuse and Neglect, the State Child Fatality Review Team and Local Child Fatality Review Teams. These entities were given duties and responsibilities including, but not limited to: evaluating the extent to which State and local agencies are effectively discharging their child protection responsibilities; and developing protocols that govern the scope of activities of local citizens review panels; annual analysis of the incidences and causes of child fatalities. Limited information is available because of the underreporting of childhood deaths due to neglect and abuse and the sealed records of suspected and/or confirmed cases of neglect and abuse.

Statewide Childhood Lead Targeting Plan: Childhood lead poisoning is a critical environmental health problem that is preventable. In response to a Legislative mandate, the MCH Program recently developed a statewide plan for targeting high risk areas of the State for childhood lead poisoning. The plan targets children under six years of age in high risk areas. In

FY 2001, funds will be provided to five health departments to test the validity of the predictor model that is being used as part of the targeting plan.

Head Start Oral Health Study: Through the SSDI Grant, the Center for Maternal and Child Health and the Office of Oral Health have subcontracted with the University of Maryland, Baltimore School of Dentistry to conduct a cross-sectional dental caries prevalence study in of children enrolled in Head Start and CSHCN. The goals of the study are (1) to assess the dental caries prevalence in 3-4 year old underserved children enrolled in Head start; (2) to assess the dental caries prevalence in CSHCN; (3) to gain insight into barriers to care for Maryland's Head Start children; (4) to examine caries risk factors in Head Start children; (5) to ascertain the amount and types of treatment that children with special health care needs are receiving. The results of this study, available in the fall of 2000, will be incorporated into the FY 2001 Title V application.

#### **Needs Assessments -- Children with Special Health Care Needs**

The Survey of Health Care Experiences of Families of Children with Special Health Care Needs was a collaborative project between Family Voices and the Heller School at Brandeis University. Maryland was one of 20 states participating in the survey. Two hundred participant families were selected from the Family Voices state mailing list and from names of CSHCN identified from the SSI eligibility list in the state. Although only 71 survey instruments were returned, both quantitative and qualitative results were derived. The quantitative information presented results from Maryland respondents in contrast to the national data collected. Qualitative information based on answers to open-ended questions about pertinent issues were also included. This information has been shared with the State Medicaid program, care providers and program staff.

A Sickle Cell Disease Focus Review Study and Pharmacy Encounter Data Analysis was performed in 1998 as a collaborative activity between the Office of Hereditary Disorders (now the Office for Genetics and Children with Special Health Care Needs) and the Medicaid Division of Children's Services and the HealthChoice and Acute Care/ Customer Support Division. The Sickle Cell Focus Review was the first such review by the HealthChoice program and will be repeated using 1999 data. The Pharmacy Analysis concluded that all MCOs have some children with low compliance that need follow-up. The summary findings of the Focus Review and the

conclusions of the Pharmacy Encounter Data Analysis resulted in the development of educational materials for MCOs as well as patient specific feedback to MCOs and PCPs regarding patient specific suggestions for improving care. This collaborative activity serves as the model for future review studies and data analysis between the State Medicaid and Title V programs.

A Needs Assessment Survey of Individuals with Spina Bifida was performed in 1998 by a grant from the Office of Hereditary Disorders to the Kennedy Krieger Institute in collaboration with the Chesapeake-Potomac Spina Bifida Association. This survey identified issues related to transition as a major need of the spina bifida population. As a result, a resource directory was prepared and distributed and an Interagency Transition Conference is planned for the Fall of 2000 that will address specific transition problems encountered by Maryland's spina bifida population, as well as other populations of CSHCN.

A Cost Survey of the Care for Individuals with Cleft Lip and Cleft Palate was conducted in 1999 for the purpose of providing information on proposed legislation that would establish parity between health maintenance organizations and other third party payers as it relates to the cleft lip and cleft palate care. This information was also instrumental in raising the age eligibility criteria for the Medicaid Rare and Expensive Program (REM) which is a carve out program under managed care. The original eligibility was from 0-15 years and the revised eligibility is now 0-22 years.

Respite care and other enabling Services were the topics of needs assessments performed by twelve local health departments during the last year. In some cases, specific funding was allocated for this assessment and with others, unspent direct care dollars were redirected into needs assessment activities. The assessments included the development and distribution of a survey instrument for families of children with special health care needs, focus groups of family members and the assessment of community capacity to offer respite services. Eight local health departments paid for summer camps for CSHCN for the first time this year and others have forged partnerships with community providers for the development of future respite services.

### **3.1.2 Needs Assessment Content**

#### **3.1.2.1 Overview of the Maternal and Child Health Population's Health Status**

The following sections provide an overview of the health status of Maryland's

MCH populations based on data and information obtained from the documents listed above. Much of the data for this section of the plan was collected prior to the release of the 1998 Maryland Vital Statistics Report. Therefore, in many cases, the data reported here is for 1997 and may be different from data reported elsewhere in the application. In addition, in several instances, 1997 data was the most recent year for which regional data were available.

### **The Health Status of Pregnant Women, Mothers and Infants**

An estimated 1.2 million women of childbearing age (ages 15-45) lived in Maryland in 1998. Each year, more than 70,000 babies are born to Maryland parents. The health of the majority of women of childbearing age, pregnant women and infants in Maryland is good to excellent as determined by available health indicators. However, available data as discussed throughout this Title V Block Grant application, indicate that improvements are needed on a number of health status indicators. Health disparities exist by race and region of residence. For example, African American women and infants are more likely to die from numerous causes than their counterparts. A summary description of selected health status indicators is provided below.

Maternal Mortality Rate: The Maternal Mortality Rate per 100,000 live births was considerably higher for Maryland (15.31 in 1998) than the U.S. (8.42 in 1997) and the Year 2000 Objective (3.3). The rate of maternal mortality among African American women is four times the rate for Caucasian women. Recent unpublished data compiled by the Maryland MCH Program and the Vital Statistics Administration indicated that domestic violence is a primary cause of maternal mortality in Maryland. No regional data were available.

Infant Mortality: In 1998, the Infant Mortality Rate per 1,000 live births for Maryland (8.6) was higher than that for the U.S. (7.2) and the year 2000 Objective (7.0). See Figures 21-25 for a comparison of IMRs for all counties in the various regions of Maryland. The Infant Mortality rate for Montgomery County (7.2 in 1998) approached the year 2000 Objective. The 2000 Objective IMRs was surpassed in the Baltimore Metro area (6.3) and in Northwest Maryland (5.9). The rates for the Eastern Shore (8.4) and Southern Maryland (8.8) were also substantially higher than that of the U.S.. However, several counties surpassed the Year 2000 Objective. These included Cecil (2.7), Dorchester (6.7), Kent (5.5), and Worcester (4.1) from the Eastern Shore, and Calvert County (4.3). The Infant Mortality Rates in Prince George's County (12.8) and in Baltimore City (12.2) were higher than the statewide average.

Ratio of Black Infant Mortality Rate to White Infant Mortality Rate: In 1998, the black/white ratio of infant mortality for Maryland (2.8) was higher than that for the U.S. (2.4). See Figures 26-30 for a comparison for black/white infant mortality ratios in all Maryland counties. The ratios for most regions in Maryland were also higher than for the U.S.. The ratio for Prince George's County was 2.0 in 1998. The average Eastern Shore ratio (1.6) of Black/White IMR is lower than Maryland and the U.S.

Neonatal Morality Rate: In 1998, the Neonatal mortality rate per 1,000 live births for Maryland (6.3) was substantially higher than that for the U.S. (4.8) and the Year 2000 Objective (4.5). Neonatal mortality rates for individual Maryland counties are depicted in Figures 31-35. Of all regions in Maryland, Northwest Maryland had the lowest Neonatal Mortality rate in 1998 at 3.0. The neonatal mortality rate in Prince George's County (9.9) was substantially higher than that of the State .

Postneonatal Mortality Rate: In 1998, the Postneonatal Mortality Rate per 1,000 live births for Maryland (2.4) was comparable to that of the U.S. (2.4) and the year 2000 Objective (2.5). The Postneonatal Mortality rates for individual counties are depicted in Figures 36-40. In Baltimore City, the Postneonatal Mortality rate was 4.8 in 1998. The Postneonatal Mortality for the Eastern Shore (2.0), the Baltimore Metro area (1.5), Montgomery County (1.6), and Southern Maryland (1.8) were even better than Maryland.

Perinatal Mortality Rate: The Perinatal Morality Rate per 1,000 live births for Maryland (15.5 in 1997) was significantly higher than that for the U.S. (7.4) in 1996) and the Year 2000 Objective (12.4). Refer to Figures 41-45 for regional rates. Perinatal Mortality Rates for Montgomery County (11.6), Southern Maryland (11.2), and Northwest Maryland (8.1) in 1997 were substantially lower than the rate for the State , and also exceeded the 2000 Objective. The Perinatal Mortality rate for Baltimore City (26.9) was significantly higher than that of the State .

Fetal Death Rate: In 1997, the Fetal Death Rate in Maryland was 9.2 (per 1,000 total deliveries). No U.S. data was available for comparison. The Fetal Death rate was substantially lower than that of the State in Southern Maryland (6.8), Montgomery County (6.7), and in Northwest Maryland (6.1). In Baltimore City, the Fetal Death rate was twice the State rate (17.1).

Low Birth Weight Live Births: In Maryland, 8.7% of live births were low birth weight (weighing 2,499 grams or less) in 1998. Most regions performed more favorably than the State. The percentage of low birth weight live births was well below the State average in Southern Maryland (6.9%) and Northwest Maryland (6.7%). Two regions performing substantially poorer in the area of low birth weight than the State were Prince George's County (10.2%) and Baltimore City (14.3%).

Very Low Birth Weight Live Births: Maryland did not compare favorably to either the US (1.5%) or the Year 2000 Objective (1.0%) for proportions of very low birth weight (VLBW) live births (weighing 1,499 grams or less). The proportion of VLBW for Maryland was 2.0% in 1997. For some regions in Maryland, however the proportions were more favorable. See Figures 16-20 for regional data. On the Eastern Shore, the proportion of very low birth weight live births for 1997 was 1.6%, with two counties exceeding the Year 2000 objective: Kent (0.5%) and Queen Anne's (0.7%).

The percentage of VLBW live births was also more favorable for Northwest Maryland (1.3%), Southern Maryland (1.4%), Montgomery county (1.4%) and the Baltimore Metro area (1.5%). The proportion of very low birth weight live births in Price George's county for 1997 was 2.7%. In Baltimore City, the proportion of very low birth weight live births for 1997 was 3.3%.

Very Low Birth Weight Infants Delivered at High-Risk Facilities: In 1998, 85.8% of Very Low birth Weight infants born in Maryland were delivered at high-risk facilities. There were no data available for the U.S. or for the various regions in Maryland.

Prenatal Care: In 1998, 87.9% of Maryland infants were born to pregnant women receiving prenatal care in the first trimester. This is slightly higher than the percentage for the United States for the same year (82.8%). The percentages for the State of Maryland and for the U.S. were lower than the Year 2000 Objective of 90.0%. See Figures 1-5 for regional data. In 1998, 92.3% of pregnant women in the Baltimore Metro area and 91.7% of pregnant women in Montgomery County received prenatal care in the first trimester. The Baltimore City percentage (78.3%) was well below that of the State.

In 1998, 1.8% of Maryland infants were born to pregnant women receiving late prenatal care (beginning in the third trimester), and 1.1% of Maryland infants were born to pregnant

women who had received no prenatal care. No U.S. data were available for comparison. See Figures 6-10 for regional data. Eastern Shore women are more likely to receive late prenatal care (2.1%) than are women in Maryland overall. The percentage of infants born to women receiving late prenatal care was 2.6% for Prince George's County and 3.1% for Baltimore City. The percentage of infants born to women receiving no prenatal care in Southern Maryland (0.6%) and in the Baltimore Metro area (0.4%) was less than that for the State .

Pregnant Women Admitted to Certified Alcohol and Drug Programs: In 1998, 1.4% of pregnant women in the State of Maryland were admitted to certified alcohol and drug programs. Of this population, 1% identified heroin, methadone and/or other opiates and synthetics as their substance of use. Since the total number of pregnant women was unknown, the percentages were calculated using the number live births as the denominator. In addition, these percentages represent only women admitted to treatment. Thus, the percentages may appear higher than the actual proportion.

The percentage of pregnant women, in the following regions, admitted to certified drug and alcohol programs was substantially lower than the State average: Baltimore Metro (0.6%), Southern Maryland (0.6%), Montgomery County(0.3%). However, the percentage in Baltimore City was 6.7%. Of these numbers, 6.3% in Baltimore City identified heroin, methadone and/or other opiates and synthetics as their substance of use followed by 0.4% in the Baltimore Metro area, 0.1% on the Eastern Shore, 0.1% in Northwest Maryland and 0.1% in Prince George's County. In Southern Maryland and Montgomery, no pregnant women admitted to certified drug and alcohol programs identified these substances. The influence of the availability of facilities and outreach programs on utilization of substance abuse treatment is unknown.

HIV/AIDS in Infants and Pregnant Women: In 1998, 1% of pregnant women in Maryland receiving testing tested were positive for HIV. There are no U.S. or regional data available for comparison. We should be cautious when looking at these results since they do not include pregnant women who were not tested. Pregnant women who were tested for HIV in Prince George's County, Baltimore City , and Baltimore Metro area were more likely to test positive than those in the State . The percentages were 1.1%, 1.8% and 1.9%, respectively. In the following regions none of the pregnant women who were tested were positive for HIV: Eastern

Shore, Northwest Maryland, Southern Maryland, and Montgomery County. In 1998, 0.1% of infants in Maryland were diagnosed with AIDS.

Congenital Syphilis Rate: In 1998, the congenital syphilis rate in Maryland (65.5 per 100,000 live births) was far higher than that for the U.S. (26.9) and the year 2000 objective (40.0). See Figures 11-15 for regional data. Regional data are only available for 1997. In 1997, the congenital syphilis rate on the Eastern Shore was 10.7. Wicomico County was the only county on the Eastern Shore with cases of congenital syphilis. There were no cases of congenital syphilis in Southern Maryland. Baltimore City's congenital syphilis rate stood at 332.5 in Baltimore City in 1997.

Newborn Screening: In 1998, the proportion of newborns with at least one screening (PKU, hypothyroidism, galactosemia, hemoglobinopathies) for Maryland met the year 2000 Objectives (100%) and exceeded that for the U.S. (94.7% in 1994). No regional data were available.

Abnormal Newborn Screenings: In 1998, 99.84% of the newborns with one abnormal screen were followed-up which met the year 2000 Objective of 100%. No regional data were available.

Newborn Hearing Screenings: The proportion of newborns with a hearing screen before hospital discharge was 19% (1999) for Maryland, which fell short of the Year 2000 Objective of 25%. No data were available for the U.S. or for the regions in Maryland. (Note: Beginning in FY 2001 universal newborn hearing screening will be implemented).

### **Gaps in the Available Data for Pregnant Women, Mothers and Infants**

Although considerable data is available regarding the health status of women and infants, there are areas where data were either unavailable or not readily accessible. Of primary concern is a lack of information related to prenatal care. Although we do know the number of women who received early, late or no prenatal care, we do not know the quality of care or the level of patient satisfaction. We were also unable to determine insurance coverage for pregnant women. (Often the birth records are incomplete or the MCHP coverage eligibility is determined during hospitalization and while the hospital ultimately receives payment, a retrospective correction of the birth certificate is not done.) In addition, pregnancy intendedness and contraceptive use prior to conception is not measured. This is especially important because literature indicates a

relationship between unintended pregnancy and delay in accessing prenatal care. (With the initiation of PRAMS in the spring of 2000, it is anticipated that in subsequent years this information will be available.)

It would also be helpful to know about alcohol use among pregnant women. The only data found that was related to this issue was the percent of pregnant women admitted to certified alcohol and drug programs. This is incomplete, however, as it does not include women who continue to use alcohol throughout pregnancy or those who might manage to stop on their own. Many of these issues will be addressed by the PRAMS (Prenatal Risk Assessment Monitoring System) questionnaire that will be given to a representative sample of women in Maryland beginning in the spring 2000.

Data is not available on health conditions of pregnant women and infants. There were no consistent data found related to diabetes, hypertension and anemia among pregnant women. In addition, data was lacking on hospitalization of pregnant women (excluding deliveries) and hospitalization of infants under one year of age. While this data is available from the hospital discharge data set, an unduplicated count of discharges is not available.

A significant gap exists regarding HIV/AIDS. Data on the number of HIV cases among newborns and among pregnant women are unavailable. We have very limited information regarding infants with AIDS (only a statewide percentage) and pregnant women who were tested for HIV. Data is also lacking in terms of abuse and neglect of infants, and violence against women of childbearing age. Data are available regarding abuse and neglect cases in children. However, there were no data specific to infants. Domestic violence data when available, does not specify the age of the women involved. This is another issue that will be addressed by the new PRAMS questionnaire. (More analysis must be done on the entire safety domain given the qualitative assessment as well as telephone surveys and local health department narratives that indicate that domestic violence and child abuse are two prevalent public health concerns).

Finally, the following data were available at the State but not the county level: (1) the percent of very low birth weight infants delivered at high-risk facilities, (2) the percent of newborns who receive hearing screening before hospital discharge and (3) the percent of mothers who breast-fed their infants at the time of discharge. It would be beneficial to have country-

specific data on these indicators so that we could determine where there is a need for services and education.

### **The Health Status of Children and Adolescents**

Maryland's 1.4 million children are its most important and precious resource. Several recent reports have documented improvements in the health of Maryland's children such as declining teen pregnancy rates and increasing immunization rates. There is every reason to expect that most of Maryland's children will grow up to become healthy and productive members of society. However, the available data also suggest that there are troubling trends and challenges that could block the attainment of a healthy future for many of Maryland's children and adolescents. According to the 1999 Kids Count Data Book published by the Annie E. Casey Foundation, Maryland, one of the nation's wealthiest states, ranked 24<sup>th</sup> on 10 indicators of child well-being. At least 12% of Maryland's children were defined to be at high risk for future failure as measured by six indicators including poverty, and lack of health insurance coverage. Most at risk are children who grow up in poor, minority, and disadvantaged families and communities. A summary of the major health indicators for children and adolescents is provided below.

Children without Health Insurance: In 1997, the estimated percentage of children with no health insurance in Maryland (13.9) was lower than that of the U.S. (16.1%). See Figures 46-50 for regional data. The percentages in all Maryland regions were not as favorable, however, particularly on the Eastern Shore, where 18.9% of children are uninsured. Some areas of Maryland were substantially more successful than the State in obtaining health insurance for children. Perhaps this is an indication of affluence and access to private insurance. In Southern Maryland, only 9.8% of children were uninsured; in Montgomery County, the percentage was 9.7%. The competing forces that will influence coverage or lack thereof is the impact of MCHP, the reduction in access to HealthChoice for children with parents who are no longer eligible for welfare assistance (TANF), and the impact of both documented and undocumented immigrants.

Medicaid Eligibility/Services Received: The percentage of potentially Medicaid eligible children who received a service paid by the Maryland medical assistance program was 82.3% (1996). No data were available for the U.S. or for the various regions in Maryland.

Immunizations: In 1998, the percentage of children through age 2 who had completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus

Influenza and Hepatitis B in Maryland (80%) was greater than that for the U.S. (80.8%), but was less than the Year 2000 Objective (90.0%). It should be noted that Maryland is developing an immunization surveillance system that should enable the State to collect more accurate and timely data.

Lead Exposure and Poisoning: The percentage of children aged 0-72 months who were screened for lead poisoning by blood testing in Maryland was 25.3% in 1997. No U.S. data or Year 2000 objectives were available for comparison. Data for various regions in Maryland can be found in figures 56-60. The percentage of children screened for lead poisoning/exposure was very low in the Baltimore Metro area (9.3%), but extremely high in Baltimore City (35.1%). Although the other regions in Maryland performed comparably to the State in this area, there were some counties in which the percentage of children screened was significantly lower than that of the State, most notably Cecil County (5.8%) on the Eastern Shore, and Frederick (7.) and Washington (5.1) counties in Northwest Maryland.

Asthma Mortality Rate: In 1997, the asthma mortality rate per 100,000 children aged 1-14 was higher for Maryland (0.98) than for the U.S. (0.3). The rate for Maryland dropped in 1998 to 0.19. No U.S. data for 1998 could be found for comparison. In addition, no regional data were available.

Child Death Rate due to Sickle Cell Disease: The rate of death to children aged 1-4 caused by sickle cell disease in Maryland was 7.0 in 1997 and 0.0 in 1998. There were no data available for the U.S. or for the various regions in Maryland.

Protective Dental Sealants: The percentage of third grade children who had received protective sealants on at least one permanent molar tooth was 16.7% in Maryland in 1997. This is much less than the Year 2000 Objective (50.0%). No regional data or U.S. were available. It is anticipated that when the Dental Sealant Study is undertaken during FY 2001 the percent of children with dental sealants will increase. The results of that anticipated study along with the Oral Health Head Start Study currently underway (funded by SSDI) will be part of the FY 2002 application.

Early Intervention-Infant and Toddlers Program: In 1998, 3.4% of Maryland children aged 0-3 received early intervention services. In that same time period, 3.2% of all 9-13 year-olds

living in Maryland were referred to local Infants and Toddlers Programs. There are no U.S. data available for comparison.

Teen Birth Rate: In 1997, the teen birth rate per 1,000 teenagers aged 15-17 years was lower in Maryland (26.38) than in the U.S. (30.4). The Maryland teen birth rate was also considerably more favorable than the year 2000 Objective (50.0). Figures 51-55 depict regional teen birth rates. Consistent with the low State rate, the 1997 teen birth rate was very low in the Baltimore Metro area (15.73) and Montgomery County (12.42). The teen birth rate in Baltimore City, however, was extremely unfavorable (69.56).

Alcohol Use in Adolescents: In 1998, 17.0% of 6<sup>th</sup> graders attending public schools in the State of Maryland reported that they had used alcohol at least once. Almost one in ten 6<sup>th</sup> graders indicated that they had used alcohol in the past thirty days. The percent of 10<sup>th</sup> graders attending public schools that had ever used alcohol was 62.7 in 1998. In addition, 42.9% of 10<sup>th</sup> graders reported using alcohol in the last thirty days. In Southern Maryland, 24.6% of 6<sup>th</sup> graders reported ever using alcohol, a much greater percentage than the State overall. The percentage of 6<sup>th</sup> graders reporting ever using alcohol was lower than that of the State in Montgomery (9.5%) and Prince George's (10.9%). Only 4.1% of 6<sup>th</sup> graders in Montgomery County and 5.1% of 6<sup>th</sup> graders in Prince George's County had used alcohol in the past 30 days. The percentage of 10<sup>th</sup> graders who reported ever having used alcohol was substantially higher on the Eastern Shore (73.8%) than for the State .

Adolescent Cigarette Use: In 1998, the percentage of 6<sup>th</sup> graders attending public schools reported ever used cigarettes was 10.7%. In 1998, 46.1% of 10<sup>th</sup> graders who attended public schools reported that they had used cigarettes at least once. 22.3% of Maryland 10<sup>th</sup> graders reported that they had used cigarettes in the last thirty days. There were no U.S. data for comparison. The percentage of 6<sup>th</sup> graders who had ever smoked was higher than the State average on the Eastern Shore (19.1%) and in Southern Maryland (19.1%). Montgomery County had the least percentage of 6<sup>th</sup> graders (6.2%) that reported ever smoking and only 2.2% had smoked in the last thirty days. The percentage of 6<sup>th</sup> graders who had smoked in the last thirty days was also low in Prince George's County (2.5%). Only 32.3% of 10<sup>th</sup> graders in Baltimore City reported ever having used cigarettes; only 11.2% had smoked cigarettes in the last thirty days.

Drug Use in Adolescents: In 1998, 8.9% of 6<sup>th</sup> graders attending public schools in the State of Maryland reported that they had used at least once a drug other than alcohol or tobacco. The percent of 10<sup>th</sup> graders who attended public school that had ever used a drug other than alcohol or tobacco was 62.7% in 1998. In addition, 42.9% of 10<sup>th</sup> graders reported that they had used a drug other than alcohol or tobacco in the last thirty days. U.S. data were not available for comparison. 6<sup>th</sup> graders in Prince George's County (1996) reported less drug use than 6<sup>th</sup> graders throughout the State. Only 3.5% indicated having ever used drugs other than alcohol or tobacco, and only 2.6% reported using drugs in the last thirty days. 6<sup>th</sup> graders in Baltimore City reported more drug use than 6<sup>th</sup> graders in the State. Almost 12% of Baltimore city 6<sup>th</sup> graders reporting using drugs other than alcohol or tobacco at least once. The percentage of 6<sup>th</sup> graders reporting the use of drugs in the last thirty days was 7.7%.

Juvenile Justice: Between 1997 and 1998, the violence-related suspension rate in Maryland was 48.9 per 1,000 students. In 1997, the Juvenile Violent Crime Arrest Rate was 66.3 per 10,000 children aged 10-17. The rate for Non-Violent Crime arrests of children aged 10-17 was 262.1 for the same year. No U.S. data were available for comparison. Montgomery County performed much more favorably than the State in the area of juvenile justice. The violence-related suspension rate was 27.5; the arrest rate for juvenile violent crimes was 20.4; and the arrest rate for juvenile non-violent crimes was 108.9. The performance of Baltimore City in the area of juvenile justice was significantly less favorable than that of the State. The violence related suspension rate was 92.8; the arrest rate for juvenile violent crimes was 165.1; and the arrest rate for juvenile non-violent crimes was 344.6

Child Abuse and Neglect: The percentage of investigations in which credible evidence of abuse and/or neglect was found in Maryland was 25.0% in 1998. No U.S. data were available for comparison. The percentage of investigations in Prince George's County in which credible evidence of abuse and/or neglect was found (34.0%) was considerably higher than that of the State. In Southern Maryland, only 15.3% of child abuse/neglect investigations were found to have credible evidence.

Out-of-home Placements: In 1998, 0.09% of Maryland children were in out-of-home placements. There were no U.S. data available for comparison. All regions in Maryland had

similarly low percentages of out-of-home placements for children, with the exception of Northwest Maryland, where the percentage was 0.28%.

Child Death Rate: The child death rate per 100,000 children aged 1-14 in Maryland (23.1) was comparable to that of the U.S. (23.8) in 1997. Both Maryland and U.S. performed better than the Year 2000 Objective (28.6). No regional data were available.

Child Deaths due to Motor Vehicle Crashes: The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children was 2.4 in Maryland in 1997. This rate is very favorable when compared to the rate for the U.S. (5.0) and to the Year 2000 Objective (4.4). Regional data were not available for this indicator.

Rate of accidental deaths (10-19 year-olds): In 1997, the rate of accidental deaths per 100,000 youth aged 10-19 was 14.19 for the State of Maryland. No U.S. data were available for comparison. The accidental death rate was higher on the Eastern Shore (25.11) and in Southern Maryland (22.9) than that of the State. Montgomery County has a very low accidental death rate for youth (7.92).

Suicide Death Rate: In 1997, the rate of suicide deaths among youth 15-19 years of age in Maryland (7.01) was lower than that for the U.S. (9.45) and the year 2000 Objective (8.20). There were no regional data. The rate of suicide deaths per 100,000 youth aged 10-19 was 3.4 for the State of Maryland in 1997. No U.S. data were available for comparison for this age group. However, regional data were available. Regions with the highest suicide rate among 10-19 year olds were the Eastern Shore (5.76) and Southern Maryland (5.75). Maryland regions with the lowest suicide rate among 10-19 year-olds were Montgomery County (1.98) and Prince George's County (1.88).

Rate of Homicide Deaths (10-19 year-olds): The rate of homicide deaths per 100,000 youth aged 10-19 was 14.93 for the State. The rate of homicide deaths among 10-19 year-olds in Baltimore City was extremely high (66.42 per 100,000). There were no homicide deaths among 10-19 year old youth in Northwest Maryland in 1997.

Rate of all Violent Deaths (10-19 year-olds): In 1997, the rate of all violent deaths per 100,000 youth aged 10-19 was 32.52 for the State of Maryland. No U.S. data were available for comparison. The violent death rate among youth was lower than that of the State in the

Baltimore Metro area (16.95), Northwest Maryland (17.0), and Montgomery County (1%). In Baltimore City, the rate of all violent deaths among youth aged 10-19 was 90.47.

### **Gaps in the Available Health Status Data for Children and Adolescents**

Unlike maternal health data that has some standard definitions for data elements and can be obtained through birth records and various registries. However, a similar data set does not exist for monitoring the health of children and adolescents. Limited consistent and comparable data is available on the health of school aged children. There is no reliable surveillance system for immunizations (although one is under development) or asthma. In addition, there is no reliable data on utilization of school health services that can provide, for example the number of unique individuals utilizing services, chronic illnesses with and without maintenance medication, or the number of children diagnosed with ADHD. Further, there is no data available to link child health and school performance measures. There is even less data available on children who do not attend public schools. As more and more children attend private schools or are home schooled, this data gap is likely to increase.

Data were also lacking with regard to Ambulatory Sensitive conditions in children. Hospital discharge data may have been helpful in this area. However, as stated before, it is impossible to identify repeat admissions for the same condition. Therefore, at best, we could only estimate the number of children hospitalized due to ambulatory sensitive conditions for a specific time period.

Data gaps were also present in the area of nutrition. Several of the Healthy People 2000 and Healthy People 2010 Objectives are related to obesity and exercise. However, data related to these issues were not readily available in the State of Maryland . The number of children who were eligible for and actually receiving subsidized school lunches was obtainable. However, these data were not reliable and consistent across all school districts.

There is a lack of data reported for children and adolescents related to mental health issues. Reliable data for psychiatric admissions and emergency room visits for mental health problems were unavailable for the youth population. It was also impossible to identify the number of children and adolescents who were seriously emotionally disturbed. Some data were available regarding visits to school mental health counselors. However, these data were not complete and

available for all schools or included duplicated counts. In addition, there is no way to determine if comparable definitions are being used.

Finally, the following data were available only at the State level: (1) the number of children with dental visits in the last twelve months for medical assistance; (2) the percent of third grade children with protective dental sealants on at least one permanent tooth; (3) the percent of Medicaid-eligible children who have received a service paid by the Medicaid program; (4) the percent of MCHP-eligible children who have received services, and (5) the percent of children through age 2 who have completed immunizations. It would be useful to know which counties have the greatest need for dental services and which counties had problems with children completing immunizations in a timely manner.

### **The Health Status of Children with Special Health Care Needs**

Children with special health care needs are defined as children who have a chronic physical, developmental, behavioral, or emotional condition and who require health care. Nationally, it is estimated that between 12-15% of American children have a special health care need. There is no accurate data which describe the prevalence of CSHCN in Maryland. However, data from several sources provides estimates of the numbers of children with special health care needs. Firstly, data from the 1994-95 disability supplement of the National Health Interview Survey estimates that approximately 184,000 Maryland children had a special health care need in 1994-95. Excluding children with a mental health disorder, the estimated number decreased to 171,000. Secondly, between 12,000 - 13,000 Maryland children under the age of 18 receive SSI each year. About two-thirds of these children qualify for SSI due to some type of mental disorder including mental retardation. Thirdly, the Medical Assistance Program has allotted up to 200 waiver slots to care for children with complex medical needs. In December 1999, 179 children were enrolled in the Waiver and another, 2,084 children and adolescents under the age of 21 were enrolled in REM (a Medicaid case management program for enrollees with selected rare and expensive health disorders). Finally, the Maryland Infants and Toddlers Program served 6,817 children aged 0-3 with developmental problems in FY 1999.

This was the population for which the greatest number of data gaps was found. There is currently limited data available on the health status, needs and service utilization patterns of CSHCN in Maryland. Information related to health insurance coverage for CSHCN is also

lacking. Dental services were another major service gap identified for the CSHCN population. Like the other populations, adequate data on dental care was not available. Data was also lacking in terms of the ratio of providers and pediatric subspecialties to the number of CSHCN by county. This data is vital to determining where lack of service for this population exists.

**3.1.2.1 Direct Health Care Services**

**3.1.2.1 Enabling Services**

**3.1.2.2 Population-Based Services**

**3.1.2.3 Infrastructure Services**

The following sections summarize and describe the major health needs of Maryland's three major MCH population groups based on preliminary findings from the various sources used to conduct the needs assessment. Further analyses will be conducted during the coming year. Findings, summaries and conclusions will then be incorporated into a five to ten year statewide MCH strategic plan.

For ease of the reader, this section addresses each of the four levels of the pyramid according to the various targeted populations: (1) pregnant women, mothers and infants, (2) children and adolescents and (3) CSHCN. A fourth general category narrative that encompasses all three-population groups is placed at the end of the pyramid. Summary tables of MCH problems and needs for each level of the pyramid by population group are provided. Supporting documentation is also noted. Much of the information provided in each of the tables was provided by the qualitative study that was done by the University of Maryland School of Nursing. Quantitative data is used to support the qualitative findings, where appropriate.

**The Health Needs of Pregnant Women, Mothers and Infants**

<b>Pregnant Women, Mothers and Infants Direct Services – Problems Identified</b>	Supporting Documentation
Inadequate access to comprehensive, continuous health care -Delay in accessing care if receiving other social services beyond MCHP -Post-partum women, lose coverage if TANF discontinued -Family Planning; preconception health -Accessing specialty care, especially on Eastern Shore and Western Maryland	<b>Health Status Indicators</b> -Timing of accessing prenatal care -Rates of VLBW, LBW -Maternal and Infant Mortality Rates -Disparities among population groups -STD Rate, including Congenital Syphilis Rate -Adolescent birth rate -Abortion Rate

<ul style="list-style-type: none"> <li>-Health care for the undocumented and immigrant population who do not qualify for social services</li> <li>-Need for medical home for women of child-bearing age</li> </ul>	<p><b>Other Studies</b></p> <ul style="list-style-type: none"> <li>-Health Improvement Plans (State, LHD)</li> <li>-Core Funding Plans (LHD)</li> <li>-LHD Priority List</li> <li>-FIMR</li> <li>-Family Planning Data</li> <li>-BFRSS</li> <li>-Title V Needs Assessment</li> <li>-Pre-natal Risk Assessment Forms</li> <li>-Healthy Generations/Home Visiting Data System</li> </ul>
<p>Inadequate access to comprehensive, continuous ancillary health services</p> <ul style="list-style-type: none"> <li>-Dental and vision screening and treatment, particularly on Eastern Shore, Southern and Western Maryland</li> <li>-Improve access to and coverage of mental health services throughout the State (parity, availability)</li> <li>-Substance abuse treatment services in general and particular with a residential and child care component, especially noted on the Eastern Shore and Baltimore City</li> <li>-Lack of screening pregnant women for substance abuse, domestic violence, or risk of STDs including HIV</li> </ul>	<p><b>Health Status Indicators</b></p> <ul style="list-style-type: none"> <li>-Timing of accessing prenatal care</li> <li>-Rates of VLBW, LBW</li> </ul> <p><b>Other Studies</b></p> <ul style="list-style-type: none"> <li>-Health Improvement Plans (State, LHD)</li> <li>-FIMR</li> <li>-Title V Needs Assessment</li> <li>-Pre-natal Risk Assessment Forms</li> <li>-Healthy Generations/Home Visiting Data System</li> <li>-Certified Drug and Alcohol Treatment Programs</li> <li>-Review of Maternal Mortality Records</li> </ul>

There is a need for comprehensive, continual health insurance coverage for women beyond pregnancy. Currently, the State recognizes the importance of health care in ensuring the health and welfare of both mothers and infants. In spite of the fact that many of the pregnant women up to 200% of the federal poverty level (FPL) have comprehensive medical and dental coverage through MCHP, this coverage does not extend beyond six weeks postpartum. Often care is needed beyond the duration of pregnancy. As one individual interviewed during the Title V Needs Assessment stated, “You have to be pregnant to get health care.” This need for comprehensive, continual coverage is even more critical for undocumented immigrants who are not eligible for publicly funded programs.

Several other points mentioned by clients and providers through the qualitative aspect of the Title V Needs Assessment that were barriers to care were: (1) “if you don’t have the card, or

the wrong provider is on the card, they won't see you"; (2) "if you tell them that you have a drug problem they will take your kids away from you" or "If you go for health care and the provider finds drugs in your system then they are going to take away your kids; but they should offer you drug treatment before they take you kids away". LHD personnel in Western Maryland cited "alcohol use as a community norm" while Montgomery County LDH personnel indicated "there is no coverage for mental health".

Discussion: Access to comprehensive health care and subsequent referrals for specialty services continue to be a concern of consumers, private providers and public health officials. Maryland is currently implementing the following intervention strategies:

- Expansion of Medicaid coverage for prenatal and postpartum women up to 200% of FPL (to expand to up to 300% of poverty level in July 2001).
- Collaboration between the Medical Assistance Program and CPHA in providing dental coverage for pregnant women and ensuring access to providers accepting Medical Assistance clients.
- A Statewide home visiting program with extensive care coordination functions.
- Family planning services
- Substance abuse treatment through State Medicaid funds for pregnant women, and other funding from CPHA including priority placement in treatment programs.
- The Crenshaw Initiative which provides for a system of maternal health care regardless of the woman's economic or citizenship status.
- Improved Pregnancy Outcome Program.
- Abstinence education programs throughout the State.
- Genetics counseling

Pregnant Women, Mothers and Infants <b>Enabling Services – Problems Identified</b>	Supporting Documentation
<b>Increased fragmentation of care</b> -Managed care providers rather than LHD -Limited or no access to referrals -Care coordination varies	<b>Other Studies</b> Title V Needs Assessment Core Funding Proposal—LHD LHD Priority Needs Report
<b>Lack of health promotion/intervention</b> -Limited Preventive Care: ‘Kick” Count, what to expect—labor multiple gestation, infant transport issues, -Smoking cessation: screening, referrals -Child birth education: referrals, cost -Parenting skills -Pre-conception counseling -Culturally appropriate messages -Alcohol; impact FAS	<b>Other studies</b> FIMR Title V Needs Assessment
<b>Transportation, translation and outreach services</b>	Title V Needs Assessment
<b>Support services</b> -Bereavement -SIDS -Teen parents -Child care -Bonding linkages for long-distance NICUs	<b>Other studies</b> FIMR Title V Needs Assessment Grant Proposals from LHD to State Community Assessments

Maryland’s expanded coverage of health care for pregnant women up to 200% of FPL through an expansion of Medical Assistance (HealthChoice) has been met with mixed opinions. While all have welcomed the expanded coverage that MCHP offers to uninsured children and pregnant women, some believe that MCHP has resulted in increased fragmentation of care, lack of knowledge on the part of providers as to how to access referrals for clients, lack of health promotion and prevention messages and increased client, public and legislators expectations. At one time the first two concerns were addressed by the local health departments that have a strong and exemplary public health services, but with limited hours and categorical services were unable to provide the comprehensive medical services that MCHP is able to provide. The expectation is

that managed care and the private sector can provide the quality, holistic and culturally competent care that the public health sector has historically provided, but for less cost.

Since preventive services are not reimbursable, sufficient time is often not allotted to address some of the more complex issues that pregnant women may present such as smoking, substance use, or mental health issues. In addition, while private sector practitioners may be knowledgeable about medical and subspecialty referrals, they often have limited experience in making referrals for services (e.g., substance abuse and mental health treatment, parenting skills, transportation issues) that are traditionally viewed as being in the realm of public health. What is also not known at this time is what the full impact of ‘Welfare Reform’ (TANF) on maintenance of care and access to care due to financial assistance. Maryland is aggressively pursuing the outreach efforts to ensure that women do not lose their coverage inappropriately when their TANF coverage expires.

Discussion: The need for most of the above enabling services was derived from the personal statements made to the Title V Needs Assessment team, or in detail accounts of FIMR reports, LHD community assessments and core funding proposals. It is often these enabling services that ensures the success in accessing and maintaining services and achieving the desired outcome—healthy women, mothers, and babies. In the area of enabling services, the Title V Program has historically supported home visiting and care coordination services. The opportunity now exists for these funds to also be directed to other enabling activities such as transportation and translators. Currently, Maryland has intervention strategies in the following areas:

- Care Coordination through home visiting; in Charles County public health nurses also provide care coordination for the physicians at their offices
- The Center for Infant and Child Loss provides counseling and supportive services to family members who have lost a child due to SIDS or other causes
- Translation services are available in some counties but are often insufficient
- Medical Assistance provides transportation, though the logistics (multiple bus transfers, limited cab services or a 7 day notice) may hamper the intent of the Program.
- Assistance through continuing education programs is available to assist providers in become culturally competent or more knowledgeable about resources for referrals.
- The MCH Program has funded community assessments to identify and monitor gaps in services and to recommend intervention strategies.

<b>Pregnant Women, Mothers and infants Population-based Services—Problems Identified</b>	Supporting Documentation
<b>Life-long learning—health promotion</b> -Pre-conception Counseling, not done -Folic acid usage, limited to well educated -Genetic Counseling -Breast Feeding -Smoking, alcohol, substance use prevention -Responsible sexual behavior	<b>Health Status Indicators</b> -Newborn Screening Records -STD Rate, including Congenital Syphilis Rate <b>Other Studies</b> -Title V Needs Assessment -FIMR Reports -MMR -Home visiting data system -WIC -Core Funding Plans (LHD)
<b>Safety Issues</b> -Prevention and identification of domestic violence; access to safe houses -Injury prevention	<b>Other Studies</b> Maternal Mortality Review Calls to hotlines
<b>Family Planning</b> -Unintended pregnancy -STD	
<b>Health Information Line</b>	Title V Needs Assessment

Both the Eastern Shore and Western Maryland regions are seeing an increase in rate of unemployment and poverty in spite of the positive economic outlook for Maryland as a whole. Poverty levels are also high in Baltimore City and in other ‘Pockets’ throughout the State. What has been learned is when care coordination with or without a home visiting program is present the function complements MCHP through advocacy on the client’s behalf, the provision of health messages that are periodically reinforced, ensuring greater success in maintenance of care and receiving and accessing referrals. Several intervention strategies that Maryland has undertaken are:

- Folic Acid Campaign
- Inclusion of preconception health care into the family planning services provided by LHDs and MCH grantees.

<b>Pregnant Women, Mother and Infants Infrastructure Services—Problems Identified</b>	Supporting Documentation
<b>Public Health Capacity, limited</b> -Epidemiology, -Data Information System -Ongoing Community Assessments -Ongoing Special Studies	<b>Other Studies</b> Health Improvement Plan Title V Needs Assessment SSDI
<b>Public Health Staff</b> -Culturally and bilingual competent, limited -Appropriate skills for emerging functions and population needs, very limited -Professional shortages both geographically and within specialties: physicians, mental health, dental, nursing and social work	<b>Other Studies</b> Health Improvement Plan Title V Needs Assessment Primary Care Analysis
System of Care: Not available -Undocumented population -Women of child-bearing years -Men 18-45 years -Reimbursement for preventive care	<b>Other Studies</b> Title V Needs Assessment Core Funding Plan--LHD
<b>Care Coordination for Providers – Much need</b> -Continuing Education -Education re: public health role, referrals -Care coordination of patients from office	Title V Needs Assessment
<b>Maryland Mothers</b> -Support system that ensures continuum of healthy lifestyle	<b>Other Studies</b> Title V Needs Assessment FIMR

Maryland women generally did not identify access to maternal health services as a problem. However, many women expressed a need for continuing health benefits beyond pregnancy. These women also expressed concerns about the limited availability and access to dental services. Both providers and consumers noted a need for linkages to accurate and up-to-date health information, preferably, through a one-stop telephone health line for MCH issues. Care coordination was also identified as need by both providers and consumers. All noted that since health insurance in general does not reimburse for preventive services, screening and health promotion is not provided, except in cases when a medical illness is noted. Physicians noted that they have been unable to keep up with the changes in Medical Assistance in spite of the outreach and education

materials that are provided. Throughout this two-year process, the need for improvements in the MCH Program's epidemiological capacity has become increasingly apparent.

Maryland has been addressing some of the above concerns by:

- Negotiating with dental providers to provide service in some underserved areas:
- Passing legislation to assist dentists who agree to practice in underserved areas with their educational costs.
- Applying for and receiving a grant from the CSTE to hire a senior epidemiologist.
- Instituting PRAMS.

Maryland recognizes the need to evaluate more closely the results of the needs assessment to determine (1) if additional resources for current programs are needed; (2) if new intervention strategies and/or programs are needed; or (3) if due to the lack of appropriate data, a surveillance or data management system must be put in place.

### The Health Needs of Children and Adolescents

Preventive and Primary Child Health – Direct Services—Problems Identified	Supporting Documentation
<p>Improve access to comprehensive, continuous health care</p> <ul style="list-style-type: none"> <li>-MCHP enrollment decreases with child’s age; few adolescent covered</li> <li>-Health care for the undocumented and non-citizen population who do not qualify for MCHP</li> <li>-Lack of a medical home, that is developmentally appropriate for adolescents</li> <li>-Adolescents lack assurance of confidentiality, particularly in rural areas: Eastern Shore, Southern and Western MD; limits access</li> <li>-Family Planning, including Pre-conception counseling</li> <li>-Non-responsive parent to completing MCHP eligibility</li> </ul>	<p><b>Health Status Indicators</b></p> <ul style="list-style-type: none"> <li>-MCHP enrollment rates</li> <li>-STD Rate</li> <li>-Adolescent birth rate</li> <li>-Hospital Discharge Data</li> </ul> <p><b>Other Studies</b></p> <ul style="list-style-type: none"> <li>-Health Improvement Plans (State, LHD)</li> <li>-Core Funding Plans (LHD)</li> <li>-LHD Priority List</li> <li>-FIMR</li> <li>-Family Planning Data</li> <li>-BFRSS</li> <li>-Title V Needs Assessment</li> <li>-Community Needs Assessment (Tri-County-Eastern Shore {adult/child &amp; adolescent/CSHCN}, Allegany Co.)</li> <li>-Home Visiting Data System</li> <li>-School Health Surveys</li> </ul>
<p>Improve access to comprehensive, continuous ancillary health services</p>	<p><b>Health Status Indicators</b></p> <ul style="list-style-type: none"> <li>-MCHP utilization rates</li> </ul>

<ul style="list-style-type: none"> <li>-Dental services not available</li> <li>-Improve access and coverage of mental health services throughout the State (parity, availability)</li> <li>-Substance Abuse Counseling (alcohol and drug)</li> <li>-Smoking Cessation Programs</li> </ul>	<p><b>Other Studies</b></p> <ul style="list-style-type: none"> <li>-Health Improvement Plans (State, LHD)</li> <li>-FIMR</li> <li>-Title V Needs Assessment</li> <li>-Core Funding Plans (LHD)</li> <li>-LHD Priority Plan</li> <li>-School Health Surveys</li> <li>-Community Needs Assessment (Tri-County-Eastern Shore, Allegany Co.)</li> <li>-MD Adolescent Survey</li> <li>-BFRSS</li> </ul>
<p>Increased morbidity among children and adolescents</p> <ul style="list-style-type: none"> <li>-ADHD</li> <li>-Asthma</li> <li>-Mental Health—Depression</li> </ul>	<p><b>Other Studies</b></p> <ul style="list-style-type: none"> <li>Title V Needs Assessment</li> <li>Health Improvement Plan (State and LHD)</li> <li>Core Funding (LHD)</li> <li>Community Assessments</li> <li>Legislative Task Force</li> <li>School Health Surveys</li> </ul>

Maryland historically has been concerned about her children and adolescents. Even before SCHIP became popular with federal financial incentives, Maryland had a health insurance plan for children (Kids Count) and a progressive Minor Consent Law to ensure that adolescents are able to confidentially access certain health care services. Yet even though Medicaid provides a comprehensive health benefits package, health service issues continue to be a concern. This is especially true for the adolescent population desiring (1) access, (2) confidentiality and (3) providers competent in adolescent development and concerns. Unfortunately parents, schools and communities are reporting an increase in (1) morbidity and extensive use of maintenance medication, especially for asthma and ADHD related diagnoses, (2) mental health issues, especially depression, and the inability to access mental health services and well as substance abuse treatment facilities. This is further compounded by the inability to access dental care. These concerns were cited throughout the State and were especially highlighted in rural communities.

Discussion: Current intervention strategies that Maryland is implementing are:

- Providing extensive media/outreach plans within schools, WIC, faith community, LHD to enroll children/adolescents in MCHP

- Funding various youth and adolescent programs through LHD and community-based organizations that are culturally sensitive, and competent.
- Funding various school based clinics and school based health centers
- Providing dental case management (pilot program) in areas that have low MCHP provider participant rate.
- Funding home visiting services throughout the State.
- Providing early intervention services (Infant and Toddler Program) through a collaborative effort with the LHD and School Systems.
- Providing teen parenting classes and clinics to ensure that infants and toddlers are immunized and accessing well-child care.
- Providing a voucher reward system on the Eastern Shore (4 counties) to ensure compliance with the recommended CDC immunization schedule.

<b>Preventive and Primary Child Health— Enabling Services—Problems Identified</b>	Supporting Documentation
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<b>Comprehensive insurance coverage</b> -Coverage of medication not on the MCO's formulary -Coverage of inhalers/durable medical	Title V Needs Assessment
<b>Fragmentation of adolescent health care</b> -Must focus on areas beyond family planning -Care Coordination -Varied school nurse coverage	<b>Other Studies</b> Title V Needs Assessment Community Assessments (Allegany Co.)
<b>Transportation, translation services</b>	Title V Needs Assessment
<b>After School Child Care</b> -Availability -Affordability -Competency of Staff	Title V Needs Assessment
<b>Health Education/Promotion</b> -Drug and Alcohol quality and frequency decreases in middle and high schools -Source for quality information that ensures privacy for teens, but also a source for parents -Conflict Resolution	<b>Other Studies</b> Title V Needs Assessment Community Assessments (Tri-County and Allegany Co.)

To better understand the importance of this area, interviews, and focus groups were used to quantify the concerns. Within this section of the pyramid, more anecdotal information is used because so little data is available. The most revealing comments came from public health nurses, school health nurses and adolescents. Public health nurses shared that while children may have health insurance, often the MCOs formulary or benefit coverage prevented some of the more obvious items from being covered. As one stated “They, the parent, do not know their benefit package”. The Tri-County Assessment revealed that school nurses were the individuals from whom most adolescents preferred to obtain accurate information. The students felt their privacy was protected and non-judgmental information was obtained, including referrals if needed. Most communities cited comprehensive school health programs, where a registered nurse is available in every school as a need that the entire community could benefit from.

Students in Allegany County felt that not enough information was provided at the high school level on drugs and alcohol, and furthermore, that drugs and alcohol should receive the same attention as tobacco. Many communities, especially the rural areas cited drug and alcohol as a problem, with few treatment resources being available. Child care was viewed as a necessity that

was not readily available to everyone. All viewed that this was a problem, particularly for pre-school and elementary school children, as more single parent homes and dual income parents become the norm.

Discussion: Maryland’s intervention strategies have included the following:

- A Medical Assistance/MCHP Program that aggressively intervenes on behalf of client when problem areas arise.
- Home visiting program that are funded through core funds to ensure coverage beyond Medicaid eligibility if necessary.
- All first time mothers are contacted to determine if a home visit by the public health nurses from the LHD is desired; health education, immunization ‘rewards’ and care coordination is provided (Eastern shore-4 counties); Olds model is used in Baltimore City.
- Assist providers to become more culturally and developmentally competent when caring for adolescents
- Communities are linking with providers to ensure health services are provided for undocumented and/or children lacking health insurance for whatever reason.
- Provision of transportation, translation, including sign language, and outreach services are provided.
- The State is increasing its funding of school health centers through multiple funding streams,—two new programs are listed as Wellness Centers, that focus on comprehensive services, including dental, extensive mental health services for student and their family, adolescent specific health messages. (This is viewed as an enabling service because it cannot replace a medical home.)
- Monitoring gaps in services and access at the community level through community health assessment, close monitoring of contracts, site visits to LHD with contract follow-up.
- State nurse-consultants provide technical assistance to LHD, community providers and school health nurses.

<b>Preventive and Primary Child Health— Population-Based Services—Problems Identified</b>	Supporting Documentation
Health Screening (Lack of)	<b>Health Status Indicators</b>

<ul style="list-style-type: none"> <li>-Lead Poisoning of targeted populations</li> <li>-Required school screenings (vision, hearing and scoliosis), particularly the private and home school children. <ul style="list-style-type: none"> <li>-ESPDT screening of all children, including developmental delays with appropriate referrals</li> <li>-Mental Health Status</li> <li>-Sexual Activity/Responsible Behavior</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>-Lead Poisoning Registry</li> <li>-MA quality review activity</li> </ul> <p>Other Studies:</p> <ul style="list-style-type: none"> <li>-Health Improvement Plan (State, LHD)</li> <li>-Core Funding (LHD)</li> <li>-LHD Priority List</li> <li>-LPAC Meetings</li> <li>-County Priorities</li> <li>-Community Needs Assessment</li> <li>-Title V Needs Assessment</li> </ul>
<p>Safety Issues:</p> <ul style="list-style-type: none"> <li>-Baby Walkers</li> <li>-Car Seat Installation</li> <li>-Safe sport, playground equipment and grounds <ul style="list-style-type: none"> <li>-Swimming /drowning (Eastern Shore, home pools, water gardens)/spinal injuries</li> <li>-Car accidents/joy driving with or without alcohol</li> <li>-Occupational Injuries—crab industry</li> <li>-Child Neglect and Abuse</li> <li>-Conflict Resolution between children, adolescents—violence increasing</li> <li>-Intentional injuries increasing (City, Eastern Shore, Western MD)</li> </ul> </li> </ul>	<p>Health Status Indicators:</p> <ul style="list-style-type: none"> <li>-Death Rate</li> <li>-Vital Statistics</li> <li>-FIMR</li> <li>-Child Fatality Review</li> </ul> <p>Emergency Room Visits</p> <ul style="list-style-type: none"> <li>-CPHA Reports</li> <li>-Core Funding (LHD)</li> <li>-Title V Needs Assessment</li> <li>-Community Assessment (Tri-County and Allegany County_</li> <li>-Maryland Adolescent Survey</li> <li>-Police Accident Reports</li> <li>-School Health Nurse Surveys</li> </ul>
<p><b>Newborn Universal Hearing Screening-Phase-in Healthy Behaviors:</b></p> <ul style="list-style-type: none"> <li>-Nutrition, Physical Activity—Obesity increasing</li> <li>-Responsible Sexual Behavior</li> <li>-Family Planning, pre-conception</li> <li>-STDs</li> <li>-Tobacco use, including smokeless tobacco</li> <li>-Alcohol and Substance Abuse—early and frequent use</li> </ul>	<p><b>Legislative Requirement</b></p> <p><b>Health Status Indicators:</b></p> <ul style="list-style-type: none"> <li>-Teen Pregnancy Rate</li> </ul> <p><b>Other Studies</b></p> <ul style="list-style-type: none"> <li>-Maryland Adolescent Survey</li> <li>-State Grants to LHD</li> <li>-Family Planning Data System</li> <li>-BFRSS</li> <li>-Title V Needs Assessment</li> <li>-Community Needs Assessment (Eastern Shore: adult/child; Tri-County, Allegany Co.)</li> <li>-Police Injury Reports</li> </ul>

<p><b>Children at Risk for Failure</b></p> <ul style="list-style-type: none"> <li>-Poverty</li> <li>-Dysfunctional Family</li> <li>-Increased Morbidity</li> <li>-Community Hopelessness</li> </ul>	<p><b>Other Studies</b></p> <ul style="list-style-type: none"> <li>Title V Needs Assessment</li> <li>School Health Surveys</li> <li>LHD Site Visit/LPAC Meetings</li> <li>Community Assessment</li> </ul>
<p><b>Environmental Issues</b></p> <ul style="list-style-type: none"> <li>-Lack of fluoride (Cecil, St. Mary’s, well-water)</li> <li>-Asthma (Eastern Shore, Southern/Western MD, Montgomery and Prince George’s Co.)</li> <li>-Lead Contamination</li> </ul>	<p><b>Other Studies</b></p> <ul style="list-style-type: none"> <li>Title V Needs Assessment</li> <li>LHD communication</li> <li>Community Assessments</li> </ul>
<p><b>Health Disparity</b></p> <ul style="list-style-type: none"> <li>-SIDS</li> <li>-Intentional Violence</li> <li>-Asthma</li> <li>-Lead Poisoning and Exposure</li> <li>-Low Immunization Rate, selective areas</li> <li>-At risk for school failure</li> </ul>	<p><b>Health Status Indicators:</b></p> <ul style="list-style-type: none"> <li>-Hospital Discharge Records</li> <li>-Vital Statistics: death, morbidity reports</li> <li>-Lead Registries rate/screens</li> <li>-Immunization Registries</li> </ul> <p><b>Other Studies:</b></p> <ul style="list-style-type: none"> <li>Title V Needs Assessment</li> <li>Community Assessments</li> <li>Health Improvement Plan (State and LHD)</li> </ul>

As one would expect the real challenges that lay before us in public health are the population-based issues and infrastructure issues (to be addressed later). For years public health has advocated for access to care, and yet, as we near almost 100% coverage for pregnant women and children, we are left with the cold realization that our public health work has just begun. This is the future role for Title V interventions, and yet many of these needs will require active, ongoing partnership among many agencies, including some that have not been public health traditional partners. It is the Title V Needs Assessment, coupled with various community assessments and ongoing discussions with local health departments and school health personnel that have identified the key concerns/problems in the area. Maryland has very limited surveillance and data systems to ascertain and confidently identify the health issues.

What has been learned is that Maryland’s children appear to be becoming sicker; that means they are more vulnerable to school failure and not reaching adulthood successfully. What is most frequently cited by a wide variety of individuals in various formats is the increase in:

- (1) the incidence of asthma,
- (2) the incidence of ADHD,

- (3) the incidence of children/adolescents with mental health issues, particularly depression, loneliness
- (4) the incidence of children on maintenance medication, regardless of the reason,
- (5) the incidence of child neglect and abuse throughout the State (anecdotal information) and general violence in selective pockets (anecdotal information),
- (6) use of tobacco, alcohol and substance abuse at an even earlier age (this is particularly true in Baltimore City, Eastern Shore and Western Maryland), and
- (7) obesity and lack of physical activity beginning with elementary aged children.

Most concerns have focused on school-age children and adolescents, not pre-school children with the exception of newborn/infants, immunizations for selective regions and child care issues. All have cited the morbidity increases as the child enters adolescence.

Discussion: Maryland has been transferring funds from direct service to population and infrastructure beginning with FY 2000. A review of the FY 2001 budgets will show a gradual shifting of these funds. For the FY 2001 Title V budget, funds have shifted from direct services and are now allocated to enabling services. However it is anticipated that in the forthcoming years more will be allocated to the population-based services. Examples of some of the activities that Maryland provides are:

- Multiple media campaign targeted for: asthma awareness, lead paint poisoning, abstinence education, teen pregnancy prevention, tobacco prevention and Back to Sleep—SIDS campaign targeted to the African-American community.
- Development of a lead-targeted plan that includes surveillance, identification of areas at risk, blood screenings, treatment and case management.
- Adolescent continual education for providers
- Adolescent skill building programs throughout the State.
- CPHA is in the process of implementing a newborn universal hearing screening program.

<b>Preventive and Primary Child Health—Infrastructure Services—Problems Identified</b>	Supporting Documentation
<b>Lack of surveillance systems</b> -Asthma -Lead -Immunization (Pilot)	<b>Other Studies</b> State Data Survey Title V Needs Assessment Health Improvement Plan (State)
<b>Lack of Surveys</b>  -YRBS -Emergency Room Visit Utilization -Hospital Discharge -School Health Utilization Surveys	<b>Other Studies</b> State Data Survey Title V Needs Assessment Health Improvement Plan (State)
Lack of comprehensive systems for vulnerable populations -Adolescents -Mental Health -School Health—Reimbursement Mechanism -Adolescent Link—Health Line -Children in private or home school: screening -Alcohol and Drug Treatment Programs -Quality, affordable child care	<b>Other Studies</b> Title V Needs Assessment Health Improvement Plan (State) Primary Care Analysis
<b>Need for Professional Education</b> -Ensure professional competency: screening issues, -Coaches knowledge about injury prevention and appropriate treatment of sport injuries -Role of Public Health -How to access services	<b>Other Studies</b> Title V Needs Assessment FIMR Health Improvement Plan (State)

It is only when one has come so far, that one realizes how far they still have to travel. So true, Maryland has one of the most progressive comprehensive health care delivery system, and it is only when so many of the vulnerable population's needs are met are you able to look at subpopulations and determine what still needs to be done. To more effectively plan intervention strategies it is noted that surveillance and user friendly systems must be in place. Maryland is just beginning to put these in place: e.g., PRAMS, CFR System to compliment the existing FIMR System, the opportunity to hire a senior epidemiologist as a result of being awarded the CSTE grant for FY 2001. What has been noted as a result of this assessment is the great needs of

adolescents and the need of health professionals to have in-depth, continuing education on a variety of public health concerns and services.

Discussion: Maryland is currently doing the following:

- Evaluating how to address the adolescent issues and the development of a system of care
- Beginning to enhance its MCH epidemiological structure.
- Initiating with the intent of expanding community health assessments.
- Providing ongoing provider education.

**The Health Needs of Children with Special Health Care Needs**

<b>CSHCH—Direct Service— Problems Identified</b>	<b>Supporting Documentation</b>
Access to Comprehensive Health Care within the Community -Medical Home -Access to Subspecialty Care, in or near home -Genetic Clinics, unknown -Financial Support for follow-up laboratory tests, including genetic laboratory tests. -Undocumented, non-citizen child -MCO Formulary does not cover prescriptions	<b>Other Studies</b> Title V Needs Assessment Dental Survey LHD Priority Needs FIMR BRFS Community Assessment (Tri-County Eastern Shore, Allegany Co.) Core Funding (LHD)
<b>Access to comprehensive, continuous ancillary health services.</b> -Mental Health Services for child and family, particularly when mainstreaming -Dental Health Services	<b>Other Studies</b> Title V Needs Assessment Dental Survey Health Improvement Plan (State)

Prior to the implementation of MCHP, the vast majority of families up to 185% of FPL had subspecialty services or ‘wrap-around’ services provided by the CMS Program. With the advent of MCHP all of these families were enrolled in MCHP and subsequently became eligible for primary care coverage as well as subspecialty services. This transition resulted in clients leaving physicians familiar with their child and the child’s medical condition and being assigned to a provider, often a general practitioner who had limited experience with the medical conditions. The fragmentation that resulted when families left the public health clinics, also occurred for CSHCN and their families. Both the CMS Program and the Medical Assistance Program has been working on alleviating the families concerns. MCHP has been in existence since July 1998.

Discussion: Maryland has developed several interventions to assist CSHCN and their families:

- The eligibility for CMS Programs was expanded to be the same as MCHP, thereby preventing confusion and interruption of services.
- The CMS Program provides funding for the undocumented to access health services and wrap-around services, for example, medication not covered on the formulary, hearing aids, etc.
- Nurse-consultants have established linkages with the MCHP-MCOs and provide guidance and technical assistance to ensure continuum of care and role of public health in complementing the MCO services.
- Funding is provided to LHD through categorical grants and core funding and university subspecialty clinics for genetics and CSHCN.
- CPHA through SSDI funds is conducting a pilot CSHCN dental study to determine what are the dental practice needs that must be addressed for this population. It is anticipated that the results will be available in time for next year’s application.

CSHCN—Enabling Services—Problems Identified	Supporting Documentation
<b>Care Coordination</b> -Transportation and Translation Services -Family Support System -Follow-up to Genetic Counseling	<b>Other Studies</b> Title V Needs Assessment Core Funding—LHD State Grants to LHD CMS Redesign Evaluation
<b>Respite Care</b>	<b>Other Studies</b> Title V Needs Assessment Priority Needs—LHD CMS Redesign Evaluation

Parents of CSHCN and their providers are a highly visible advocacy group who readily volunteered for interviews and focus groups (Title V Needs Assessment). Parents of children who have special needs perceive their children as ‘invisible’. Confidentiality procedures have often worked against parents who need to link with other parents who have children with similar medical

conditions or developmental concerns. Resolving this issue would enable parents to develop a more effective advocacy group on behalf of their children.

Maryland is currently providing the following interventions:

- Developing Children’s Link, health information line to enhance communications amongst families. This is in addition to the current 800 line.
- Supporting Parents’ Place, Maryland’s chapter of Family Voice.
- Providing care coordination services, including continuing education programs for professionals.
- Developing a respite care initiative.

CSHCN—Population-Based Services— Problems Identified	Supporting Documentation
<b>School Health Program</b> -Chronic medical conditions are putting strain on general school health service	School Health Survey
<b>Child Abuse, especially emotional</b> -Need for Education -Need for Parental Support Services	Title V Needs Assessment
<b>Early Intervention/Transitional Planning</b> -Screen, Refer and Access Services	Title V Needs Assessment
<b>Family Planning</b> -Pre-conception Counseling -Genetic Counseling	State MCH Office Reports

While making up approximately 8-10% of the total child/adolescent population, in some subpopulation this percentage may actually approach 20%. Because of improved medical technology, many children who previously would have either not survived infancy or early childhood are now living throughout the spectrum of childhood and entering young adulthood. This advancement not only places more demands on the health delivery and education system with limited resources, but also requires providers and insurance companies to refine their current way of thinking. Mental health counseling for preventive intervention, coupled with early intervention and ongoing therapy intervention is a must for these children to reach their fullest potential. And as with all adolescents, these adolescents and young adults ‘fall-in-love’, wish to marry and have children. This requires appropriate services from culturally competent providers to assist them as they transition into adulthood.

Discussion: Maryland provides the following strategies to assist CSHCN:

- Pre-conception and genetic counseling on the State level.
- Active Early Intervention Program linking CPHA and the various local public schools to ensure services.
- Technical assistance to MCOs to understand that therapeutic intervention is often necessary not to promote improvement, but rather to prevent regression.

CSHCN—Infrastructure Services—Problems Identified	Supporting Documentation
<b>Statewide System of Care for CSHCH</b> -Out-of-State access areas bordering PA, WV	<b>Other Studies</b> Title V Needs Assessment Health Improvement Plan (State)
<b>Provider Education</b> -General Practitioner -School System: Educator	<b>Other Studies</b> Title V Needs Assessment School Health Survey
<b>Housing, requirements</b> -Transitional housing, young adults	Title V Needs Assessment
<b>Surveillance System</b> -Extent of population, location, diagnosis, access issues unknown -Linkage for families	<b>Other Studies</b> Title V Needs Assessment Health Improvement Plan (State) CMS Program Evaluation

This section provides the reader with the realization of the complexity of these children and their lives, yet to date we still do not know, who and how many CSCHN are in the State much less their needs. Until that information is known, an effective, reliable system of care that will extend to young adulthood will not occur. What is known is if the child has SSI even when they reach 19 years of age they will have medical assistance, because Maryland links SSI eligibility with medical assistance. Maryland had embarked and negotiated to expand the CSHCN/SLAITS telephone survey in the hopes of obtaining some of this information. Unfortunately the service was costly (\$100,000) and still would not have provided the information needed to accomplish system planning.

**Issues that Encompasses the Entire MCH Population, not a Specific Group**

As a result of the needs assessment several issues surface that do not neatly fit into the population or MCH service groups. Rather they are broader, reaching areas and are listed below:

- Absence of any discussion of adolescent, young adult males
- Role of poverty influencing wellness
- Job training and quality employment for young adults to enable them to stay or return to the area after college
- Hopelessness of community leaders and communities in general
- Poverty increasing on Eastern Shore and Western Maryland, unlike the rest of the state, while child abuse/neglect, substance misuse and decrease in school readiness increases.
- **Maternal and Child Health Infrastructure**
  - Need to improve Epidemiological Capacity
    - Surveillance, MIS, Special Studies
    - Community Assessments
  - Financial Capacity
    - Tracking of Title V as it increases in complexity
    - Budget and fiduciary responsibility
  - Administrative Capacity
  - Professional staff with appropriate skills
  - State personnel process
- Community, Liaison Capacity
  - Legislative
  - Community, Professional Partnerships

### **Maryland's Health System Strengths**

When doing a statewide needs assessment, it is so easy to focus on barriers, unmet needs, emerging issues, such as reimbursement of preventive screening, counseling and health services provided in school, environment issues such as lead poisoning and asthma and client dissatisfaction. However, Maryland was very fortunate when conducting a variety of assessments including the Title V needs assessments to learning of the strengths of the system. Below is a brief list of those strengths broadly stated:

1. Public Health Nursing Care Coordination
  - Advocated for disenfranchised client
  - Reduced barriers to care

- Ensured rapid access of pregnant women to care
  - Enabled access to dental services, substance abuse treatment, subspecialty care
2. School Health Programs
- School based health clinics were viewed as a plus for communities
  - Communities were willing to accept a modified school health clinic program
  - Communities felt assured when full-time nurses were in each school
  - Teenagers viewed school nurses as the best source for health information
3. Local Health Department Programs
- Communities liked One-Stop Shopping System of LHD
  - Physicians believed that care coordination done by LHD was an asset
  - Providers believed only LHD really knew the referral process
  - Communities that had home visiting services for all new mothers were viewed an added benefit of the quality of life in the community
  - Communities liked the partnership with businesses that provider ‘coupons’ for families when a child completes the milestone immunization level
  - LHD that provide care coordination for the provider were viewed as an asset
4. Increase, comprehensive financial eligibility of MCHP
- Working poor had comprehensive coverage for children for first time
  - Pregnant women had full service to a variety of care beyond maternal health
  - Pregnant women were under MCHP at higher financial level
5. Families liked the pediatric care received from pediatricians

#### Summary of Needs Assessment Findings: Problems, Gaps and Barriers

- Inadequate access to care, particularly uninsured
- Lack of accessible health care providers in some regions of the State, particularly for dental and mental health services
- Need improved systems of care for vulnerable populations, including adolescents and CSHCN
- Need more care coordination services to address system fragmentation
- Need additional resources and improved surveillance systems to environmentally health issues such as asthma and lead poisoning

- Need additional interventions to address injury and safety concerns such as domestic violence and sports injuries
- Need to promote Life-long Learning/health promotion
- Need to strengthen state and local infrastructure building activities
- Need to eliminated/reduce health disparities

### 3.2 Health Status Indicators

Please refer to Forms C1-C3 and D1-D2 in Supporting Documents, Sections 5.4 and 5.6.

#### 3.2.1 Priority Needs

As stated in the previous section while the needs assessment has enabled Maryland to identify specific issues for a given population, until a more detailed analysis can be undertaken (during FY 2001), Maryland will continue to provide the services identified as in the Annual Plan (4.0). The additional analysis is necessary because of new, yet non-quantitative items identified and the need to more accurately determine various health disparity causal relationships.

Beginning with last year and continuing through this year, Maryland will continue to reallocate funds towards the base of the MCH Service Pyramid, thereby more accurately reflecting the core public health functions. A review of the MCH priorities concluded that our priorities when slightly modified are appropriate and even more timely than reflected its previous applications. While the priorities are numbered, the assigned number does not reflect its importance rather a general relationship to where the priority relates to the MCH Service Pyramid. It should be noted that given the manner in which this list is constructed many of these priorities related to more than one section of the pyramid. For the purpose of this application the priorities were reorganized to closely reflect the order of the pyramid from direct services to infrastructure building. However, the MCH Program believes all of the priorities are of equal importance and must be considered in relation to each other.

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

The needs assessment indicated a need to expand this priority because accessing substance abuse treatment impacted on accessing early and maintaining pre-natal care, thus improving pregnancy

and newborn outcomes. In addition, throughout the state there was an expressed need to have and to be able to access mental health services. The mental health status during and after pregnancy often was cited in various FIMR analysis. In addition, it was often stated as an increasing need for children to ensure success in school as well as not engage in risk-taking behaviors. In the previous application this was priority number 3.

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

This priority was expanded to include preventive environmental measures since many of the jurisdictions still do not have fluoride in their water system either because of political action or because of the use of well water. [Recently one jurisdiction (with the worst dental caries rate of the state) elected to begin using fluoride for the first time in its history, while another jurisdiction stopped using fluoride when building a new water treatment facility due to cost.] Access to care regardless of the family's income continues to be an issue throughout the state but in particular on the Eastern Shore and in Western Maryland. By the same token, medical assistance clients have the greatest difficulty regardless of their residency because of reimbursement rates and reluctance on the part of dentist to accept medical assistance clients. This was priority #9 in the previous application.

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

This priority was greatly revised to reflect the commitment of CPHA, MCH programs to eliminate health disparities. A review of much of the vital statistics and hospital discharge data reflect significant difference between African-Americans and Caucasian-Americans on both morbidity and mortality. A concerted effort will be undertaken to determine the causative factors of key disparities, such as domestic violence and asthma. This priority separated morbidity and mortality because of the significant mortality rates in Maryland. The later is covered below in priority #7. In last year's application this priority was # 5.

4. *Ensure that the genetic contribution to infant and children's mortality, morbidity and disability continue to be addressed within the Title V Programs.*

This priority was unchanged. It became evident (Statewide Assessment) that most providers and the general population were unaware of the genetic clinics in the State and the various services including

care coordination. The MCH Program will be expanding its genetic activity through universal newborn hearing screening and linking genetic and CSHCN clinics and outreach efforts statewide. This priority was #8 in last year's application.

*5. To ensure healthy births by a reduction in the rate of low birth weight.*

This became a new priority because of the persistent low birth weight among African-American newborns and its contributing factor to fetal and infant mortality. It is anticipated that the implementation of PRAMS may assist us in identifying factors that can be modified through public health intervention.

*6. To prevent and/or reduce child, adolescent and CSHCN morbidity that results in lack of school readiness and increased school absentee rate.*

Throughout the statewide needs assessment and the community assessments both qualitative and quantitative data revealed that morbidity is increasing among students due to asthma, dental caries, mental health concerns and risk-taking behavior. This was not only contributing to a lack of wellness on the part of the students, but also, contributing to poor school performance. Significant number of adults expressed a concern that our children were at risk and that the risks were increasing. Asthma is currently the leading reason for school absenteeism in Maryland and it disproportionately affects African-American children. Morbidity issues are increasing for CSHCN because many health care benefit packages do not understand that preventing further deterioration, rather than improving wellness is the objective of many children's plan of care. Another issue confronting the State is that as more children receive a non-public or home schooling education the school health screenings that routinely have occurred in public schools are not taking place. This priority was written to show the relationship between health and school readiness and performance. This priority was combined from last year's #6 and #7 priority.

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

While this priority has been rewritten to more accurately reflect the priority, it remains as a stand-alone priority rather than incorporated into number 6 above. This not only is a priority of DHMH, but is one of the most easily preventable health disparity issues confronting the African-American population. Baltimore City has a disproportionate amount of the positive lead poisoning children amongst her children when compared to the rest of the State. A recent study indicated that the City's children with the lowest rate of school readiness and school success have the highest rate of positive lead poisonings. This was listed as priority #10 in last year's application.

*8. To reduce mortality of mothers, infants and children by identifying probable and causal relationships and implementing subsequent preventive measures.*

Maryland has made a significant commitment to eliminate maternal, infant and child mortality. Unfortunately, vital statistic data continue to indicate that we are not only significantly higher than the nation and the HP 2000 and HP 2010 Objectives, but that this mortality disproportionately occurs among the African-American population. While there were great strides made on infant mortality, in recent years the rate has been erratic and increasing. This mortality is most evident in Baltimore City and Prince George's County for maternal and infant mortality. Adolescent mortality (for different reasons) is disproportionately higher in Baltimore City and on the Eastern Shore and Western Maryland than for the rest of the State. Reduction of maternal, infant and child fatalities is a priority of DHMH as well as the elimination of health disparities. This particular priority was separated from last year's priority #5.

*9. To actively involve families, advocates and other stakeholders in the solution strategies involving the MCH population.*

Throughout the assessment, especially when discussions involved families of CSHCN it was evident that parental and advocate involvement was necessary. This was further expressed by the need to more effectively network for change, however confidentiality laws were hampering this effort. All families recognized the need for privacy laws. This priority the same as last year's was previously listed as #4.

*10. To improve the MCH public health information/surveillance, epidemiological capabilities including community assessments.*

The various assessments that the MCH Program developed during the past two years have enabled us to more accurately identify our epidemiological needs and state decisive steps to ensure that we achieve full epidemiological capacity. This Statewide assessment enable us to more easily identify data elements and systems that are lacking, yet needed to make sound public health programmatic decisions and policy. CPHA has identified this as an MCH Program priority. The priority has been expanded to include community assessments, thereby ensuring the viability and quality of the local health departments, but also the need to conduct community assessments on regional issues or in the interim years between the Statewide assessment. Last year this was listed as priority #1.

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

This is a new priority to reflect not only the expectations of the Title V Block Grant, but also Maryland's General Assembly expectations. Maryland has implemented 'Managing For Results' that links program objectives, outcomes and budget allocation. The MFR process is to be yearly reported. The State Budget Office accepted the use of MCHB performance measures as the unit of measure for the MCH Program.

Maryland does not view this list as static or complete, rather as new knowledge is gained, the priorities will evolve to reflect the needs of Maryland's individuals and families. The current assessment already indicates a need to further evaluate (1) the role of care coordination; (2) health delivery systems for adolescent males, especially 18-24 year old age group; (3) the health delivery system for women when not pregnant, including the 18-24 year old age group; (4) the role of life-long learning and (5) the need to form partnerships beyond the traditional public health partnerships. Until further analysis is made programmatic development and resource allocation is not possible.

Below is a listing of the eleven priorities without the rationale for their selection. It is anticipated that any future modifications in the State's negotiated measures will be a reflection of these priorities.

#### **Maryland MCH Priority List—2001**

1. To improve access to quality health care, including substance abuse treatment and mental health care to Maryland's pregnant women, mothers, infants and children/adolescents including children with special health care needs.
2. To improve access to oral health care for children, including instituting preventive environmental measures.
3. To eliminate health disparities and reduce morbidity of pregnant women, mothers, infants, children and adolescents, including children with special health care needs.
4. Ensure that the genetic contribution to infant and children's mortality, morbidity and disability continue to be addressed within the Title V Programs.
5. To ensure healthy births by a reduction in the rate of low birth weight.
6. To prevent and/or reduce child, adolescent and CSHCN morbidity that results in lack of school readiness and increased school absentee rate.
7. To prevent, identify, screen and treat children for lead exposure and lead poisoning.

8. To reduce mortality among mothers infants and children.
9. To actively involve families, advocates and other stakeholders in the development and implementation of strategies involving the MCH population.
10. To improve the MCH public health information/surveillance, epidemiological capabilities
11. To develop performance and outcome measures, thereby, ensuring public accountability

### **3.3 Annual Budget and Budget Justification**

#### **3.3.1 Completion of Budget Forms**

Refer to budget columns of Form 2, Form 3, Form 4 and Form 5, in the Supporting Document Section.

#### **3.3.2 Other Requirements**

##### Maintenance of Effort

Maryland meets the maintenance of effort requirement of Sec. 505 (a)(4).

##### Justification

Maryland allocates the Maternal and Child Health Block Grant funds using a criteria that includes (1) unmet health need based on assessments, (2) local health department fiscal shortfalls within the identified core categories, (3) level of poverty and estimated maternal and child (birth-21 years of age) population, and (4) performance measures and outcome measures. Funds may be reallocated throughout the year when unexpected needs are identified. (Budgets are developed two years prior to authorized spending. For example during the summer of 2000, the MCH Budgets for FY 2002 are developed. During the 2001 Legislative Session, the FY 2002 will be approved with possible modification.) Throughout the development and subsequent expenditure of the MCH budget, the grant is fiscally and programmatically monitored to ensure that the funding levels adhere to the “30-30-10” Title V requirement. In addition, throughout the two-year process, but particularly during the budget development and the revision phase (based on legislative authorized budget), the MCH Offices evaluate the MCH Service Pyramid fiscal allocation to ensure that it reflects the spirit and intent of MCHB. For this, the FY 2001

application, the budget allocation is based on budgets developed during the summer of 1999 and with slight revisions as a result of the legislative session.

LEVEL OF SERVICE	MATCH
Direct Service	11.89%
Enabling Service	48.61%
Population Service	9.67%
Infrastructure Service	29.82%

30-30-10	MATCH
Preventive/primary/Child	41.38%
CSHCN	31.38%
Administration	3.31%
Maternal/infant	23.94%

The budget for FY 2001 incorporates (1) national performance measures and outcomes, (2) Maryland’s priorities and performance measures, (3) impact of the expansion of HealthChoice’s and MCHP eligibility and services—therapies are now paid for by Medical Assistance rather than being a carve-out, (4) legislative mandates for universal hearing screening, increased lead poisoning prevention activities, maternal mortality and child fatality review results, and (5) final stage of the CSHCN Redesign.

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

Any amount payable to the State under this title from allotments for this fiscal year which remain unobligated at the end of that year are carried forward and obligated in the following fiscal year.

The State share in MCH services is considerable, more than meeting the requirements for state match. State appropriations dedicated to MCH related activity include:

- Early Intervention Services
- Genetic Screening and Genetic Services

- Immunization, Vaccine Distribution
- Lead Prevention Programs, including Laboratory Analysis
- School-based health centers
- State Core Funding Grants to LHD
- Family Planning Services
- HIV/AIDS Services, including Counseling and Testing Services
- Local Health Department Services
- Communicable Disease Services, including STD and Tuberculosis
- Medical Assistance through HealthChoice and MCHP
- Substance Abuse Services
- Mental Health Services
- Juvenile Justice Services

Federal Sources of MCH related dollars other than the block grant include:

- Early Intervention, Part C
- Centers for Disease Control and Prevention (Immunization, Public health Infrastructure, including INPHO Grant)
- Abstinence Education
- Family Planning
- WIC
  
- HIV/AIDS
- SSDI (Community Assessments, Epidemiology)

### **3.4 Performance Measures**

#### **3.4.1 National "Core" Five Year Performance Measures**

Maryland's five year targets for each of the national and state performance measures are provided on Form 11 which is located in Section V, Supporting Documents. The methodology for determining the five year targets will be revisited during FY 2001 and appropriate changes will be made.



**Figure 4**  
**PERFORMANCE MEASURES SUMMARY SHEET**

Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	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
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	PBS	IB	C	P	RF
1) Percent of children aged 0-72 months screened for lead poisoning/exposure by blood testing			X		X		
2) Percent of at risk infants receiving one or more prevention focused home visits within the first eight weeks of life			X				X
3) Asthma mortality rate (per 1,000,000) among children aged 1-14			X			X	
4) The degree to which the State CSHCN program implements key components of a strategic plan to redesign the program.				X		X	
5) Percent of women who do not smoke pregnancy			X				X
6) Congenital syphilis rate in Maryland		X					X
7) The percent of perinatal health care organizations that participate in a statewide perinatal data system.				X	X		
8) Percent of infants with abnormal newborn screening tests who are followed-up			X			X	
9) The rate of deaths to children aged 1-4 caused by sickle cell disease		X					X

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

### 3.4.1.1.1 Five Year Performance Objectives

Maryland's five year performance objectives for each of the national performance measures are provided on Form 11 which is located in Section V, Supporting Documents.

### 3.4.2 State "Negotiated" Five Year Performance Measures

#### 3.4.2.1 Development of State Performance Measures

During FY 1998, Maryland developed nine state performance measures based on priority needs and the availability of data to measure progress. These nine measures are outlined below. Maryland has developed nine State performance measures as outlined in the "the Negotiated Performance Measure Detail sheets contained in Section V, Supporting Documents, Section 5.6. The selected negotiated measures were chosen based on review of

trends in vital statistics data, program data, and discussions with program staff which documented the need to:

1. Increase lead screen rates - currently only 14% of Maryland children aged 0-6 receive lead screening by blood test
2. Reduce child abuse and neglect and improve child health outcomes through preventive efforts such as nurse home visiting.
3. Reduce asthma related morbidity and mortality.
4. Implement the CMS Redesign Plan
5. Reduce smoking during pregnancy
6. Reduce congenital syphilis
7. Establish a perinatal data system
8. Assure that infants with abnormal screening tests receive follow-up
9. Reduce mortality due to sickle cell disease.

These negotiated measures are subject to change based on findings from the comprehensive needs assessment to be finalized in FY 2001. The results of this needs assessment will be thoroughly reviewed and discussed among key MCH stakeholders in FY 2001. As Maryland prepares to develop a comprehensive 5 year MCH strategic plan, it is expected that MCH priorities may shift, and consequently, it is expected that there will be changes to the State negotiated performance measures. This process will provide an opportunity for the State to identify priority needs and performance measures in a more systematic, data drive manner.

#### **3.4.2.2 Discussion of State Performance Measures**

##### **3.4.2.3 Five Year Performance Objectives**

Maryland's five year performance objectives for each of the State performance measures are provided on Form 11 which is located in Section V, Supporting Documents.

##### **3.4.2.4 Review of State Performance Measures**

Maryland looks forward to discussions and negotiations on our State performance measures during our annual review session in August 2000.

#### **3.4.3 Outcome Measures**

Please refer to Form 12 in the Supporting Documents section.

#### **IV. REQUIREMENTS FOR THE ANNUAL PLAN [Section 505 (a)(2)(A)]**

##### **4.1 Program Activities Related to Performance Measures**

With this submission of the FY 2001 Annual Plan, the State of Maryland continues to demonstrate its commitment to improving health outcomes for the MCH population. Given that Maryland had limited surveillance, data information systems and MCH epidemiological support, the MCH Offices elected to undertake a qualitative and quantitative needs assessment through a contractual arrangement with Johns Hopkins School of Hygiene and Public Health (quantitative) and University of Maryland School of Nursing (qualitative). Simultaneously various other assessments were undertaken, most notably the Health Improvement Plan and Community Needs Assessment for Adolescents. For the purpose of this application all of these assessments were linked and compared to various State funded grant proposals from LHD and community based organizations. Given the complexity of this undertaken and the timing of the receipt of some of these reports, the State has elected to maintain the intervention plan developed during the summer of 1999 for FY 2001. Thus, for the FY 2002 application a revised strategic plan will be presented with possible reallocation of resources and/or identification of new sources of funding. The State priorities and the State negotiated performance measures will in all likelihood also be modified. Any modifications will be based on (1) various health status indicators, results of various assessments, surveillance information (2) role of the MCH Offices and (3) community and legislative concerns.

A summary of the FY 2001 plan for each of the three MCH population groups follows:

##### Pregnant Women, Mothers and Infants

- Continuation of maternal health infrastructure building activities (IPO and Crenshaw)
- Continuation of FIMR
- Expansion of Maternal Mortality Review begun in FY 2000
- Implementation of PRAMS
- Continuation of Family Planning services including preconception health care

##### Children and Adolescents

- Continuation of enabling and population-based services
- Implementation of Child Fatality Review (CFR)
- Testing and Implementation of the Lead Target Plan

- Continuation of a media campaign for childhood asthma and evaluation of possible surveillance options
- Evaluation of options for developing an adolescent system of care
- Continuation of the Abstinence Education Program

#### Children with Special Health Care Needs

- Expansion of program eligibility
- Continuation of direct services for eligible children
- Expansion of enabling services
- Implementation of the Universal Hearing Screening Program
- Evaluate approaches to implementing a Statewide system of care
- Implementation of regional resource services
- Evaluation of options for funding respite care, a new initiative

It is anticipated that FY 2001 will be a challenging and exciting year. During the coming year, a team will be formed to review and analyze the various assessments to develop an MCH strategic plan that identifies priorities, intervention strategies, and time frames. Team members will include representatives from the MCH Program, local health departments, MCH grantees and vendors, family representatives, other MCH stakeholders. Additional data and information will be available to the State as a result of PRAMS, the hiring of senior level MCH epidemiologist, and availability of the results from various community-based MCH needs assessments.

The FY 2001 annual plan which follows describes the relationship between Maryland's MCH priorities, the National and State performance measures and the role of Title V programs and activities. Performance measure related activities are described by level of pyramid and service population groups. Maryland's two MCH units will work as a team along with other administrations and agencies to accomplish the targets set for each of the performance and outcome measures.

#### **4.1.1a. Direct Preventive and Primary Services for Pregnant Women, Mothers and Infants**

Since FY 1997, the Center for Maternal and Child Health, (formerly the Office of Maternal Health and Family Planning and the Office of Children's Health) has significantly shifted its focus from direct health care services to infrastructure building services and to a lesser degree enabling and population based services. However, in order to adequately address the priority needs of improving pregnancy and birth outcomes, there remains a need to fund and support direct health care services particularly for such vulnerable mothers, infants and adolescents. During FY 2001, the CMCH will continue to administer the Title X funded Family Planning Program with the goal of reducing the numbers of unplanned, unintended pregnancies. This Program will also continue to provide screening and treatment services for any infections identified.

It is expected that the *Family Planning Program* will provide comprehensive services to over 70,000 women in FY 2001. Preconception health services have been incorporated into *the Family Planning Program* as a standard of care. Preconception health can help women optimize their health before pregnancy and thereby avoid adverse pregnancy outcomes, such as low birth weight. Women who receive preconception counseling are also more apt to plan their pregnancies and receive early prenatal care. Since the unintended pregnancy rate is approximately 50%, offering preconception health services to all women of reproductive age regardless of whether or not they are actively planning a pregnancy will capture a large segment of the population who would not normally benefit from this counseling. In FY 2001, awareness of the need to consume folic acid to prevent neural tube birth defects will also continue to be promoted by every health department to women of childbearing age. Colposcopy services as well as cervical and breast cancer screening will also continue to be provided in areas of the State with limited health care providers.

#### **4.1.1b. Direct Preventive and Primary Services for Children and Adolescents**

During FY 2001, the Title V program will continue the process begun in FY 1999 of redirecting preventive and primary care program activities and funds from the provision and payment of direct services to enabling, population based and infrastructure building services. However, block grant funds will continue to be used to address the direct health care needs of school-aged children as well as uninsured and underinsured children and adolescents who continue to lack access to care.

In FY 2001, the CMCH, under the *Comprehensive Primary Care Services Program*, will continue to fund the Children and Youth (C&Y) Program in Baltimore City to provide preventive and primary care services to uninsured and underinsured children and adolescents. Strategies to move the C& Y Program and its subgrantees away from the provision of direct care to a greater focus on enabling and population based services will continue in FY 2001. Efforts to move greater numbers of uninsured children into the MCHP Program will continue. New programs concerned with asthma prevention and teen health promotion will be implemented. The program will target infants and young children through age 6 and older adolescents. Children less than age 6 will be screened for possible lead exposure and poisoning. Services will be targeted to areas and socioeconomic groups who experience difficulties in accessing medical care due to such barriers as poverty, substance abuse and recent immigration.

The FY 2000 Title V needs assessment identified a need for comprehensive, continual health care coverage for women beyond pregnancy. This continual coverage is especially critical for immigrant and undocumented women who are not eligible for Medicaid/MCHP services. The CMCH plans to further explore this issue and options to address it during FY 2001.

The needs assessment noted signs of increasing morbidity among school aged children in Maryland. Asthma, ADHD, and depression were identified as acute concerns. About half of Maryland schools have comprehensive school health programs and during this past Legislative Session, legislation introduced to use part of the State's tobacco settlement monies to fund school health programs in every school, failed. The School Health Program will continue to monitor attempts to improve access to school health services and to actively seek new funding opportunities. This coming year, the *School Health Program* will support the provision of primary health services to pre-adolescent and adolescents students enrolled in school health programs, including school based health centers. Title V funds will partially support four school based health centers and will also continue to be used by local health departments to support school health programs throughout the State.

#### **4.1.1c. Direct Preventive and Primary Services for Children with Special Health Care Needs**

Maryland's CSHCN Program, coordinated by the new Office for Genetics and Children with Special Health Care Needs, continues to transition from direct services to enabling,

population based and infrastructure building services. This shift is the result of the transitioning of eligible children to MCHP. The number of children served through the Title V funded CSHCN direct services decreased from 12,000 in FY 1997 to 2,000 in FY 2000. During fiscal year 2001, the income eligibility standards for the CSHCN Program will increase from 200% of the federal poverty level (FPL) to 300% of the FPL. As a result of this increase, it is anticipated that an additional approximately 18,000 CSHCN will be financially eligible to apply for direct services funded through the CSHCN Program in FY 2001. Approximately 4,300 of these CSHCN will be without health insurance and, therefore, likely to apply. Direct care services will also be targeted to older adolescents (19-22), undocumented children, and children requiring special services not covered by Medicaid.

***Specialty and Subspecialty Services (Performance Measure 02: The degree to which the State CSHCN Program provides or pays for specialty and subspecialty services, including care coordination)*** -- Direct care services for CSHCN are primarily specialty care services provided through tertiary care centers in Maryland. Specialty care services are provided by referral from primary care providers or through specialists continuing to serve established clients. Covered services will continue to include inpatient and outpatient care, medical and sub-specialty care, OT, PT, speech, hearing services, medical equipment and supplies, nutrition services, developmental and neurologic assessments, early intervention services and care coordination. Under the CSHCN Five Year Action Plan, these services will continue to be provided to eligible children who are not otherwise covered for these services.

Specialty services may be difficult to access in some areas of the State even for children who are covered by private insurance. In FY 2001, the CSHCN program plans to pursue funding arrangements with the tertiary care Centers of Excellence to support provision of these services via a network of outreach clinics. Services will be provided to all children needing them including financially eligible children and children who are otherwise unable to access them despite insurance coverage. These arrangements will remove geographical barriers to accessing specialty care services.

***Rehabilitative Services (Performance Measure 01: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN Program)*** -- All children receiving SSI in Maryland are eligible to receive services through the

Medicaid Program which provides medically necessary specialty services. Because Maryland's Medicaid Program provides a comprehensive package of primary and specialty services including rehabilitative services, the CSHCN program expects that less than 1% of the State's SSI beneficiaries under age 16 will receive supplemental services through Title V. SSI enrolled children in need of additional services receive them in the same manner as non-SSI enrolled children. Rehabilitative PT/OT services are provided under HealthChoice as carved out services. SSI children needing assistance in accessing these services may be aided by Health Choice special needs coordinators. Should additional assistance be needed, the Title V program will assist them. Since the list of SSI eligible children is provided to the Title V program on a regular basis, these children will be contacted to make them aware of the services available and encouraged to call for any needed assistance.

*Genetic Services* --Direct care services for genetic disorders and birth defects will continue to be provided through a cooperatively funded network of genetics outreach clinics and voluntary agencies. With the advent of HealthChoice and MCHP, fewer children in some areas (the upper Eastern Shore and Carroll County) are utilizing the network's clinics. Most local health departments are no longer Medicaid providers and, therefore, cannot refer children to the clinics. Another reason is that many MCOs have contracted for specialty care with institutions other than those providing the local outreach clinic and, therefore, will not utilize the clinic. In FY 2001, OGSNC will continue to fund grants to the four institutions comprising the network that delivers direct care services for genetic disorders and expects to provide services to approximately 1,500 children and their families (approximately 8,000 individuals). The clinics in Cecil and Carroll counties have been discontinued and other arrangements for providing the services to these areas are being explored.

***Medical Child Care Program*** -- Another direct service to be funded by OGCSHCN is the Medical Child Care Program which began in FY 1991. This Program provides specialized day care for Maryland children aged six weeks to three years who have complex medical conditions or needs which preclude their attending traditional day care centers. Title V will continue to support two centers located in Baltimore and Montgomery Counties in FY 2001. These centers will offer full-time nursing supervision, developmentally appropriate child care services, social work services, and parent education and support for up to 85 eligible children each year. An evaluation

of the costs and outcomes for these children is in process through a Memoranda of Agreement with the Schaefer Center at the University of Maryland at Baltimore and the Center for Health Program Development and Management at the University of Maryland, Baltimore County.

#### **4.1.2a. Enabling Services for Pregnant Women, Mothers and Infants**

Enabling services are essential to improving birth and pregnancy outcomes because they improve access to health care services. In FY 2001, the CMCH will continue to provide enabling services for pregnant women, mothers and infants. These services will include support for nurse home visiting services, the MCH Hotline, outreach to special populations, and outreach, education and monitoring activities to prevent congenital syphilis. In addition as pointed out in the needs assessment, Title V will examine further ways, such as expanding the provision of transportation services and translators, to extend enabling services to the pregnant women and infants.

The *Healthy Start Home Visiting Program* is projected to provide services to at least 5,000 mothers and infants in FY 2001. Home visiting programs provide care coordination, promote immunizations, offer and monitor referrals for health services, and provide counseling and other supportive services.

***Congenital Syphilis Prevention (MD Performance Measure 06: Congenital Syphilis Rate)*** -- In 1997, Maryland had the highest rate of primary and secondary syphilis of any State in the United States. This was influenced by Baltimore City having the highest syphilis rate of any metropolitan area. In 1997, Maryland had the third highest congenital syphilis rate in the nation. Most of the cases were concentrated in Baltimore City, which had a congenital syphilis rate, nearly twenty times that of the national rate. Maryland and Baltimore City's congenital syphilis rates declined dramatically between 1996 and 1999.

During FY 2001, the Title V Program will continue partnerships with the STD Control Program, the Baltimore City Health Department, the criminal justice system, the CDC, health care provider groups and others to further reduce the number of congenital syphilis cases. Each jurisdiction will promote routine prenatal syphilis screening through perinatal conferences, baby fairs, FIMR educational sessions, and community health fairs. The Congenital Syphilis Workgroup, comprised of members from CMCH, local health departments, and the STD Control Program, developed protocols for case management and tracking of women who test positive for

syphilis and require treatment. In FY 2001, this new protocol will be used to assure adequate testing, treatment, and surveillance of mothers and infants at risk for syphilis.

In FY 2000, educational materials were sent to all obstetrical providers in the State to make them aware of guidelines for syphilis and other STD testing during pregnancy. These materials highlighted a new Maryland State law mandating that syphilis testing be done during the first prenatal visit and at 28 weeks gestation (instead of 3rd trimester). In addition, the Baltimore City Health Commissioner issued an order mandating syphilis screening be done at delivery. Further efforts to educate providers will continue in FY 2001.

#### **4.1.2b. Enabling Services for Children and Adolescents**

In FY 2001, each local health department will continue to provide enabling services to assist children and families in accessing preventive and primary care services. These enabling services include care coordination, home visiting, health education, outreach and inter-agency coordination. LHDs also will continue to work collaboratively with local Departments of Social Services to identify appropriate services for families with infants and children at risk for abuse and neglect and to partner with other agencies and organizations to ensure that home visiting services are coordinated.

The Home Visiting Program works with LHDs to assure the linkage necessary for early identification and referral of at-risk pregnant women, infants and young children. One component of this program is a computer based information system, HGEN, located in 13 of 24 LHDs. This system was designed to support public health nursing interventions and care coordination activities. The system provides health status and outcome data for the targeted population that is used to plan child health care, as well as for program evaluation and development. HGEN will continue to be supported by the CMCH in FY 2001.

As local health departments have transitioned from providing direct service to non-direct care services, they have assumed a key role in ensuring the successful implementation of HealthChoice and MCHP. Community outreach is done to identify children eligible for Medicaid and MCHP. Once eligible children are identified, local health departments assist with the application and enrollment processes. As ombudsmen, LHDs receive referrals from the Medicaid Complaint Unit and provide necessary interventions to resolve complaints. Patient education and care coordination services are provided to recipients referred by the MCOs for not being

compliant with their health care plans. Local health departments plan to continue these activities in FY 2001.

Maryland is home to an increasing number of non-English speaking and bilingual families, particularly in Montgomery County, Prince George's County and on the Eastern Shore. This has been particularly challenging in the Washington Metropolitan area where children in the public school system speak over 100 different languages. On the Eastern Shore, the predominant non-English languages are Spanish and Korean. Local health departments are actively recruiting and employing translators and bilingual staff. Several local health departments will continue to provide translation/language and other enabling services to assist children and families in gaining access to needed services.

The needs assessment identified adolescent oriented systems of care including care coordination for adolescents, health education and health promotion programs to prevent substance abuse, and accessible after school programs as major needs. The CMCH will explore opportunities to address these needs as a part of its strategic planning process during FY 2001.

#### **4.1.2c. Enabling Services for Children with Special Health Care Needs**

In FY 2001, the CSHCN program will continue to develop regional activities to assure community based early identification, outreach and access to resource information and services. The OGCSHCN and the CMCH will work together to compile a data base of all Maternal and Child Health activities undertaken by each LHD, by sending staff to visit each LHD to inventory activities, and will produce a comprehensive statewide picture of Maternal and Child Health activities. A regional service coordinator will be hired to facilitate the development of regional activities. Activities will be developed in collaboration with the LHD, community organizations serving CSHCN, regional family representatives, the Centers of Excellence, and the Maryland Chapter of the American Academy of Pediatrics. These regional activities will also include developing mechanisms for identifying regional service gaps and needs, exploring outreach strategies and evaluating the role of the LHD in provision of specialty services.

Enabling services will be further enhanced through inter-agency collaborative efforts between Kennedy Krieger Institute, Maryland State Department of Education and Maryland Department of Health and Mental Hygiene. This effort provides on-site training and technical assistance for families, school personnel and community service providers throughout Maryland to

maximize the integration of children and adolescents with special health care needs into the educational setting.

In FY 2001, CSHCN will continue its partnership with the Shriner's Hospital through the MCHB funded "Choices Program". As part of this partnership, CSHCN nurses will continue to work with the Shriner's Network to identify children eligible for the CSHCN program or MCHP. The CSHCN program( formerly CMS) also plans to work with the local Boumi Temple to support the development of enabling services such as specialized camps for CSHCN.

***Medical Home (Performance Measure 03: Percent of CSHCN in the State who have a medical/health home)*** -- The CSHCN Program is in the second year of transitioning from predominately direct services to the provision of enabling and infrastructure building services. Title V funds, which have historically supported specialty clinics in LHDs, will continue to be reprogrammed in FY 2001 to permit LHDs to fund activities such as transportation, outreach and education, care coordination, and family support services.

***Sickle Follow-up Program (MD Performance Measure 09: The rate of deaths to children aged 1-4 by sickle cell disease)*** -- Maryland has the lowest mortality rate among young children with sickle cell disease in the nation (0.8 deaths per 1,000 patient years in Maryland vs. 6.8 deaths per 1,000 patient years for the U.S.) The success is largely credited to the OGCSHCN administered Sickle Cell Disease Follow-up Program which will continue to operate in FY 2001. This program follows children with sickle cell disease and other hemoglobin disorders long term, with the following services: case management, home visiting, annual pediatric hematology evaluations (outreach clinics), genetic counseling, parent education, support groups and a summer camp. Eighty percent of pediatric sickle cell patients are enrolled in HealthChoice and sickle cell disease is one of the HealthChoice quality assurance benchmarks. During FY 2001, OGCSHCN will continue to assist Medicaid in performing focused chart reviews and interfacing with providers and MCOs to ensure that the standards established by the Office are maintained.

***Genetic Services*** --Enabling services for children with genetic disorders and birth defects will include case management for approximately 11,300 children with sickle cell disease, 281 children with PKU and other metabolic diseases and 300 patients with hemophilia. Assistance with transportation to medical appointments, social services consultations, home visiting, parent

and patient education and annual health status reevaluation with care plan revision will be provided to these populations as needed.

Throughout the transition to HealthChoice and MCHP, the Office of Hereditary Disorders (now OGCSCHN) has been assisting both the patient and their parents in linking with an MCO. The provider is very frequently a new provider to the patient and their parents. Often, because genetic disorders rarely occur within any given practice, the new provider may have had limited or no experience in the medical management of a given genetic disorder. The OGCSHCN has aggressively identified these new providers and provided education, standards of care and historical plans of care on each patient, some of who have been followed for more than a decade by this Office. The OGCSHCN will continue to provide consultation to these new providers as well as monitor maintenance and access to subspecialists.

The OGCSHCN will continue to fund the Kennedy Kreiger Institute to provide the staff that perform the complex metabolic tests needed by children and adults served by the genetics units at the various university teaching hospitals in the State. The OGCSHCN will also continue to fund the reference laboratory for the inborn errors of galactosemia pathway.

*Campership Programs* -- In FY 2001, Maryland will continue to support special camps for children with sickle cell disease and PKU. Monies will be awarded to the Maryland Alliance of PKU families to hold a PKU camp for affected children and their families. The sickle cell disease camp is supported by a grant to the Maryland Chapter of the Sickle Cell Disease Association of America. Both camps provide counseling and nutritional services as well as extensive networking opportunities for the affected families. The PKU camp provides intensive coaching in how to manage the PKU diet. The sickle cell camp includes academic skill building activities and sickle cell disease-related health education. It is anticipated that at least 150 children will attend these summer camps.

#### **4.1.3a. Population Based Services for Pregnant Women, Mothers and Infants**

This coming year, population based services for pregnant women will continue to focus on preventing teen pregnancy; promoting abstinence education, and improving birth outcomes by reducing smoking during pregnancy and promoting the taking of folic acid both prior to and during pregnancy. Population based strategies to improve the health of infants will encompass the

promotion of breastfeeding, newborn screening, hearing screening, and counseling for sudden infant death syndrome.

***Newborn Screening Program (Performance Measure 04: Percent of newborns born in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinathies)*** -- The Newborn Screening Program will continue to identify newborn babies with eight rare and serious disorders of body chemistry: biotinidase deficiency, branched chain ketoacidurais, galactosemia, homocystinuria, hypothyroidism, PKU, sickle cell anemia and Tyrosinemia. Maryland has historically had a strong program of state sponsored services for genetic orders and expects to continue to screen 100% of newborns for the disorders listed above and provide the necessary follow-up for the infant as well as provide counseling, health education and family support to the affected families.

***Universal Hearing Screening Program (Performance Measure 10: Percentage of newborns who have been screened for hearing impairment)*** -- During the 1999 Maryland Legislative Session, a law mandating the establishment of a Universal Newborn Hearing Screening Program within DHMH passed. As of July 1, 2000, this law requires that every baby born in a Maryland hospital be screened for possible hearing loss. As many as 420 of the 70,000+ babies born each year in Maryland are hearing impaired. Screening methods include testing by either Otoacoustic Emissions or Auditory Brain Stem Response.

The Office for Genetics and Children with Special Health Care Needs is responsible for administering the program. The results of each screen are to be reported to DHMH. Any risk factors increasing the baby's chance for a hearing loss are reported along with the results. DHMH will send the results of the screening to the baby's parents and pediatrician. Follow-up services including referrals will be provided by OGCSHCN if the baby is diagnosed with a hearing loss. Additional funding will be provided during FY 2001 for this expanded activity.

***Teen Pregnancy Prevention Program (Performance Measure 06: The rate of births (per 1,000) for teenagers aged 15 through 17 years)*** -- The Maryland Family Planning program will continue to make services for teens a top priority. Local health departments will continue to expand partnerships with provider organizations and community groups such as schools and churches to improve and increase services given to adolescents. The Healthy Teens and Young Adults Project will continue to offer comprehensive, holistic health services to adolescents in

Baltimore City, Prince George's and Anne Arundel counties. The Maryland Abstinence Education and Coordination Program will continue to partner with the Governor's Council on Adolescent Pregnancy (GCAP) to promote abstinence and reduce adolescent pregnancy. Campaign for Our Children, the abstinence based multi-media campaign will continue to run television, radio and poster ads.

***Folic Acid Awareness Campaign*** -- An important part of pre-pregnancy planning is promoting folic acid consumption by all women of childbearing age. The US Public Health Service estimates this will decrease the number of neural tube birth defects in this country by 50 - 70%. The Birth Defects Reporting and Information System in the OGCSHCN also serves on the committee and routinely sends a letter about folic acid to every family reported to the system because of a neural tube defect. In collaboration with the March of Dimes, the CMCH will continue to chair a multi-disciplinary, multi-agency committee to increase awareness and consumption of folic acid by women before pregnancy. During FY 2001, educational and promotional events, will be used to publicize the benefits of folic acid to Marylanders.

***Breastfeeding Promotion (Performance Measure 09: Percentage of mothers who breastfeed their infants at hospital discharge)*** -- Breastfeeding promotion activities both in the WIC program and through local health departments will continue in FY 2001. Local health departments promote breastfeeding by (1) distributing educational materials to preconceptional and pregnant women and (2) supporting educational programs to improve the knowledge of health care providers about breastfeeding. The importance of breastfeeding will also be discussed and encouraged during home visits by public health nurses with pregnant and postpartum women and during WIC nutritional site visits. Local health departments will also continue to sponsor free breastfeeding classes and breastfeeding pump loaner programs.

***Smoking Cessation in Pregnancy Program (MD Performance Measure 05: Percent of women who do not smoke during pregnancy)*** -- Pregnancy is an opportune time to conduct smoking cessation sessions. Patients are motivated to prevent harm to their babies and providers see their patients fairly regularly. The Smoking Cessation in Pregnancy Program will continue to operate in FY 2001. This Program provides counseling and materials to help pregnant women stop smoking. Services are provided by nurses in local health departments and in Medicaid managed care organizations.

#### **4.1.3b. Population Based Services for Children and Adolescents**

In FY 2001, population based services for children and adolescents in Maryland will continue to focus on childhood immunizations, lead screening, childhood injury prevention, and counseling for SIDS:

***Immunization Program (Performance Measure 05: Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis)*** -- According to the National Immunization Survey, approximately 80% of Maryland children are fully immunized by age 3. The CMCH will continue to support Center for Immunizations and LHD efforts to improve childhood immunizations in Maryland during FY 2001. The Center for Immunizations is largely responsible for statewide immunization activities in Maryland. During FY 2001, the Center for Immunizations plans to hire additional nurses statewide to identify and monitor immunization delayed children. Efforts to develop and maintain a statewide immunization registry will also continue. An immunization registry is currently being piloted and it is anticipated that it will be fully operational by FY 2002.

***Childhood Lead Screening Program (MD Performance Measure 01: Percent of children aged 0-72 months screened for lead poisoning/exposure by blood test)*** -- In January 2000 Governor Parris N. Glendening declared that the State of Maryland must aggressively expand its efforts to protect children from the tragedy of lead poisoning. He announced a comprehensive plan to significantly reduce the likelihood that children in low-income neighborhoods, particularly in Baltimore City, will be exposed to toxic lead in the future. During FY 2001, the DHMH will continue to support lead screening as a priority. The CMCH administers the Childhood Lead Screening Program which was legislatively mandated in 1997. The program's goal is to target children under six years of age in high-risk areas who are required to be screened for lead exposure and possible lead poisoning. Under this legislation, funds were appropriated to provide nursing support to two jurisdictions, Baltimore City and Prince George's County, a suburb of Washington, D.C. with historically high exposure rates. Public health nursing staff assure a system of education and outreach to improve the screening rates for childhood lead poisoning and increase awareness of the risk and of preventive measures. Furthermore, CMCH is

mandated under legislation to increase screening and develop educational and outreach materials, assist each jurisdiction, monitor and evaluate the program.

To fulfill this mandate a predictive model for identifying areas most at risk for childhood lead poisoning was developed. Under this model four risk levels were identified. Those children residing in “high”, “moderate” and “low” risk areas will be required to be blood lead tested under new legislation passed in the 2000 legislative session. This legislation is effective July 1, 2000. Those children residing in areas of “undetermined” risk must be given the lead risk assessment questionnaire. In FY 2001 the CMCH plans to test and validate the predictive model. Each LHD will have received information on their risk levels in their jurisdiction. CMCH staff will work with each jurisdiction to develop strategies for outreaching to providers, families and communities to increase blood lead testing across the state. Special emphasis will be made in Baltimore City. Funding will be provided to the City under a new Governor’s Initiative to prevent childhood lead poisoning. Funding will also be provided to the State lab to increase their capacity to process increased numbers of lead specimens. CMCH will continue to work closely with the Department of the Environment and the Department of Housing and Community Development to implement coordinated strategies to prevent lead poisoning. The CMCH will begin to receive quarterly reports on the number of children screened in order to track to progress of implementation of the new laws.

Title V funds will continue to support the Baltimore City Health Department's Lead Paint Poisoning Prevention Project. This grant supports outreach, community education, case management and referral of children with elevated blood lead levels and provides professional and technical staff assistance for families whose homes pose an environmental threat to children. Funding support will also continue to be provided to the Coalition to End Childhood Lead Poisoning to work with CMCH on outreach to providers. It is anticipated that new provider outreach materials will be developed and made more user-friendly to encourage providers to increase blood lead testing.

***Injury Prevention Program (Performance Measure 08: The rate of deaths to children aged 0-14 caused by motor vehicle crashes per 100,000 children)*** -- Motor vehicle accidents are a leading cause of death for children ages 0-14 in Maryland. Over the past decade, deaths due to motor vehicle crashes have been declining. Programs such as the Kids in Safety Seats Program

(KISS) administered by the Office of Health Education as well as other efforts to promote car seat belt compliance through the Maryland Department of Transportation are partially credited with the decline. CMCH is a member of the Statewide Injury Prevention Network which is coordinated by the Office of Injury Prevention.

Through multiple education campaigns involving community/advocate organizations, DHMH has been able to reduce the number of alcohol related accidents that resulted in children's deaths. To further reduce deaths, the KISS Program has developed a public awareness campaign and "check points" for checking that children's car seats are properly installed. Parents have the option of stopping and having the child's car seat evaluated. If incorrectly installed, the State staff correctly installs the car seat and provides instruction on proper installation. If the car seat does not meet federal guidelines a new car seat is given to the child without any cost to the family. This public service program has been very successful and embraced by families. It is anticipated that this will continue during FY 2001.

***Oral Health Program (Performance Measure 07: Percent of third grade children who have received protective sealants on at least one permanent molar)*** -- The Secretary has determined dental health to be a priority area for the Department. In FY 2001, the Office of Oral Health(OOH) will award funds to local health departments to develop preventive oral health programs including, but not limited to the following: school and clinic based dental sealant programs; community water flouridation support; baby bottle tooth decay; pre and postnatal education programs; and spit tobacco education. Title V funds awarded through core funding to local health departments will continue to support oral health programs.

HealthChoice provides comprehensive dental services for eligible children and adolescents. However, the Program is experiencing difficulties in recruiting sufficient numbers of dental providers to address the need. During FY 2001, the OOH will continue to collaborate with the Medicaid Program to identify and recruit pediatric dental providers.

Legislative action taken in 1998 mandated that the DHMH, through the Office of Oral Health, conduct a statewide oral health clinical evaluation of Maryland school children in FY 2001. This survey is to determine and assess oral health status and progress regarding dental caries experience and unmet need, dental sealant use, early childhood caries and access to dental treatment and preventive services. An oral health assessment was last completed in 1995 and was

previously funded by the Office of Children's Health using SSDI grant funds. The CMCH will continue to be an active participant on the Oral Health Advisory Committee and assist with the implementation of the oral health assessment plan.

***Sudden Infant Death Syndrome Program*** -- The Center for Maternal and Child Health will continue to provide ongoing support of the activities of the Center for Infant and Child Loss. This Center conducts the Maryland SIDS Project at the University of Maryland School of Medicine to provide prevention through information and education, as well as counseling to families experiencing a SIDS death. In addition, the Center will provide prevention and health information to professionals throughout the State. The Project also provides other infant related death counseling education and collaborates with CMCH and local and state child fatality review boards. SIDS disproportionately affects African American infants. During the coming year, the Center will continue to target its 'Back to Sleep Campaign' media campaign to African-American communities.

#### **4.1.3c. Population Based Services for Children with Special Health Care Needs**

Regional strategies to promote access to services and other enabling services to CSHCN will also include population-based activities. The availability of information and resources will be available to all CSHCN regardless of their coverage or diagnosis under the OGCSHCN program. Family support services through the regional family networks and representatives will also be available to the entire population of CSHCN.

#### **4.1.4a. Infrastructure Building Services for Pregnant Women, Mothers and Infants**

***Improving Pregnancy and Birth Outcomes --(Performance Measure 15: Percent of very low birth weight live births; Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester; Performance Measure 17: Percent of very low birth weight infants born at facilities for high-risk deliveries and neonates)*** --In FY 2001, efforts to will be made to impact the State's very low birth weight rate through the Improved Pregnancy Outcome (IPO) Program and the Crenshaw Perinatal Health Initiative. The IPO Program began in 1978 as a supplemental Title V grant. Funds were allocated to selected Maryland jurisdictions with the worst perinatal health indicators for the

provision of direct services, case management, and home visiting. Over the years, the IPO Program has evolved from a prenatal care services project into a statewide perinatal systems building program which seeks to improve pregnancy outcomes for the total population. All 24 local health departments, as well as community based organizations, receive IPO funds in order to address core public health functions which benefit all pregnant women and their newborns. During FY 2001, IPO activities will focus on such infrastructure building and populations based strategies as fetal and infant mortality review, provider education, standards development, and assessment.

The goal of the Crenshaw Perinatal Health Initiative is to improve pregnancy outcomes by promoting the development and maintenance of regionalized, interdisciplinary systems for assuring the availability and accessibility of quality patient care services. Funds are competitively awarded to local grantees to develop regional perinatal plans and coordinate community-based perinatal services. Funded activities include (1) building on the findings of local fetal and infant mortality review committees to effect systems improvements, (2) promoting the collections and dissemination of perinatal outcomes data to hospitals for continuous quality improvement purposes, (3) collaborating with community organizations to improve maternal and infant health and (4) providing multi-media public education campaigns.

In FY 2001, the IPO Program and Crenshaw Perinatal Health Initiative will continue community based perinatal systems building at the county and regional levels. Regionalization has enabled 13 counties to link their resources successfully into 3 regions (Southern Maryland: Anne Arundel, Calvert, Charles, St. Mary's, Prince George's, Mid-Shore: Talbot, Dorchester, Queen Anne's, Caroline, Kent, and Lower Shore: Wicomico, Worcester, Somerset). In addition, counties adjacent to other states have forged strong bonds with out-of-state hospitals - Christiana Hospital, Delaware, West Virginia University School of Medicine, and George Washington School of Medicine/Children's Hospital. Perinatal systems building at each county and region will continue in FY 2001.

The Maryland Perinatal Health Initiative is a partnership of the Commission on Infant Mortality Prevention, the Association of Maryland Hospitals and Health Systems, and the Department of Health and Mental Hygiene. This partnership was formed specifically to improve very low birth weight neonatal mortality in Maryland by ensuring all very low birth weight infants

are born at the appropriate subspecialty center - where their chance of survival is greatest. Assurance of each perinatal center's adherence to perinatal guidelines is done through site visits conducted by multi disciplinary members of the initiative. All level I and II perinatal centers have already had site visits.

The Maryland Institute of Emergency Medical Services System (MIEMSS) has statutory authority for designating hospital as specialty perinatal care centers for emergency transport purposes in Maryland. In FY 2000, the CMCH and MIEMSS began working together to improve perinatal health outcomes in Maryland. Part of this collaborative effort involves the setting of hospital standards for levels of perinatal care, on site hospital visits to verify initially and reverify periodically a hospital's compliance with perinatal standards, and the collection and analysis of perinatal health related data and information. This partnership will continue in FY 2001. A database will also be established for maternal/neonatal transports.

***Pregnancy Risk Assessment Monitoring System (PRAMS)*** -- The CMCH and the Vital Statistics Administration began participating in the Pregnancy Risk Assessment Monitoring System (PRAMS) in CY 2000. This is a population based risk factor surveillance system and part of the Centers for Disease Control and prevention initiative to reduce infant mortality and low birth weight. Questionnaires soliciting information about smoking during pregnancy, entry into prenatal care, breast-feeding, folic acid consumption, as well as other important risk factors will continue to be sent to a sample of 2000 Maryland moms who have recently delivered during FY 2001. The initial findings from this first population based survey of women who have given birth in Maryland will be available in FY 2001.

The PRAMS data will be critical for analysis of care for the maternal and infant population. Findings from PRAMS will be used to enhance our understanding of maternal behaviors and their relationship to adverse pregnancy outcomes. This data will aid in the development and assessment of programs designed to identify high-risk pregnancy and reduce adverse pregnancy outcomes.

***Fetal and Infant Mortality Review*** -- Through a multi-year federal Maternal and Child Health Bureau (MCHB) grant awarded to Maryland in 1997, OMHFP started facilitation of fetal and infant mortality review (FIMR) throughout the state. FIMR is a case based process for a specific community to assess problems and then provide opportunities to make corrective changes

in its perinatal systems. Perinatal outcome review has become an important adjunct to developing systems reform. A process for conducting fetal and infant mortality review currently exists for each jurisdiction in the State. The Center for Maternal and Child Health is committed to seeing that FIMR activities continue in FY 2001. IPO Program and Crenshaw Initiative funds support the work of local FIMR committees.

***Maternal Mortality Review*** -- Maryland's maternal mortality rate is significantly higher than the national rate. This past legislative session, bills were passed to address this problem by requiring the DHMH to establish a maternal mortality review process. DHMH is required to identify maternal deaths cases, review records and data, consult with experts and make recommendations regarding prevention of maternal death. Prior to passage of this law, there was no statutory body charged with investigating cause of maternal death in Maryland. Maternal deaths are thought to be under reported due to concerns over civil litigation or criminal prosecution. During FY 2001, the CMCH in conjunction with the University of Maryland School of Medicine will establish a statewide maternal mortality review process with the goal of reducing the risks for maternal mortality for pregnant women in Maryland.

#### **4.1.4b Infrastructure Building Services for Children and Adolescents**

Title V funds have historically supported the delivery of primary health care services to uninsured and underinsured children and adolescents. With the advent of the Maryland Children's Health Program, many children and adolescents who were previously uninsured, now have access to insurance coverage. MCHP began enrolling children in July 1998. As of June 2000, more than 70,000 children and adolescents had enrolled. The success of MCHP in expanding insurance coverage has allowed a shifting in funding emphasis to occur from clinical services to infrastructure building activities.

***Medicaid/MCHP (Performance Measure #12: Percent of children without health insurance and Performance Measure #13: Percent of potentially eligible children in this age group received a service paid by the Medicaid Program)*** -- Lack of health insurance coverage has historically been identified as a major barrier to the receipt of timely health services. Cognizant of this fact, the State of Maryland implemented the Maryland Children's Health Insurance Program (MCHP), effective July 1, 1999, for children through age 18 and all pregnant women up to 200% of FPL. Legislation authorizing a private option MCHP program for families

up to 300% of the FPL was passed this year and will take effect July 1, 2001. The CSHCN program will draft regulations this year to make CSHCN with family incomes up to 300% eligible for services from the CSHCN program. This is especially important because the private option benefit package will be less comprehensive than the current HealthChoice based MCHP benefit package.

The Title V programs will continue to support the Medicaid Program to enroll eligible children and adolescents. Outreach strategies include a grassroots information dissemination campaign involving collaboration with State agencies; advocacy and community-based groups and provider organizations; a general public media and advertising campaign; and streamlining of the application process. The State will continue to coordinate its outreach efforts with local health departments, community health centers, managed care organizations, and other public and private providers who have historic experience with uninsured low income population. In addition, eligibility information is distributed through schools, licensed day care centers, and Healthy Start programs.

***Adolescent Health Program*** -- There are about 1.0 million adolescents and young adults, ages 10-24, living in Maryland. Adolescents and young adults have unique health needs which require expertise in adolescent health care, as well as support services not present in traditional pediatric office based practices. Thus, in FY 2000, a new initiative was implemented to improve the health of adolescents and young adults in Maryland. Initial planning activities consisted of assessing the comprehensiveness, availability, and quality of services provided to adolescents in Maryland recommending improvements to the health care system to make it more adolescent oriented. Improving the service system for adolescents was also identified as a priority in the State's Child and Adolescent Health Improvement Plan. In FY 2001, activities will focus on systems development, standards setting, program planning, provider education, and the provision of enabling services such as outreach and care coordination. Funding will also continue to be provided to local health departments and school health programs to provide preventive and primary health services to adolescents eligible for public or private insurance programs.

During FY 2000, five county based adolescent health needs assessments were undertaken. Four of the counties will be submitting final reports in the Summer of 2000 and the fifth county

will follow in the Spring of 2001. As a result of these studies, an analysis will be conducted to determine appropriate interventions to address identified needs.

***Suicide Prevention (Performance Measure 16: The rate (per 100,000) of suicide deaths among youth 15-19)*** -- Homicide and suicide are leading causes of deaths among adolescents in Maryland. Suicide rates among Maryland adolescents aged 15-19 decreased from 7.4 deaths per 100,000 in 1994 to 5.6 deaths per 100,000 in 1998. Maryland is recognized as a national leader in preventing adolescent suicides. Maryland was the first State in the Nation to offer a toll free decentralized hotline service to meet the needs of troubled youth. The 24-hour toll free Youth Crisis Hotline is staffed by trained counselors. This decentralization has enabled the counselor to access or refer the youth to local agencies for assistance. A State Coordinator, in the Mental Hygiene Administration, in collaboration with the Governor's Interagency Workgroup on Youth Suicide Prevention and CMCH, will continue to plan and implement an annual statewide adolescent suicide prevention conference, periodic media campaigns and school based youth suicide prevention programs. CMCH will continue this collaborative effort and will seek various options to enhance this partnership.

***Childhood Asthma Program (Performance Measure 03: Asthma Mortality rate (per 1,000,000) among children aged 1-14)*** -- During this past year the CMCH appointed an asthma coordinator to address the disturbing increase in asthma morbidity and mortality, among Maryland's children. The asthma coordinator position was established in response to CMCH commitment to enhance Maryland's approach to community-wide initiatives related to childhood asthma. The Statewide Initiative involves prevention efforts such as asthma awareness, health education, and surveillance. As part of the MCHP quality assurance, asthma has been listed as one of the benchmarks.

Under the Asthma initiative, CMCH will be working closely with the Department of Education to promote asthma awareness in schools, school nurse training on asthma, and development of close linkages between schools and primary care providers to promote effective asthma management. Outreach will be done with primary care providers to provide education on asthma diagnosis and management specifically the development of asthma action plans as recommended by the National Heart, Lung, and Blood Institute.

***Child Fatality Review*** -- The 1999 legislation to enact child welfare--Citizen Review Panels and Child Fatality Review Teams has as its express purpose improving Maryland's system of protecting children specifically the reduction of child abuse and neglect. The CMCH is charged with establishing and supporting State Child Fatality Review Teams (CFR) and local CFR teams throughout Maryland. When addressing the issue of child maltreatment and especially child fatalities, prevention is a recurring theme. The CFR Teams' coordinated approach, to the investigation of child deaths is through multi-disciplinary efforts of physicians, public health nurses, coroners, prosecutors, medical examiners, law enforcement, CPS workers and others. Well designed and organized CFR Teams are powerful prevention tools for defining the underlying nature and scope of fatalities and for offering solutions. State funds have been appropriated to hire an epidemiologist to assist with CFR activities. The Center for Maternal and Child Health is committed to provide leadership in this complex, urgent child health issue.

#### **4.1.4c. Infrastructure Building Services for Children with Special Health Care Needs**

***Health Insurance Coverage(Performance Measure 11: Percent of CSHCN in the State CSHCN Program with a source of insurance for primary and specialty care)*** --There are an estimated 183,000 CSHCN in Maryland. An estimated 85% of these children have insurance for primary and specialty care. The private option MCHP initiative will provide the opportunity to obtain subsidized coverage for CSHCN with family incomes up to 300% of the FPL. During FY 2001, the OGCSHCN will work to improve access to health insurance for the 15% of CSHCN who lack coverage. Activities will include the expansion of CSHCN eligibility to 300% of the FPL to close some gaps in the benefit package.

***Family Involvement (Performance Measure 14: The degree to which the State assures family participation in the program and policy activities in the State CSHCN Program)*** --The OGCSHCN promotes the practice of family-centered community based and culturally competent care. Strengthening the family-centeredness of the program has been a priority and will continue to be so in FY 2001. The OGCSHCN will continue to support Parents Place of Maryland to maintain the regional family representative network established in FY 1999 and supported through FY 2000. Through this regional family network, outreach and collaboration with families will continue. A marketing strategy will be developed to assure that families across Maryland will have knowledge of the CMS program and the services provided as well as how to access these

services. In FY 2001, the CSHCN program plans to develop a resource database which will be used to answer inquiries about program services and to link all components of the service system. It will also be linked to other agencies and organizations serving CSHCN. The regional resource coordinator will be crucial to this project.

***CMS Redesign Plan (MD Performance Measure 04: Implementation of the key components of the CMS Redesign Strategic Plan)*** -- During FY 2001, the CSCHN Strategic Plan will continue to be implemented. The budget for FY 2001 continues the significant shifting of dollars from direct services to selective populations, enabling and infrastructure activity which began in FY 2000. In the coming year, the OGCSHCN plans to place emphasis on the following components of the strategic plan: (1) Promotion of partnerships and linkages with families, providers and community-based agencies and programs serving CSHCN, (2) assurance and standards development, (3) assessment and policy development, (4) enhancement and expansion of health and health-related service network, and (5) training and education.

As part of the Centers of Excellence (COE) project, funds will be provided to one COE on behalf of all four centers to convene an advisory workgroup to provide further input in the development of the strategic direction of the CSHCN program. During FY 2001, recommendations provided by the advisory group will be evaluated and implemented as appropriate. The training and educational needs of families will be addressed through regional activities, however specific training activities will be conducted in collaboration with Parents Place. Through the partnership with the CSHCN Program, they will identify parent educational and training needs and work with OGCSHCN to meet those needs. Also, through the COE project clinical guidelines will be developed and /or promoted for selected clinical conditions. These guidelines will then be disseminated to primary care providers to aid them in their care of CSHCN, specifically in the coordination of care with the specialty care providers. A conference, *Care Coordination for Children with Special Health Care Needs*, will be held on September 14, 2000. A forum on the needs of older CSHCN as they transition to the adult medical care system is planned for the fall of 2000. The forum will bring together primary care providers, specialty providers, parents, patients and voluntary groups.

The OGCSHCN will be conducting a forum on the transitional service needs of CSHCN in the fall. A needs assessment tool for transitional services will be developed for those children

with spina bifida and sickle cell disease who age out of MCHP. This is particularly critical for the children with spina bifida who until recently did not live to early adulthood.

***Newborn Screening Follow-up Program (MD Performance Measure 08: Percent of infants with abnormal newborn screening tests who are followed up)*** -- The newborn screening program has historically been able to follow up almost all “not normal” test results to resolution. However, in recent years a few infants with borderline test results have been lost to follow up. Infants whose specimens take longer in transit from the hospital to the newborn screening laboratory are at increased risk of being lost to follow up, especially if the family is moving, homeless or undocumented. A courier system to pick up specimens from the hospitals and transport them to the laboratory is expected to be instituted in the coming year. A new computerized data handling system is also expected to help. In addition, new follow up and data entry personnel are being hired for the new newborn hearing screening program and will work cooperatively with the metabolic newborn screening staff.

The OSGCSHCN will also be adapting the model, developed 10 years ago, for the prevention, rapid intervention and follow-up of galactosemia in the Amish communities of Southern Maryland to address the problem of maple syrup urine community. The problem of galactosemia, which is at very high incidence in the Southern Maryland Amish community was addressed by screening the DNA of each member of the community for the common GALT mutations. Health education and genetic counseling were also provided. A courier system was set up to allow rapid testing of any newborn at risk and the infant was fed a lactose free formula until galactosemia was ruled out. When the community became aware of the role of inbreeding in the high incidence of galactosemia in their community, they began branching out to other Amish communities in anticipation of reducing the incidence of galactosemia in the community by expanding their choice of mates. Recently, however, a newborn was diagnosed with MSUD in the community. One of this child's parents is from the Lancaster Amish community that has a high incidence of MSUD. The OGCSCN will now develop a screening program in the community for the Amish MSUD mutations, in the hope of identifying pregnancies at risk for rapid MSUD newborn screening and temporary dietary management by the metabolic nutritionists in the Office.

***Client Based Data System*** -- The OGCSHCN is currently working with INPHO II Project to develop a client-based data system that will be linked to birth certificates, newborn screenings and ultimately immunizations. It is anticipated that the birth certificates and newborn screenings will be linked within the year. Ultimately, the newborn screening will be able to be linked with the universal hearing results. The Office has developed a 'mock-up' combination form that includes newborn screenings, infant hearing, birth defects, and immunizations done in the hospitals and breast feeding information. This form will be used on a pilot basis within the Office during the year prior to being field tested.

***Evaluation of the Medical Child Care Centers*** -- The evaluation of the Title V funded medical child care centers which began in FY 2000 will be completed in FY 2001. The evaluation will include both qualitative and quantitative measures including a parent satisfaction survey, analyses of program outcomes and a cost analysis.

#### **4.2 Other Program Activities**

Below are a variety of program activities that link either with all of the MCH offices or within several divisions of one office. While some may reflect infrastructure, or perhaps enabling or population based services, they are placed here for ease of reading. Also, other Title V grant awards are briefly discussed in this section (SSDI and Abstinence Education). Neither of these discussions are meant to convey the total breadth and depth of these grants. Please refer to their respective application for details.

##### Title V Needs Assessment/ MCH Strategic Plan

As discussed in the opening section of the plan, during this coming fiscal year, the MCH Program will use the results of the Title V Needs Assessment completed in FY 2000 to develop an MCH strategic plan. Input into the strategic planning process will be sought from local health departments, parent groups, health care providers, and other major stakeholders.

##### MCH Hotline

The MCH/Medicaid Programs will continue to operate an 800 number telephone line for MCH outreach, information and referral (1-800-456-8900). This line is located and operated by the Medical Assistance Program and is used to provide information and education about the Medical Assistance Program. The Center for Maternal and Child Health will continue to assist in this effort.

### Conferences and Training

CMCH recognizes the importance of enhancing public health competency through ongoing training and education. It achieves this activity by providing training opportunities to LHD public health personnel in important MCH domains such as home visiting, school and adolescent health, screenings and surveillance and asthma education. Several conferences will be supported by the MCH Program this coming year. These include the annual reproductive health update, the annual school health nurse institute, the abstinence education conference, and a summit on safe motherhood. The Safe Motherhood Summit will suggest solutions for the problem of maternal mortality in Maryland.

### Youth Risk Behavioral Survey (YRBS)

Maryland is one of the few States in the nation that does not participate in the YRBS. During FY 2001, the CMCH will continue to work with the Maryland State Department of Education, the Superintendents of Schools, Board of Education and School Health Council to reduce barriers to the implementation of YRBS.

### State System Development Initiative (SSDI) Grant

The Center for Maternal and Child Health is the recipient of the State Systems Development Initiative (SSDI). During FY 2001, grant funds will continue to be used to support MCH needs assessment and strategic planning activities. Funds will continue to be allocated for local health department based MCH needs assessment, and priority setting. This will also involve assisting local health departments in developing performance measures and identifying outcome measurements. The SSDI Coordinator's prime activity will be to assist local health departments, recipients of a significant portion of all Title V combined dollars in this endeavor. In addition, MCH health disparities will be examined and recommendations for reducing the disparities will be developed. A senior epidemiologist will be hired to assist with data analysis efforts. (See SSDI grant, methodology section for details).

### Abstinence Education Initiative

Maryland's abstinence education program targets nine to eighteen year old youth in an effort to increase abstinence, thereby decreasing the rate of adolescent sexual activity, child bearing, and sexually transmitted diseases. Maryland's program is a collaborative effort, involving many stakeholders, including the Governor's Council on Adolescent Pregnancy. In FY 2001,

this grant will continue to provide funding for the Council's abstinence based media campaign and to support community-based after-school and summer programs which offer alternatives to risky behaviors and provide an abstinence only message. (Please refer to the abstinence initiative grant for details).

#### Medical Assistance/Title V Collaboration

The Memorandum of Agreement between Medicaid and the MCH Program is periodically updated. Examples of collaborative activities include the following:

1. The Healthy Start Program Nurse Home Visiting Program will continue as a collaborative effort between MCH programs in local health departments and the Medical Assistance Program.
2. EPSDT collaborates extensively with the CMCH especially regarding CSHCN.
3. The MCH Medicaid 800 line as discussed above.
4. MCH programs in local health departments will continue to provide outreach, enrollment and ombudsmen services for the MCHP program.
5. Various committees, workgroups and partnering has occurred throughout the redesign and implementation of MCHP and other legislative issues such as lead poisoning screening and complimentary therapy concerns at various stages of development and identifying services that while MA cannot cover, CSHCN can cover.

#### **4.3 Public Input [Section 505(a)(5)(F)]**

Four public forums were held in June 2000. Approximately 300 invitations were sent to local health departments, health officers, and MCH offices. A total of 100 individuals representing local health departments, providers, and community organizations attended. In addition, an announcement is to be placed in the July issue of the Maryland Register indicating the availability of copies of the MCH Block Grant application.

The forums included a formal presentation of the MCH Title V history, overview, grant application process, GPRA, federal and State performance measures and an overview of the results of the needs assessment. A summary of the power point presentation, agenda, sample questions and comments are included in Appendix I and on the MCH web site ([www.mdpublichealth.org](http://www.mdpublichealth.org)) under Family Health Services and Primary Care. The MCH Programs

anticipates conducting additional public meetings throughout the State in preparation for the development of the MCH strategic plan during FY 2001.

**4.4 Technical Assistance [Section 509 (a)(4)]**

Maryland is not submitting a request for technical assistance during FY 2001.

**V. SUPPORTING DOCUMENTS**

**5.1 Glossary**

**5.2 Assurances and Certifications**

**5.3 Other Supporting Documents**

**Organizational Charts**

**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**

**5.9 National Core Performance Measure Detail Sheets**

**5.10 State "Negotiated Performance Measure Detail Sheets**

**5.11 Outcome Measure Detail Sheets**

## 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 Children With Special Health Care Needs (CSHCN, see definition below) - 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 years 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.

CFR-\* During the 1999 Legislative Session, The State Council of Child Abuse and Neglect, the State and Local Child Fatality Review Teams were established. Mandated responsibilities include annual analysis of the incidences and causes of child fatalities that include but not limited to reviewing records, identifying children at risk for neglect and/or abuse, performance of studies of local operations, review of training needs development and delivery of training programs and public education activities.

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 a chronic physical, developmental, behavioral, or emotional condition 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)

Crenshaw Perinatal Health Initiative-\* The goal of the Crenshaw Initiative is to promote a regional, interdisciplinary systems approach to assuring the availability and accessibility of quality patient care services in order to improve pregnancy outcomes.

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 (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death.

Direct Health Care 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 of with Medicaid, WIC and educations. 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.

FIMR-\* Fetal and Infant Mortality Review, funded by Title V set-aside program for special Projects of Regional and Nation Significance, is a component of the (1) Statewide perinatal systems development and quality improvement and (2) to integrate and coordinate perinatal outcome reviews with other related review processes including Maternal Mortality Review, Child Fatality Review and maternal-neonatal transport outcomes. The intent is to determine causative and relational causes that impact of fetal and infant death, identify intervention strategies thereby reducing fetal and infant mortality.

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.

HealthChoice-\* The Maryland managed care medical assistance program up to 100% of federal poverty level. All of the MCOs have elected to voluntarily include dental health coverage for adults. Dental health care for children is a requirement.

Healthy Kids-\* The Maryland Medical Assistance Program's for EPSDT services.

Healthy Start-\* The Maryland medical assistance perinatal, postpartum and child, zero-2 years of age home visiting program.

IPO-\* Improved Pregnancy Outcome has evolved from a prenatal care services project which targeted high risk communities into a statewide perinatal systems building program which seeks to improve pregnancy outcomes for the total populations. Efforts have focused on public health oriented, population-based strategies that involve assessment, assurance, and policy development at the community level.

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”)

MCHP-\* Maryland Child Health Program is the State’s SCHIP option. MCHP an extension of medical assistance provides comprehensive coverage for pregnant women, including 6 weeks post-partum and children, including children with special health care needs. Coverage is available for women and children up to 200% of federal poverty level. Beginning July 2001, the eligibility will increase to 300% FPL

Measures - (see “Performance Measures”)

MMR-\* During the 2000 Legislative Session, the Maternal Morality Review Committee was established with the intent of identifying causes of maternal death cases, review records and data, consult with experts and make recommendations regarding prevention

Needs Assessment - a study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is to 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, EMSC, Healthy Start, SPRANS, HIV/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. (See also, Jurisdictions)

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. 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, In-eligibility, 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
- 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
- 5.9 National “Core” Performance Measure Detail Sheets
- 5.10 State "Negotiated" Performance Measure Detail Sheets
- 5.11 Outcome Measure Detail Sheets