



## 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>).

This PDF was produced by the National Center for Education in Maternal and Child Health under its cooperative agreement (MCU-119301) with the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services.



**2001 Maternal and Child Health  
Block Grant Application and  
1999 Report**

July 15, 2000

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# **I. Common Requirements for Application and Annual Report**

## **I.4 Overview of the State**

### ***Context in Which the Title V Program Operates***

Washington's Title V agency, the Office of Maternal Child Health (OMCH), works to promote and develop an environment that supports the optimal health of all women of child bearing age, infants, children, adolescents and their families.

Funding for direct health care services (including immunizations and well child visits) is shifting away from public health to the medical community and other providers. In the context of a changing health care system, Washington's OMCH programs work to ensure statewide infrastructure building functions such as data collection, needs assessment, surveillance, planning and evaluation, systems and policy development, monitoring, provision of training, and technical assistance to assure quality of care. To fill gaps, OMCH continues to support some direct preventive health and dental services for uninsured and for Medicaid insured families. In addition, OMCH is working to identify quality measures of the medical care system that is in transition. In this environment, OMCH's challenge is to assure improvements and protections for the health of the community.

### ***New Agency Leadership/Organizational Structure***

Mary Selecky was approved by the Legislature as the new Secretary of the Department of Health in April of 1999. Ms. Selecky made new appointments and reorganized the executive levels of the Department during the past year. New appointments include: State Health Officer, Dr. Maxine Hayes, MD, MPH, (former TitleV Director); Assistant Secretary for Community and Family Health, Jack Williams; Assistant Secretary for Environmental Health, Bill White; Assistant Secretary for Epidemiology, Health Statistics and Public Health Laboratories, Jac Davies; Assistant Secretary for Health Systems Quality Assurance, Ron Weaver; Assistant Secretary for Management Services, Frank Hickey; Special Assistant to the Secretary, Eric Slagel; Deputy Secretary, Nancy Ellison, and Chief Technology Information Officer, Gary Schricker. (See the attached updated organizational chart for an overview of the revised structure.) These new appointments complete the DOH leadership team and have resulted in emerging new direction for the department's future.

## ***DOH Strategic Planning***

DOH is engaged in a strategic planning effort. This planning effort will focus on setting the direction for the entire agency for the next five years, and has included a comprehensive look at all aspects of the department.

It includes several key steps: analyzing past and future trends; reviewing feedback from customers, employees and stakeholders; identifying vital issues and aligning goals and objectives using the Baldrige “Balanced Scorecard” model. Based on these steps and the Baldrige criteria, the following ten goals were selected:

- Goal 1: Increase the public’s, DOH employees’, and stakeholders’ knowledge and understanding of the agency’s mission, vision, key approaches, and results.
- Goal 2: Improve health outcomes for the people of Washington State by selecting and achieving agency-wide performance measures and targets.
- Goal 3: Increase how well program and project funding align with peoples’ health outcomes and agency wide performance targets.
- Goal 4: Utilize customer needs and satisfaction data to influence agency priorities and operations.
- Goal 5: Enhance strategic partnerships and collaborative relationships to maximize health outcomes.
- Goal 6: Improve the collection and analysis of the agency’s process data.
- Goal 7: Increase the effectiveness and timelines of internal and external communications.
- Goal 8: Increase the effectiveness and efficiency of programs and services.
- Goal 9: Engage and enable a competent and committed workforce.
- Goal 10: Increase employee satisfaction and retention.

Performance Measures and Strategic Initiatives have been developed corresponding to each of these goals. DOH is now involved in developing plans on a division level to implement the initiatives that have been selected.

## ***Public Health Improvement Plan Update***

The Washington State Legislature requires DOH to produce a Public Health Improvement Plan (PHIP) each biennium, with the next plan due to the Legislature in January 2001 (RCW 43.70.520). Several key partners have agreed to work with DOH in developing the next plan. These groups include: Washington State Association of Local Public Health Officials (WSALPHO); the University of Washington’s School of Public Health and Community Medicine; and the State Board of Health.

A Steering Committee, comprised of representatives from the four groups has created a joint vision of a desired future public health system and proposed a workplan. The focus of this plan development will be to integrate the public health functions into a whole system. The steering committee has identified seven elements of focus in their effort to improve the system: communications, key health problems, access to

health care services, information and technology, workforce development, financing, and accountability/standards.

### ***Impact of Initiative 695 (I-695)***

In November 1999, an initiative to repeal the state motor vehicle excise tax (MVET) and require voter approval on all state and local government tax and fee increases was passed by the voters. This initiative set the fee for annual car licensure at \$30 per vehicle, a major decrease for most car owners. MVET funds provided \$400 million to local governments (counties, cities, public health departments/districts, and transit systems). This reduction directly impacts the criminal justice system, transportation systems, public health, and other community services.

In public health, MVET funding has historically provided for a number of essential services such as Communicable Disease Control and disease prevention. These funds also enabled the draw-down of federal match dollars. As of January 2000 (when the initiative took effect), local public health estimated a potential loss of \$26 million in CY 2000 alone. This amount includes 9% of local health funding, and 30% of the discretionary funding for Local Health Jurisdictions (LHJs). Several specific examples of the anticipated impact of I-695 on LHJs were identified in January, 2000:

- Southwest Washington Health District laid off 31 people in December.
- Yakima Health District estimated losing 92% of it's local funding for public health.
- Tacoma-Pierce projected a loss of 50 FTEs, closure of some Family Support Centers, cutting the adolescent program by 50%, and cutting all media programs on tobacco and youth violence.

During the winter 2000 session, the Governor and Legislature decided to restore some of the MVET cuts through use of surplus revenues (45% restored in 2000, 90% restored in 2001). Nevertheless, the long-term effects of I-695 will continue to impact public health into the future.

### ***Overview of the State***

Washington State encompasses 66,662 square miles in the northwest corner of the United States. British Columbia, Idaho, Oregon and the Pacific Ocean form its borders. The Cascade Mountains, which run the entire length of the state, divide the east and west portions of the state. The mountains significantly influence the climate, transportation and population distribution. About 78% of the state's population lives west of the mountains, where the three most populated counties, King, Snohomish and Pierce are located. The average population density in the state in 1999 was estimated at 86.5 persons per square

mile, similar to the national rate. Disparity in land types, however, has resulted in an uneven distribution of resources, and economic opportunities for Washington’s population. In turn, this has caused high demographic contrasts. Population density ranged from 789 persons per square mile in King County to 3 persons per square mile in Garfield and Ferry Counties.<sup>1</sup>



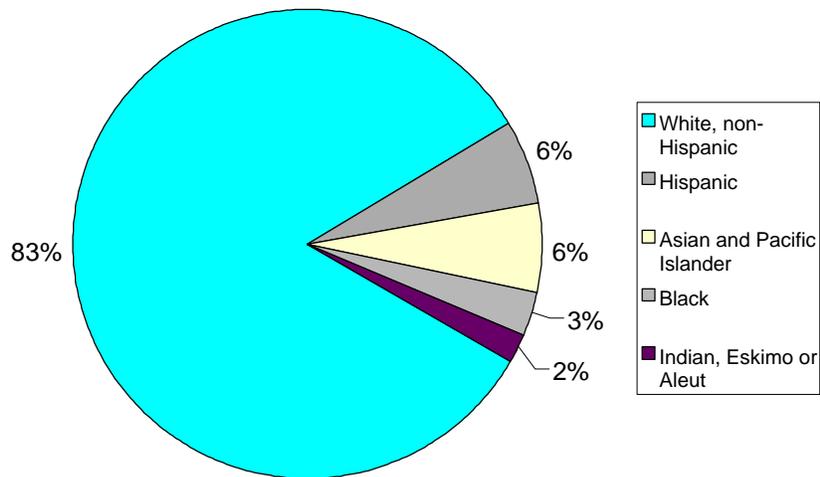
There are 39 counties in Washington, each with its own local government. These counties form 34 independent Local Health Jurisdictions (LHJs) which are funded with varying amounts of federal, state and local dollars. The three largest health jurisdictions, Seattle-King County, Tacoma-Pierce County and Snohomish County together serve over 50% of the state’s population.

Washington’s population in 1999 was estimated to be 5,757,400. This reflects an increase of 18.3% since 1990. In the early 1990’s, Washington’s population grew by over 2 % per year, nearly twice the national rate. About 40% of this growth was from natural increase (births minus deaths) and about 60% from net migration (people moving in versus people moving out). Since 1995, Washington’s population growth has slowed slightly to about 1.3% per year. The natural increase has remained fairly constant, but net migration has decreased substantially. This is most likely due to the strong national economy, resulting in

<sup>1</sup> Washington State Office of Financial Management, Population Forecasting Division, Counties Ranked by Percent Change in April 1 Population, April 1, 1990 – April 1, 1999, State of Washington, 6/30/1999.

fewer people currently looking for employment opportunities in Washington. Washington is ranked seventh in the country in both numerical and percentage growth since 1990, according to 1998 estimates from the Bureau of the Census.<sup>2</sup>

**Estimated 1999 Washington State Population by Race/Ethnicity**



Source: OFM, County Population Estimates by Race/Ethnicity, Age & Sex: 1995 and 1998, October 1998, updated March 1999.

The majority of Washington’s population identify themselves as white, non-Hispanic. In 1999, 83% of Washington’s population was estimated to be white, non-Hispanic, 6% Hispanic, 6% Asian and Pacific Islander, 3% Black, and 2% Indian, Eskimo or Aleut. This represents growing diversity in the state which was 87% white, non-Hispanic in 1990. The African American and Asian/Pacific Islander populations are located predominantly west of the Cascades in urban areas, with approximately 50% of each population residing solely in King County. In contrast, the Hispanic population resides throughout the state, with a significant proportion in rural areas east of the Cascades. There are also 27 federally recognized American Indian tribes throughout Washington with varying populations and land areas. Two of nine additional tribes in the state are also pending federal recognition.

<sup>2</sup> Washington State Office of Financial Management, Population Forecasting Division, Washington’s Population Growth Rate Shows Slight Decline, 6/30/1999.

**1999 Washington State Population Data by Age and Sex**

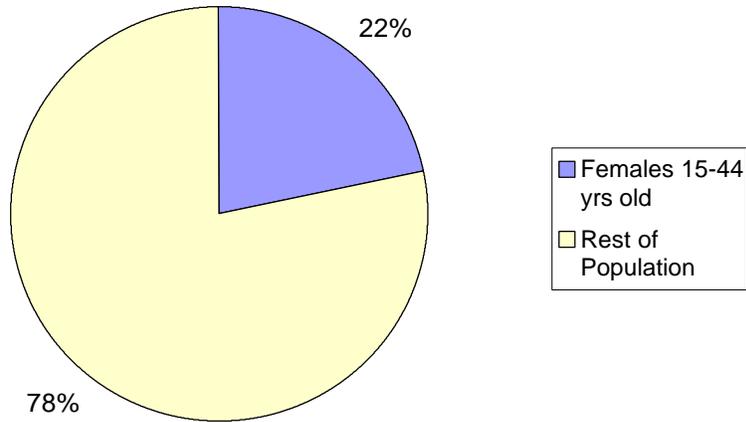
Age	Male	Female	Total
<1	40,593	38,742	79,335
1-4	164,949	157,332	322,281
5-9	230,073	218,874	448,947
10-14	222,675	211,304	433,979
15-17	127,236	120,608	247,844
18-19	85,064	79,637	164,701
20-24	184,409	172,790	357,199
25-29	191,380	182,193	373,573
30-44	702,602	690,081	1,392,683
45+	918,048	1,018,810	1,936,858
Total	2,867,029	2,890,371	5,757,400

Source: OFM, Forecast of the State Population by Age and Sex: 1970 TO 2020, November 1999.

As shown in Table 1, 22%, or 1.2 million of the estimated 5.7 million people in Washington in 1999, are women of reproductive age (15-44 years). Almost 30%, or 1.7 million, are children 19 and younger. Both of these groups include over 400,000 teenage women between 15 and 19 years old. State forecasts predict that over the next 30 years, as the children of baby boomers reach adulthood, the number of reproductive age women will increase substantially. The school age population (5-17 years) is expected to grow by about 10% over the next year and then remain fairly constant until 2015<sup>3</sup>.

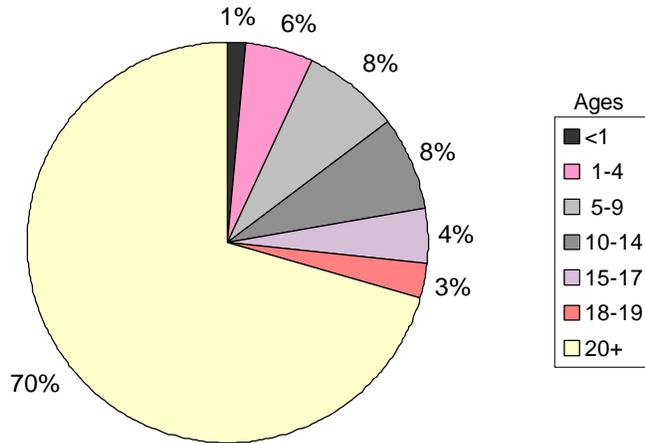
<sup>3</sup> Washington State Office of Financial Management. Forecast of the State Population by Age and Sex, 1990 to 2020. November, 1999.

### 1999 Washington State Population Data



Source: OFM, Forecast of the State Population by Age and Sex: 1970 TO 2020, November 1999.

### 1999 Washington State Population Data

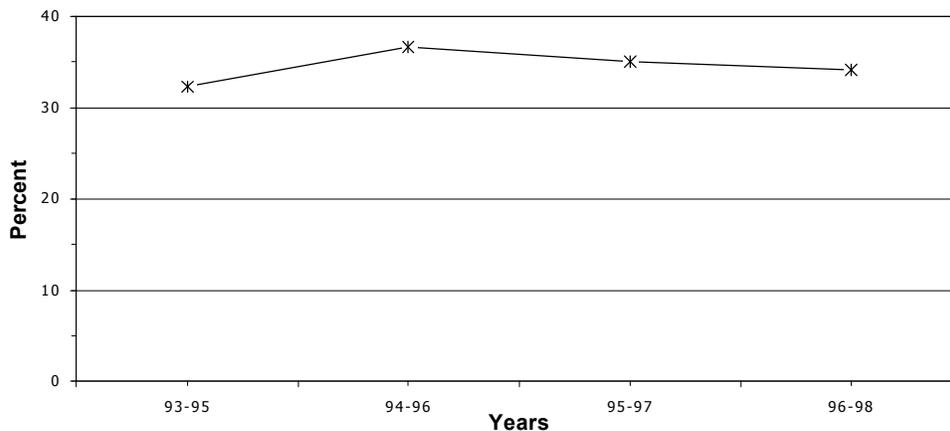


Source: OFM, Forecast of the State Population by Age and Sex: 1970 TO 2020, November 1999.

According to US Census Current Population Survey estimates, 10.0% of Washington lived below the federal poverty level (\$16,660 for a family of four in 1998) from 1996-1998. During the same period,

34.1% of children under 19 years were living below 200% of the federal poverty level (FPL).<sup>4</sup> As shown below, this rate has fluctuated over the past five years. While employment in Washington increased over the last decade, the proportion of jobs in low-wage sectors, a proxy for the percent of workers living below poverty, was fairly stable until 1995 when it began declining.<sup>5</sup> Data from the 1998 Washington State Population Survey estimate that 501,876 children were living at or below 200% FPL, 188,535 children were living at or below 100% FPL and 66,336 were living at or below 50% FPL. The survey also ascertained employment status of household members, and data indicate that the vast majority (81%) of children living at or below 200% FPL were in working households. The median household income of these working families was \$21,961. Only 67% of these families reported health insurance coverage for all twelve months during 1997.<sup>6</sup>

**Washington State Children under 19 Years of Age  
at or below 200 Percent of Poverty Level  
1993-1998**



Source: U. S. Bureau of the Census, March 1993, 1994, 1995, 1996, 1997, 1998 Current Population Surveys.  
 Note: Caution should be used when using these estimates. In March 1995, new health insurance questions were asked in the Current Population Survey. Therefore, 1993 estimates may not be comparable to 1994-1995 estimates.  
 Note: Percentages listed are averages over the three years' percentages, not the percentage of the average numbers (calculated as 'Number' divided by 'Total Children'). Results may differ slightly based on the method used.

**NOTE:** Please see Section 3.1.2.1, starting on page 90 of the Five Year Needs Assessment for a more detailed description of the impact of managed care, welfare reform, and other factors influencing health care systems in Washington State.

<sup>4</sup> US Bureau of the Census, Current Population Survey, 1996-1998.

<sup>5</sup> Washington State Office of Financial Management. Washington Tends: Social-Economic: Jobs in Low-Wage Industry Sectors, 1980-1997, 1998.

<sup>6</sup> Washington State Office of Financial Management. 1998 Washington State Population Survey Data and Research Brief No. 7, March 2000.

## ***Prioritization Process***

See Section 3.1.1, Starting on Page 86.

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

### **1.5.1 State Agency Capacity**

#### **1.5.1.1 Organizational Structure**

DOH is located within the Executive Branch of State Government, with the Secretary of Health reporting directly to the Governor. DOH works with the Governor-appointed State Board of Health to set state public health policies. The attached organizational charts for DOH also describe the five major divisions under the Secretary's direction, one of which is Community and Family Health (CFH). There are three major offices in this division: Infectious Disease and Reproductive Health (IDRH), Maternal and Child Health (OMCH), and Community Wellness and Prevention (CWP).

OMCH includes several programs that operate under the OMCH Program Director including: Immunization Section, Child and Adolescent Health Section (CAH), Maternal and Infant Health Section (MIH), Children with Special Health Care Needs Section (CSHCN), Genetics Section, and Assessment Section.

OMCH is responsible for the administration of the Title V Block Grant, the CDC Immunization Grant (which funds a large portion of the Immunization Section's work) and other health related grants. In addition to the programs identified above, OMCH subcontracts with 34 LHJs and numerous community agencies (See 1.4.2 State Agency for a description of these relationships and agencies).

The mission of the OMCH is "to promote a community environment that supports and encourages the optimal health of women of childbearing age, infants, children, adolescents, and their families." OMCH's Strategic Themes include: developing and implementing a communications plan; developing and implementing a staff development plan; systematizing review of priorities and strategic responses; modeling responsible use of data; and planning for ongoing technology. These statements are congruent with the changing MCH Block Grant Requirements and the new DOH strategic plan.

**DEPARTMENT OF HEALTH**  
March 2000

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Maxine Hayes, MD

**Secretary**  
**Mary C. Selecky**

Deputy Secretary  
Nancy Ellison

Board of Health  
Don Sloma  
Exec. Dir.

Legislative, Policy &  
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Patty Hayes

Special Projects  
Eric Slagle

Communications  
Renee Guillierie

Planning/Local Health  
Joan Brewster

Chief Technology  
Information Officer  
Gary Schricker

Management Services  
Frank Hickey

- Financial Services
- Contracts, Properties & Procurement
- Human Resources
- Risk Management

Epidemiology, Health  
Statistics & Public Health  
Laboratories  
Jac Davies

- Epidemiology
- Center for Health Statistics
- Public Health Laboratories

Health Systems Quality  
Assurance  
Ron Weaver

- Facilities & Services Licensing
- Health Professions Quality Assurance
- Emergency Medical & Trauma Prevention
- Laboratory Quality Assurance
- Community & Rural Health

Community and Family  
Health  
Jackson Williams

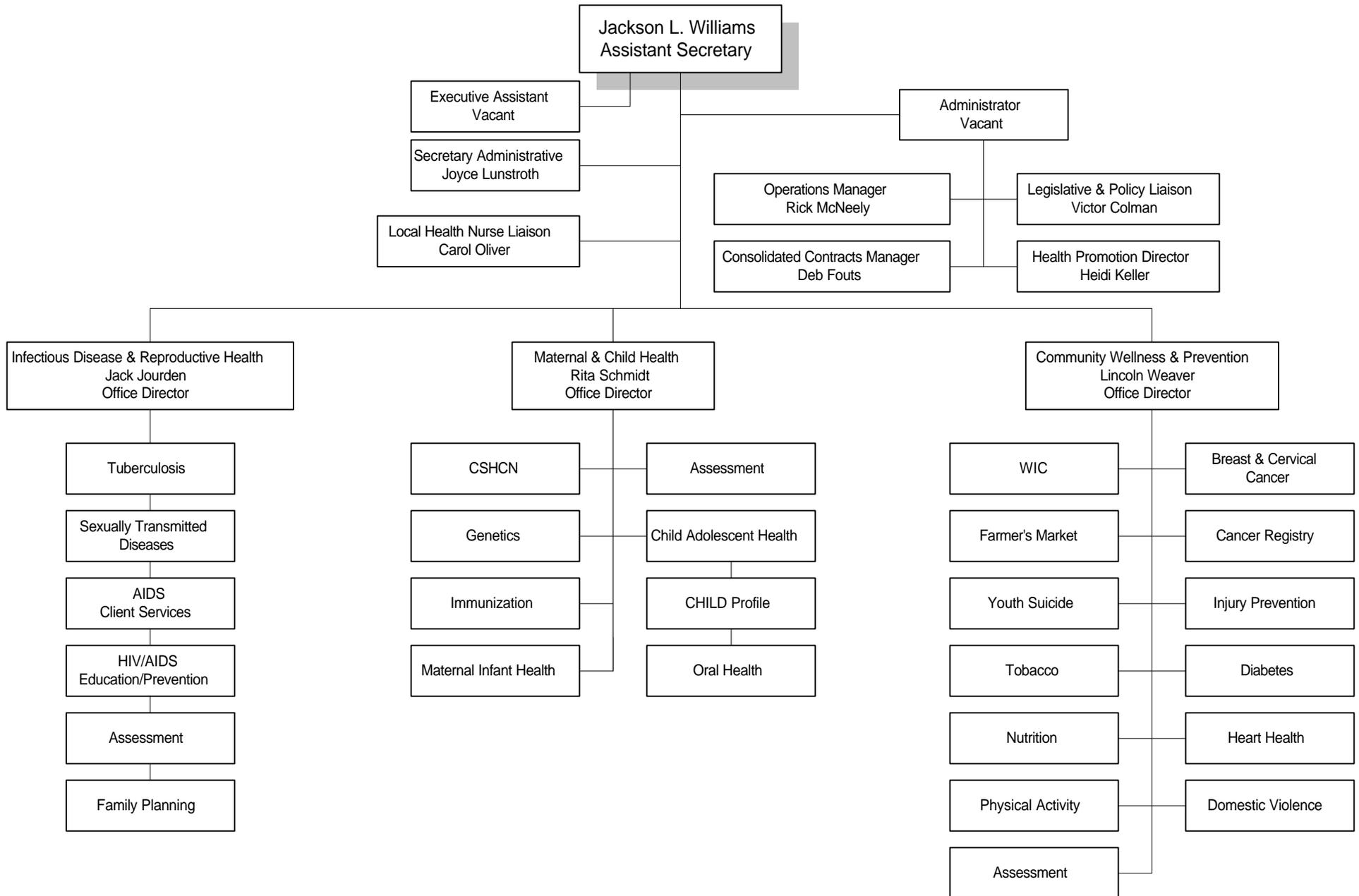
- Community Wellness & Prevention
- Infectious Disease & Reproductive Health
- Maternal & Child Health
- Health Promotions

Environmental Health  
Bill White

- Drinking Water
- Radiation Protection
- Shellfish Programs
- Toxic Substances
- Community Environmental Health

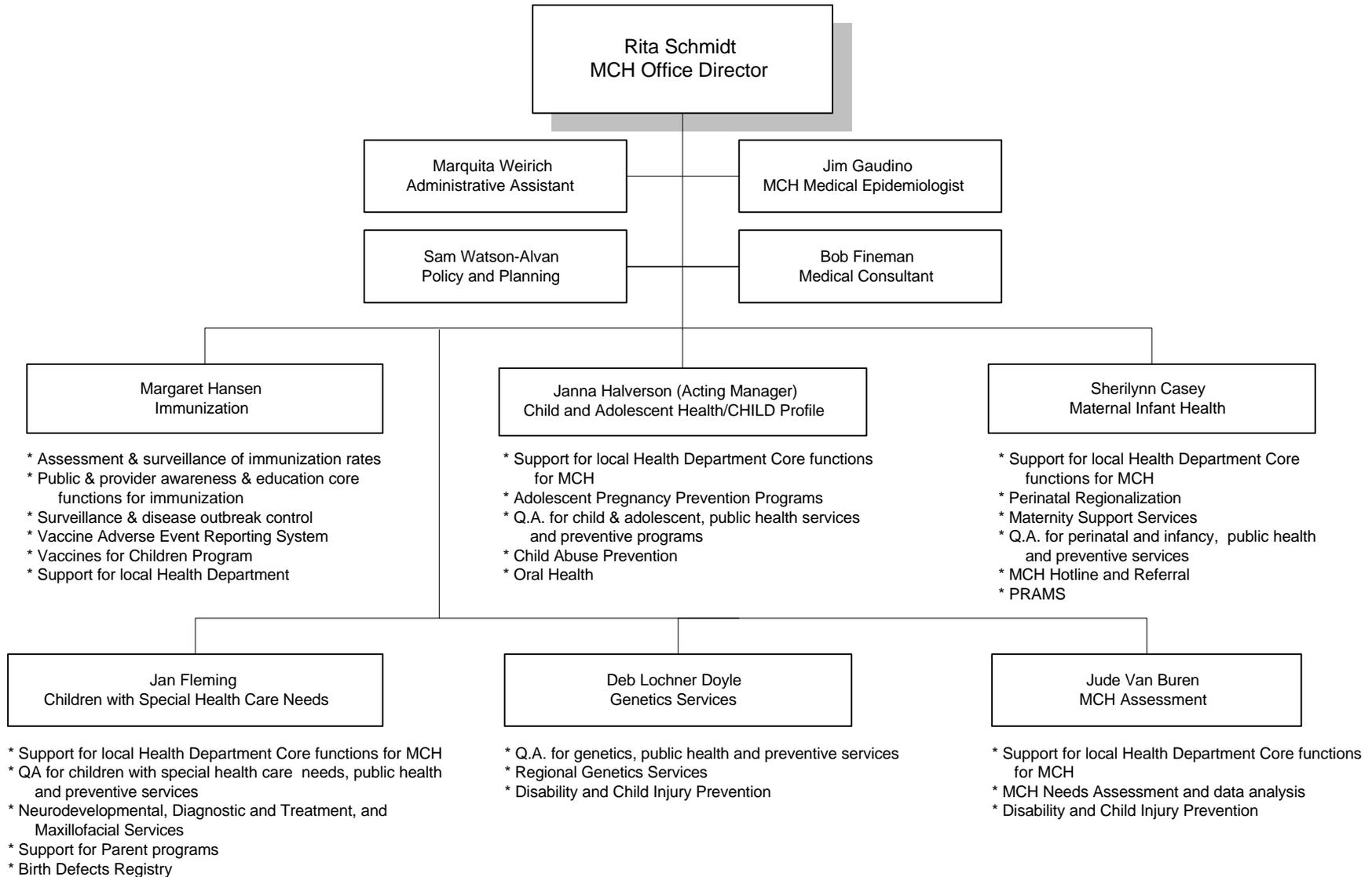
# Community and Family Health

June 30, 2000



# Maternal Child Health

JUNE 2000



The State Statutes relevant to Title V program authority and how they impact the Title V program remain the same as those outlined in pages 8-11 of the Annual Block Grant Application for 1996. Following is a summary of the recent legislative mandates that will have direct impact on Title V programs:

As reported last year, the legislature passed HB 3103 in 1998. In 1999, this bill was encoded into RCW Chapter 70.83E, Prenatal Newborn Screening for Exposure to Harmful Drugs. This bill directed DOH to develop screening criteria to identify women who use alcohol/drugs during pregnancy; develop a training protocol to improve provider ability to identify women who use substances during pregnancy; and explore the feasibility of newborn testing for drugs or alcohol. The report was completed and presented to the Legislature in January 1999 and was distributed to over 500 stakeholders statewide as well as posted on the DOH website. This activity developed systems recommendations focused on improving provider screening and identification of women using alcohol/drugs during pregnancy.

In January of 2000, the State Children's Health Insurance Program (SCHIP) bill was initiated in Washington to provide health care to children who are eligible for health care coverage under Title XXI of the federal Social Security Act. (See page 115 for more information about SCHIP).

Although no legislation was passed concerning Early Hearing-Loss Detection, Diagnosis and Intervention (EHDDI), a budget proviso was enacted providing the department with \$100,000 for a two-year period, and authorizing the agency to solicit additional support for EHDDI statewide.

### **1.5.1.2 Program Capacity**

Three sections of OMCH focus on the three major Title V populations. The Maternal, Infant Health Section (MIH) focuses on preventive and primary care for pregnant women, mothers and infants. Preventive and primary care services for children are addressed through the Child and Adolescent Section, which also includes the CHILD Profile and Oral Health Programs. Services for children with special health care needs including the mandated capacities are addressed through the Children with Special Health Care Needs Section (CSHCN). In addition, OMCH includes the Immunizations, Genetics, and Assessment Sections which work collaboratively with the three population-based sections. Following is a brief description of the basic role of each of these OMCH sections, which receive funding through Title V, State General funds, the CDC, and Title XIX.

## ***Maternal and Infant Health Section***

The MIH Section, which currently consists of 10.2 FTE, supports healthy birth outcomes by improving health and support services for pregnant and post-partum women and their infants. They achieve this goal by improving training, education, assessment and intervention and through a system of regional perinatal care that includes the availability of quality tertiary care for high risk women and newborns. Services are provided by a collaborative network consisting of state, LHJs, and non-profit providers. This network provides confidential pregnancy testing (limited) and referral, maternity support services, child development and parenting information and education. In addition, this section administers the PRAMS project, is the lead for the Interagency Agreement with Medicaid (Title XIX) for all of DOH, and provides support in the development of policies related to improved birth outcomes.

## ***Child and Adolescent Health Section***

The CAH Section, comprised of 16.15 FTE, works to promote and protect the health and well-being of children, adolescents, and their families in the context of their communities through assessing child and adolescent health status, developing strategies to improve health status, and assuring preventive health services. Through its programs, CAH promotes the use of national guidelines for well child and adolescent screening and referral, early parenting support, teen pregnancy prevention, youth development, child death review systems development, population based oral health programs, and child care health and safety consultation. In addition, this program is responsible for state level administration of the CHILD Profile universal immunization tracking and health promotion system and the Oral Health Program.

## **CHILD Profile Program**

The CHILD Profile Program, comprised of 3 FTEs based at OMCH, administers the state level aspects of the health promotion and the child immunization registry programs. CHILD Profile registers children at birth and periodically sends developmentally appropriate health messages to the child's parents. This is tied to the registry which allows the physician to input the immunizations into the child's record. CHILD Profile is collaboratively supported by DOH, King and Snohomish health districts, DSHS, Washington State Association of Local Public Health Officials (WSALPHO), and the Washington Health Foundation. King and Snohomish health districts dedicate approximately 20 FTEs to operation of the CHILD Profile system.

### **Oral Health Program**

The Oral Health Program, comprised of 1 FTE manager and 1 HRSA detailed Public Health Services dentist, works to provide leadership and support that enables communities to prevent dental disease and to increase access to oral health services.

### ***Children with Special Health Care Needs Section***

The CSHCN Section, consisting of 7.70 FTE, promotes integrated systems of care that assure the population of children with special health care needs and their families the opportunity to achieve the healthiest life possible, and to develop to their fullest potential. CSHCN staff provide leadership in addressing health system issues that impact this population; work with families and other leaders to influence priority setting, planning and policy development; and support community efforts in assessing the health and well-being of children with special health care needs and their families. This work is carried out through partnerships with other state-level agencies; through contracted relationships with LHJs; private and non-private agencies; the University of Washington, Children's Hospital and Regional Medical Center (CHRMC) in Seattle, other tertiary care centers; and family organizations. The contract with CHRMC is significant in that it extends CSHCN Program capacity in the policy areas of CSHCN assessment, quality assurance and provider education.

### ***Genetic Services Section***

The Genetic Services Section, consisting of 4 FTE's, is focused on assuring high quality comprehensive genetic services throughout the state. This section also includes activities that focus on secondary conditions of Disability Prevention, FAS Prevention, Genetics Education, Newborn Screening Technical Assistance, and Early Hearing Loss Detection, Diagnosis and Intervention.

### ***Immunization Section***

The Immunization Section, consisting of 19.50 FTE, is committed to the goal of preventing the occurrence and transmission of childhood, adolescent, and adult vaccine preventable diseases. The program provides leadership for an integrated and comprehensive immunization delivery system, universal free vaccine access for all children under age 19, expanding public awareness of the need for immunizations throughout the life span and promotion of community education,

participation, and partnerships. A total of 1,956,154 doses of vaccine are provided each year through a state operated vaccine warehouse.

### ***The Assessment Section***

The OMCH Assessment Unit, consisting of 8.1 FTE, provides data, analysis, research, surveillance, and consultative support and management of all assessment-related activities within the OMCH. Specific activities include Block Grant Performance Measure and Health Status Indicator reporting, coordination of the MCHBG Five Year Needs Assessment, analysis of PRAMS data and the development of data reports, child death review data management and analysis, cluster investigations, and birth defects surveillance. In October of 1999, this section was awarded an SSDI grant to improve assessment capacity. The grant goals include: completing the Five Year Needs Assessment; developing systematic OMCH data collection, reporting and monitoring; and disseminating data to staff, stakeholders and policy makers.

### **1.5.1.3 Other Capacity**

Following are brief biographical sketches of senior level management in lead positions.

Early in 1999, after a lengthy nationwide search, Governor Locke appointed Mary Selecky to the position of Secretary of the Department of Health (DOH). She worked for 20 years as the Administrator of Northeast Tri-County Health District, which includes Ferry, Pend Oreille and Stevens counties. Ms. Selecky was one of the early advocates for creation of the state Department of Health, and was a key player in the development of the Public Health Improvement Plan. She is a political science and history graduate of the University of Pennsylvania.

Dr. Maxine Hayes, formerly the Title V Director and Assistant Secretary for Community and Family Health, is the new Health Officer for DOH. She is also Associate Professor of Pediatrics at the University of Washington School of Medicine and is on the MCH faculty in its School of Public Health and Community Medicine. Dr. Hayes is the past president of the Association of Maternal and Child Health Programs (AMCHP).

Jackson L. Williams is the newly appointed Assistant Secretary for the Division of Community and Family Health. He has a Master of Arts in Health Education from Sacramento State University, and a Bachelor of Science in Biology from San Diego State University. He has

twenty-six years experience in health and social services management and administration. Prior to his current assignment, Mr. Williams was the chief administrator of Community and Family Health.

Rita Schmidt is the Office of Maternal and Child Health Director. She has a bachelor's degree from Pennsylvania State University and a Masters Degree in Public Health from the University of Michigan. She has 25 years experience in public health in non-profit and public settings at the local and state level, and was formerly the Title V Director for the State of Alaska.

Sherilynn Casey, Manager of the Maternal and Infant Health Section (MIH), has a Masters Degree in Public Administration from City University. She has worked for OMCH for 16 years and was previously employed as a management and research analyst, including four years with Medical Assistance Administration. She has considerable experience with contracts, interagency coordination, fiscal management, and maternal/infant health issues.

Debra Lochner Doyle, Manager of the Genetic Services Section, has a Bachelors of Science Degree in genetics from the University of Washington, and a Masters of Science Degree in Human Genetics and Genetic Counseling from Sarah Lawrence College in New York. She is board certified by the American Board of Medical Genetics and the American Board of Genetic Counseling. Before joining OMCH, Debra was a genetic counselor at several clinical settings. She is also the past President of the National Society of Genetic Counselors and a founding member of the Coalition of State Genetic Coordinators.

Dr. Robert Fineman, Medical Consultant to OMCH, has an M.D., and a Ph.D. in Anatomy and Cell Biology from SUNY in Brooklyn, New York. He has a Bachelor of Arts Degree in Chemistry from Temple University and thirty years experience in the field of genetics as a clinician, laboratorian, researcher, teacher, administrator, and consultant. Dr. Fineman is also a member of the DOH/DSHS Human Research Review Board. He has experience as a grant writer and reviewer, and has published and/or presented more than 100 manuscripts in peer-reviewed journals and at national and international meetings.

Jan Fleming, Manager of the Children with Special Health Care Needs (CSHCN), is a registered nurse with a Master of Nursing Degree and clinical specialty in children with special health care needs from the University of Washington. She has worked with children with special health care needs and their families in a University Affiliated program, in schools, in public health, and as a

Clinical Nurse Specialist in an early intervention program. She has been part of the state's CSHCN Program since 1990, first as a Public Health Nursing Consultant and now as Manager.

Janna Halverson, CHILD Profile Manager (located in CAH) and Acting CAH Manager, has a Masters of Public Health in Behavioral Science and Health Education from the University of California, Los Angeles. Her Public Health work experience started in 1989 with a Peace Corps assignment to the Ministry of Health Malawi, Africa. She has experience in program analysis, policy recommendations, systems development, inter and intra agency collaboration, and program evaluation.

Margaret Hansen, Manager of the Immunization Section, has a Bachelors of Arts in Cultural Anthropology from U.C. Davis. She has fifteen years program management experience in family planning, maternal and child health and immunizations.

Beth Hines, Manager of the Oral Health Program (located in CAH), has a Masters Degree in Public Health from Loma Linda University and a Bachelor's Degree in Dental Hygiene from the University of Southern California. She has worked for OMCH Oral Health in Washington State for nine years. Prior to this, she worked as a Primary Health Care and MCH advisor for the Peace Corps in Africa and the West Indies. She has experience in clinical dental services, health curriculum development, budget and contracts management, policy development, training and coalition building.

Tom Rogers, OMCH Budget and Contracts Coordinator, has nine years experience in MCH Block Grant fiscal issues as a Budget Program Specialist with the Department of Health. Previously, he worked for the Department of Revenue and the Department of Veterans Affairs for the State of Washington. He has a Bachelors Degree in Accounting from Western Washington University.

Cathy Wasserman, Program lead for the SSDI Grant, has a bachelor's degree from Dartmouth College, a Masters in Public Health and a Ph.D. in Epidemiology from the University of California in Berkeley. She has worked as an Epidemiologist and held several research positions from 1986 to the present. She has numerous publications in health and science journals, and is a member of the Society for Epidemiologic Research, the Society for Pediatric Epidemiologic Research, and the American Public Health Association.

Sam Watson-Alván, Policy and Planning Manager, has a Masters of Environmental Studies (MES) degree, with a focus on Political and Social Ecology, a Bachelor's Degree in Social Science/Political Economy from Evergreen State College, and a Bachelor's Degree in Western Languages and Literature from the University of the State of New York at Albany. He has prior experience in higher education policy research, education reform planning, family policy, and systems reform.

Jude Van Buren has recently joined OMCH as manager of the OMCH Assessment Section. She has a MPH and DrPH in environmental health sciences from Johns Hopkins School of Hygiene and Public Health. Previous to her graduate work, she obtained a BS in Environmental Health and an Associate Degree in Nursing. She has worked in public health for over twenty years in a variety of roles, including as a nurse, environmental sanitarian, epidemiologist and professor of environmental health sciences.

OMCH is currently conducting an extensive recruitment for Manager of the Child and Adolescent Health Section.

OMCH has a total of 66.95 full time equivalent (FTE) staff in the following specialty areas: public health administration, public health nursing, maternity care, pediatric medicine, health education, assessment, information systems, epidemiology, social work, occupational therapy, oral health, nutrition, genetics, immunizations, and disease control. In the past year, OMCH has hired a parent of a child with special health care needs as a full-time family consultant for the CSHCN program. This person works with staff on all CSHCN issues and plays an instrumental role in facilitating family consultation and participation within OMCH and at the local, regional, and state levels.

## **1.5.2 State Agency Coordination**

### ***Introduction***

OMCH has intentionally moved toward a “core health functions” model of public health during the past several years. This has involved an increase in infrastructure building services and a decrease on other types of services. The cornerstone of infrastructure building services is collaboration with other partners to achieve jointly shared goals for MCH populations. The following provides a brief description of the collaborative relationships OMCH has developed with other offices within the DOH, OMCH, Title XIX, other state agencies, and other

groups/organizations. The outcomes of many of these collaborations are described in more detail in the Report Section of this document. Outcomes not described elsewhere are described here.

### ***OMCH Relationships with Other Offices Within the Washington State DOH:***

OMCH collaborates with numerous other offices within DOH to ensure maximum effectiveness on joint priorities. Following is a brief description of these relationships and their goals:

#### **WIC**

OMCH collaborates with the WIC program to: promote breast feeding; exchange data for program monitoring; enhance referrals and address access to care issues between WIC and First Steps; coordinate coverage for special formulas for children covered by Medicaid, and provide cross training. For the past two years, OMCH trained staff in the WIC program in various methods to identify and intervene with victims of domestic violence, child abuse, and/or oral health issues. Another example of this collaboration is the sharing of the OMCH and WIC toll-free line (through a contract with Healthy Mothers, Healthy Babies) that referred 13,042 potential clients to WIC during 1999. OMCH staff work with WIC to secure data for Health Status Indicators and to explore inclusion of WIC data in systematic OMCH data reports. Finally, the Immunization Program collaborates with WIC in two WIC/Immunizations linkage projects. These project sites develop procedures for reviewing client immunization records and referring to providers, as needed.

#### **Injury Prevention**

MCH funding partially supports the following collaborative activities with the Injury Prevention Program (IPP): data collection and reporting on injuries (intentional and unintentional); youth suicide and family violence prevention activities; and the coordination and staffing of the statewide Safe Kids Coalition. The SAFE KIDS Coalition focuses on unintentional injuries to children ages 14 and below. The coalition has statewide membership with Mrs. Mona Locke, first Lady of Washington as the Honorary Chair. Washington State has nine local coalitions and several counties requesting coalition status. Four of the existing nine coalitions have become coalitions since the state leadership has existed. The State coalition coordinates the local coalitions and assists in spreading the unintentional injury prevention message to local communities.

OMCH staff has worked with IPP to establish and maintain the DOH Family Violence Workgroup, a coordinating group within DOH which addresses violence between intimate partners, child maltreatment, and sexual assault. One of the successes of this group has been the implementation of a 1999 Behavioral Risk Factor Surveillance System (BRFSS) module, which provides information about past and current family violence and child abuse issues. These data will be used to identify risk factors and inter-relatedness between child maltreatment and domestic violence, and to identify lifetime prevalence of child maltreatment.

OMCH staff also work with IPP to secure data for health status indicators and performance measures, and participate on several advisory committees addressing injury prevention. These advisory committees include the Sexual Assault Prevention Committee, the Youth Suicide Prevention Citizen Advisory Committee, and the DOH Intra-Agency Injury Prevention Workgroup.

### **Oral Health**

OMCH's Oral Health Program collaborated with DOH's Environmental Health, Epidemiology, Health Promotion, Community and Rural Health, and HIV/AIDS during 1999 to enhance preventive oral health care, and address unmet needs. OMCH also worked with the Office of Environmental Health, Drinking Water Division, on matters pertaining to fluoridation. Plans were set in place to produce a new pamphlet for the public and health providers on sources of fluoridated drinking water. Additionally, OMCH worked with DOH's Epidemiology and Health Statistics to plan and conduct a study to assess the oral health status of one and two-year old children as part of this Division's environmental lead exposure study.

OMCH works collaboratively with the Office of Health Promotion, Community and Rural Health, and the Medicaid office through joint efforts on the Oral Health CISS Grant. This grant has focused on developing community oral health coalitions. Furthermore, OMCH in partnership with HRSA, the Office of Community and Rural Health, and Office of HIV/AIDS jointly planned to fund a U.S. Public Health Service Dental Officer who began work in July, 1999. The dental officer provides technical assistance on dental health issues, works with dentists to increase their involvement in addressing the unmet oral health needs of low income populations, and coordinates a statewide oral health planning effort.

OMCH Oral Health Program collaborated with the Office of Community and Rural Health to address the needs of Benton and Franklin Counties dental access. This collaboration resulted in a

public forum on access issues, a report to the governor and on-site technical assistance to increase recruitment and retention of dentists and strategic planning with the local dental task force.

### **Infectious Disease and Reproductive Health**

OMCH collaborated with the HIV/AIDS and Family Planning Programs in the Infectious Disease and Reproductive Health Office (IDRH), and other contractors on the OMCH/HIV workgroup, co-led by OMCH staff. This workgroup develops effective policies and programs for HIV/AIDS prevention and care in the MCH populations. The objectives of the workgroup are: to assess existing CFH programs that target MCH populations for the inclusion of HIV prevention, care and surveillance; to develop or expand existing CFH policy to assure agency collaboration to provide MCH services; and to assure that HIV prevention messages, universal counseling and testing, and access to care are being offered to MCH populations.

OMCH also works with the Family Planning and Reproductive Health (FPRH) office on efforts to reduce unintended pregnancy. Meetings are convened by FPRH and include OMCH staff who work on unintended pregnancy prevention, teen pregnancy prevention, abstinence education, and assessment. MIH activities include implementation of a Maternity Support Services (MSS) performance measure. The statewide performance measure will take effect in July 2000. The performance measure will evaluate provider activities to increase family planning utilization by six weeks postpartum for MSS postpartum clients.

OMCH also coordinated with FPRH and MAA to facilitate the work required to obtain a Medicaid waiver for family planning coverage for all men and women up to 200% FPL. DOH provided the FTE for MAA which was needed to complete the work on the waiver.

### **Community and Rural Health**

OMCH works with the DOH Office of Community and Rural Health on several projects. The Office of Community and Rural Health, partly funded by the HRSA Primary Care Grant, is one of the partners involved in "Building Bright Futures for Washington's Children." Other partners include MAA, WIC, Tobacco Prevention, Environmental Health (lead poisoning), and Office of Health Promotion. The goals of this effort are to increase the rate and improve the quality of well child visits. In addition, the Office of Primary Care, Community and Rural Health, MAA, and the Health Care Authority have been working with OMCH in identifying unmet needs throughout Washington. OMCH staff served on a committee which developed a model of health system components as part of a primary care assessment of unmet needs.

## **Assessment**

OMCH Epidemiology and Assessment staff participate in a monthly department-wide Assessment Operations Group. The goal of this group is to coordinate assessment activities and facilitate communication across DOH. This collaboration has resulted in improved coordination with the Center for Health Statistics and LHJ assessment staff. Among other issues, the group is working on developing data standards and other data reporting efficiencies.

In 1999, OMCH was awarded a State Systems Development Initiative (SSDI) Grant for 10/99-9/01. The major goals of the grant are: 1) to further MCH and CSHCN data capacity by supporting the prioritization process and in depth analyses for the five year Needs Assessment, 2) to systematize MCH data collection, reporting and monitoring, and 3) to disseminate needs assessment data to influence MCH Block Grant planning and policy development. An SSDI data team has been convened to address these goals and to ensure broad collaboration within DOH and with LHJs. In addition to MCH assessment staff, team members include the CSHCN assessment coordinator, staff from the DOH Office of Community and Rural Health (the Washington State Primary Care Office), the Center for Health Statistics, and a local health assessment coordinator. By September, 2000 an annual MCH data report will be drafted for dissemination within DOH and to stakeholders. Fact sheets based on the report will be developed by June 2001. Existing forums such as the Perinatal Advisory Committee, the First Steps Workgroup, the CSHCN Communications Network, the Family Policy Council, and the MCHB Title V website, among others, will be used to disseminate the fact sheets.

OMCH Epidemiology and Assessment staff participate in a monthly department-wide Assessment Operations Group. The goal of this group is to coordinate assessment activities and facilitate communication across DOH. This collaboration has resulted in improved coordination with the Center for Health Statistics and LHJ assessment staff. Among other issues, the group is working on developing data standards and other data reporting efficiencies.

## **CHILD Profile**

In continuing to develop the CHILD Profile system, OMCH works with many programs in DOH and other state agencies who are communicating health information to the parents of children 0-6 years of age. CHILD Profile health promotion expanded statewide on July 1, 1998, providing the age-specific reminders of the need for well-child checkups and immunization and other parenting information to every family that experienced a birth since that date. The goal for the health promotion component of CHILD Profile is to provide consistent and comprehensive public health

messages to this population. Collaboration in the development of these materials improves parents' ability to understand a wide array of public health messages. It also helps the programs to assure our messages are coordinated, not contradictory, and are more cost-effective than each program creating individual materials.

### **Lead Study Collaboration**

In 1999, OMCH collaborated with the Non-Infectious Conditions Epidemiology Office of DOH in conducting a statewide study to determine 1) the prevalence of lead poisoning; 2) the prevalence of *streptococcus mutans* infection; and 3) the status of oral health and health care access in 1-2 year old children. The study was designed to provide prevalence estimates for all 1-2 year old children in Washington State and 1-2 year old Hispanic children in central Washington. A stratified random sample of 900 birth certificates was drawn and 93% of children were located. 70% of selected families agreed to participate. The prevalence of lead poisoning in 1-2 year old Washington children was 0.9% (95% confidence interval 0%, 1.9%). Most of the children with elevated blood lead levels were Hispanic children living in central Washington. The prevalence of lead poisoning in that group was 3.8% (95% CI 0%, 7.8%). While it isn't known why these children are at higher risk, some possibilities include: living in run down older residences, exposure to dust from sorts contaminated by past use of lead-arsenate containing pesticides, and use of Mexican pottery or traditional Mexican health remedies. The prevalence of infection with *streptococcus mutans* was 100% in both groups.

### **OMCH Relationships with Local Health Jurisdictions**

In Washington State, 34 LHJs partner with DOH to focus on the public health needs of local communities throughout Washington. OMCH provides funding to LHJs allowing considerable flexibility in the use of these funds. Unmet needs of MCH populations are identified by the LHJs through their local needs assessments. OMCH program staff work closely with LHJs to oversee contract activities and provide consultation and technical assistance, when needed. OMCH administrators and staff meet regularly with the Nursing Directors of LHJs, and with other local OMCH staff through MCH Regional Meetings held quarterly throughout the state. Following are some examples of the collaboration and contract activities:

- As of March, 2000, 24 of Washington's 34 LHJs contracted to participate in CHILD Profile's immunization registry.
- The Immunization Section partners with LHJs to fund several assessment capacity building projects to survey childhood vaccination coverage rates.

- OMCH contracts with 19 LHJs to provide preventive population based oral health services. These include: oral health assessment, screening and referral; promotion and education; and early disease intervention activities through WIC, First Steps, and schools. LHJs also build coalitions to increase access to dental services. Dental sealant programs provide sealants for over 7,500 second grade students in targeted low-income schools.
- Through contracts with LHJs, OMCH funds four CSHCN Regional Representatives to provide leadership and to promote networking and problem solving for CSHCN issues. These four CSHCN Regional Representatives bring issues from local CSHCN Coordinators and others within their region to the state level CSHCN Communication Network meeting every other month for ongoing discussions, problem-solving, and decision-making activities.
- OMCH has developed a regional system of teams to promote communication and provide technical assistance to the LHJs maternal and child health staff. Five regional teams comprised of a representative from each OMCH office (MIH, CAH, CSHCN, and Immunization) meet regularly with local MCH staff to share information, discuss issues of concern to the MCH population, and provide training and education about MCH population issues. The OMCH teams also work directly with each LHJ to review, discuss, and provide consultation on contracted activities.
- OMCH contracts with 34 LHJs for implementation of local child death review programs.
- OMCH contracts with two LHJs to provide teen pregnancy prevention programs.
- OMCH contracts with all LHJs for basic MCH services.
- See Appendix A and pages 79-83 for a more detailed information about LHJ activities in 1999.

### ***OMCH Relationships with Title XIX Programs***

OMCH collaborates with the state Medical Assistance Administration (MAA) in DSHS, which operates the Medicaid program (Throughout this document the term, MAA, will be used when referring to the state office and the term Medicaid will be used to refer to either the program or the population covered by the program).

An interagency agreement between MAA and OMCH has been in place since 1991. This agreement has grown from a sole focus on maternity issues to a broader collaboration addressing MCH populations and several other DOH programs such as HIV/AIDS, Community and Rural Health, and Quality Assurance of state purchased health care. Coordination continues with the

jointly sponsored First Steps Program, which serves pregnant women and infants to promote healthy births (OMCH and DSHS oversee different parts of this program). The First Steps workgroup meets monthly to get updates from programs in DSHS including MAA, managed care, WorkFirst, the Division of Alcohol and Substance Abuse (DASA), Children's Services, Research and Data Analysis, and from DOH (including OMCH and Family Planning). OMCH manages the MSS program. OMCH and MAA First Steps staff meet monthly to review the status of MSS and MCM provider agencies, plan site visits, review policy issues, plan trainings and meetings and prepare materials for quarterly bulk mailings to First Steps providers. MAA also provides administrative match for PRAMS activities not covered by the CDC grant. PRAMS data are stratified by Medicaid recipient status and used by the First Steps program to evaluate the effectiveness of program services.

The OMCH toll-free line is contracted through the Healthy Mothers Healthy Babies Coalition (HMHB). Participating funders of the toll-free line include OMCH, WIC, Family Planning, and Immunizations with administrative match provided by MAA. MAA also channels Client Outreach Project funds to DOH, which contracts with HMHB for activities aimed at increasing the number of children and pregnant women enrolled by MAA.

Partnerships between OMCH and MAA have also been developed with the mutual goal of assuring quality health services for infants, children and adolescents served by Medicaid. This goal is addressed through OMCH staff representation on the Medicaid External Quality Review Organization Contract committee (EQRO). The quality of health services delivered to Medicaid clients is monitored through the EQRO contracts. OMCH staff are represented on three subcommittees that determine this monitoring process. One of these committees focuses on CSHCN. Conversely, the Medicaid agency is represented on the OMCH Quality Assurance Team. The purpose of this team is to create a sustainable mechanism for assuring a quality health system. One strategy to achieve this is formalizing partnerships and collaborations with MAA on quality assurance activities. Additionally, OMCH staff participates on the EPSDT Improvement Committee, led by MAA and including many managed care organizations.

The OMCH Child and Adolescent Health Section works with MAA on several issues, including maintaining Medicaid Matching funds for oral health outreach activities provided by over twenty LHJs and MAA participation in current development of an Interagency Oral Health Action Plan. A close partnership has been developed with MAA and CHILD Profile and has resulted in matching funds for CHILD Profile activities, data sharing agreements, and MAA participation in

developing the health promotion materials for parents. MAA staff are also participating in a cross agency planning process initiated by CAH to develop a standard definition of the activities that should be included in a “home visit.”

The CSHCN Section works with MAA to improve access and quality of health services for children with special health care needs. CSHCN staff meet monthly with MAA staff to exchange information, address policy and program issues, and discuss questions raised by community providers and families. MAA staff also attend CSHCN Communication Network meetings every other month with representatives of CSHCN contractors and partners. This allows MAA to hear issues and concerns from all regions of the state. It also provides a mechanism for questions about MAA programs and policies to be answered and for timely updates on programs and policies to be provided.

CSHCN staff continue to coordinate information and participate on various MAA workgroups and committees for both managed care and SSI populations. CSHCN staff have been involved in: providing recommendations for additional indicators to be included in EPSDT Chart reviews; determining content, analysis, and stakeholder reports of consumer surveys; designing and promoting a uniform EPSDT chart form; and revision of managed care rules.

CSHCN staff are collaborating with MAA, the Washington State agency responsible for administering the state’s Medicaid Program, on a state pilot project to implement quality assurance measures for children with special needs. The pilot utilizes survey tools developed by the Foundation for Accountability (FACCT). FACCT is located in Oregon, and is nationally recognized for its work in developing tools for identifying children with special health care needs and measuring quality of care for children and adolescents. The FACCT children with special health care needs screener, known as the Living With Illness Measure, is being incorporated into the statewide Medicaid Consumer Assessment of Health Plans Survey (CAHPS) for children served in both Medicaid Managed Care and Fee For Service.

CSHCN staff are also working with MAA to identify children with special health care needs served by both Title V and Medicaid, in response to Health Care Financing Administration (HCFA) requirements for the Medicaid 1915B Waiver. This effort will also include working with the DSHS Division of Mental Health to identify children with special health care needs served by both Title V and the Division of Mental Health.

The Immunization Program works extensively with MAA on the Vaccines for Children (VFC) program to ensure VFC-qualified children receive adequate immunizations. This cooperative effort includes required statewide accountability activities to verify the percentage of VFC-qualified children served and to justify 48 percent funding for vaccines distributed to public and private providers.

The state OMCH program provides state match for Medicaid prenatal genetic counseling services. OMCH staff oversee the program and work with MAA to ensure that up-to-date billing instructions are in place. Medicaid also covers genetic counseling services for up to 90 days after birth.

MAA participates on the Statewide Perinatal Advisory Committee (PAC) and provides administrative match for the Perinatal regional programs located throughout the state. MAA also provides administrative match for the University of Washington (UW) School of Nursing contract which provides training to public health nurses, First Steps providers and others in local communities on Nursing Child Assessment Satellite Training (NCAST) and Region X Standards.

In 1998, MAA asked OMCH to facilitate the implementation of MAA reimbursement of planned home births. OMCH has contracted with Public Health – Seattle and King County, with Medicaid providing both the state and federal match through the interagency agreement. Activities include development of a data collection tool, planning of regional trainings for home birth providers, and staffing of a Home Birth Oversight Subcommittee of the Perinatal Advisory Committee to monitor the program and review data and critical incidents.

A comprehensive linkage of Pregnancy Risk Assessment Monitoring System (PRAMS) data to other state data bases occurs through data sharing with the First Steps Database. Linkages with PRAMS data made at First Steps include Drug, Alcohol and Substance Abuse, Child Protective Services, Temporary Assistance to Needy Families (TANF), and Medicaid Administrative data bases. This data linkage facilitates the exploration of unintended pregnancy, substance use and domestic violence, and other issues among the Medicaid populations.

With the 1999 legislature's approval of Washington's participation in SCHIP, OMCH and other offices are working closely with MAA to conduct planning and outreach to uninsured children between 200-250 percent of the federal poverty level. OMCH staff are currently initiating efforts for SCHIP and Medicaid outreach through child care consultation carried out by public health nurses at the community level.

## ***OMCH Relationships With Other State Agencies***

### **DSHS's Division of Alcohol and Substance Abuse (DASA)**

OMCH coordinated and collaborated with DASA and numerous other partners in order to address legislative initiatives on drug/alcohol use during pregnancy. Currently OMCH actively participates in the oversight committee for developing, implementing and evaluating a comprehensive treatment program for chemically dependent pregnant or parenting women and their young children. In response to the \$7 million 1999 legislative proviso, three pilot comprehensive treatment programs for these women (one urban and two rural) are being implemented.

OMCH received \$170,000 per year additional funding from DASA for drug screening activities for pregnant women. A new DOH/DSHS Interagency Agreement was developed to allow for billing. Funds have been contracted with the regional perinatal programs for statewide provider outreach and consultation. Efforts will be focused on working with the comprehensive drug treatment and case management pilots planned in Snohomish, Whatcom, and Benton-Franklin Counties. Contracts were implemented January 2000. DOH has arranged for the availability of additional expertise in the area of motivational interviewing/addiction medicine to provide technical assistance and training through the Perinatal Program contracts. OMCH has established periodic meetings with the Perinatal Program drug screening staff leads and DASA staff to facilitate and provide technical assistance in implementation. Additional activities include continued distribution of the Guidelines for Screening for Substance Abuse During Pregnancy booklet and support for PRAMS and other assessment efforts to evaluate prenatal substance abuse and provider screening rates.

OMCH continues to coordinate legislative responses and testimony on bills that focus on substance abuse during pregnancy with DASA staff. OMCH staff also provide review and comment on DASA rule revision and other documents developed that are specific to pregnant women and their health care.

### **Office of Superintendent of Public Instruction (OSPI)**

OMCH provides staffing, policy, and planning support to develop and maintain a joint work agenda for DOH and OSPI supported by the directors of both agencies. These two agencies have chosen five focus areas for their collaborative work: early childhood, safe learning environments, student health care, information systems development, and health education. The Title V

Director meets monthly with her counterpart from OSPI for updates and coordination. Planning and policy staff also meet regularly with their counterparts to help guide the process. The directors of both agencies meet periodically for joint briefings and progress reports.

Specific outcomes from this partnership include:

- Planning and administering the 1999 Washington State Youth Risk Behavior Survey of high school students.
- Testifying together in support of bills directly affecting each agency during the last legislative session, showing a higher level of public commitment to work together on issues of school age children.
- Coordinating with OSPI on a range of teen pregnancy prevention issues, abstinence education and media literacy education.
- Providing partial funding for OSPI's Teen Aware Program through an interagency agreement.
- Coordinating the statewide Smile Survey, an assessment of children's oral health status
- Promoting the use of "The Tooth Tutor," an oral health curriculum for schools.

The Immunization Program works collaboratively with OSPI's Health Services Supervisor on issues involving immunization requirements for school entry. OSPI also collaborates with OMCH by participating on the Birth Defects Surveillance Advisory Board in making recommendations to enhance birth defects surveillance. Other current efforts include implementation of the State Tobacco Prevention and Control Plan, development of the school nursing core, and joint grant application projects.

### **Family Policy Council (FPC)**

DOH is a member agency in Washington's FPC. The FPC is statutorily mandated and includes representation from the agency heads of DSHS, DCTED, the Employment Security Department (ESD), OSPI, and DOH. The Office of the Governor, and both legislative houses are also represented. FPC's mandate is twofold: to consider family policy issues and to undertake a process of reforming the service delivery system via the oversight of 53 local grassroots organizations, called Public Health and Safety Networks, throughout the state.

Through the Office of Epidemiology, DOH coordinates the provision of data to networks to support local strategic planning and policy development. OMCH assists with review of network plans and statements of work, and brokers specific technical assistance requests. OMCH also plays a leadership role in the crafting of an interagency policy agenda for FPC. Earlier this year, FPC chose the issue of early childhood supports for socially and economically isolated families as its main area of work. The process to develop a more specific interagency work agenda around this focus has led member agencies to convene an interagency think-tank to study factors impacting the way in which families thrive or fail to do so. The Think-Tank, with OMCH staff playing a leadership role, has developed a set of indicators to help describe how Washington families fare in the continuum of life experiences that lead to thriving. In addition, the Think-Tank has mapped and analyzed the Service Delivery System. Based on the above work, the Think-Tank will propose a set of strategic policy recommendations to the FPC Agency Directors. These recommendations will focus on Governance issues, program design, resource investment, and service delivery models. The work of the Think-Tank will become the cornerstone for development of an interagency policy agenda focused on helping families to thrive.

### **DSHS's Office of Procedures and Policy**

The Perinatal Partnership Against Domestic Violence (PPADV) has expanded partnerships to include: the DSHS Office of Procedures and Policy; Washington State Coalition Against Domestic Violence (WSCADV); DOH Community and Rural Health; Washington State Public Health Nursing Directors; Washington State American Medical Association, Association of Nurse Midwives, Region X Federal Women's Health, Washington State Obstetrical Association, American Nurses Association; Swedish Medical Center, Evergreen Health Care, and the Providence Health Care System. The PPADV is an advisory board that reviews training materials, provides training and marketing of the PPADV Training and curriculum, locates funding; and promotes awareness of domestic violence in the perinatal period.

### **DSHS's Children's Administration (CA)**

OMCH works with CA, which includes Child Protective Services (CPS), Child Care and other offices, on subjects of joint concern, such as chemically dependent pregnant women, child maltreatment and child death review. CPS staff participated in the development of the two legislative reports on chemical dependency and pregnancy (see explanation under DASA, Item #1 in this section). These reports focus on improving services to chemically dependent pregnant women and their infants and improving medical provider practices.

Another joint effort between OMCH and CPS involves proposing, reviewing, and commenting on legislation to reduce and/or prevent child maltreatment. In addition, OMCH and CPS share information regarding CPS and OMCH service systems. Significant progress was made during 1998 in jointly planning the child death review system for the state. An interagency agreement is being developed that will spell out the responsibilities and use of the child death review system to fulfill the data needs of both agencies.

The State Child Death Review Committee is chaired jointly by the Director of OMCH and the Director of Program and Policy Development for Children's Administration. OMCH collaborates closely with the DSHS Domestic Violence Program in supporting all local shelters for women and children and the Coalition Against Domestic Violence on the Perinatal Partnership Against Domestic Violence project, which has focused on training perinatal providers on domestic violence issues.

### **DSHS's Mental Health Division**

OMCH continues to link Mental Health Regional Support Services Staff to First Steps provider groups through joint meetings, trainings, and collaborative prevention programs. OMCH also continues to exchange information with the Mental Health Division regarding programs, data, and resource materials. The purpose of this activity is to improve access for First Steps clients to mental health services. OMCH encourages contractors in local health jurisdictions to develop partnerships with Regional Support Services staff and to bring issues related to mental health for children with special care needs to the CSHCN Communication Network meetings. Over the coming year, the Mental Health Division will provide training to LHJ's child care consultants. Additionally, in response to HCFA requirements for the Medicaid 1915B Waiver, staff from the Mental Health Division are working with the CSHCN program and MAA to identify the number of children with special health care needs served by both Title V and the Division of Mental Health.

### **DSHS's Disability Determination Service (DDS) and Social Security Administration (SSA)**

The CSHCN program maintains a Memorandum of Agreement with DDS in order to provide outreach to families of SSI applicants up to age 16. DDS provides data files of these applicants to the CSHCN program on a quarterly basis. Local CSHCN coordinators use this listing to contact families with information about local programs and services. Collaborative efforts between the two programs have addressed the Redetermination Project of SSA, ensuring mutual

outreach to provide families with information about each program, and providing information to advocates for planning purposes.

A staff member from OMCH's CSHCN serves as a Title V/Title XVI liaison. The CSHCN program maintains ongoing communication with local and regional SSA offices in order to provide the most current and pertinent information about SSI to providers and families.

### **DSHS's Division of Developmental Disabilities' Infant Toddler Early Intervention Program (ITEIP)**

OMCH is an active participant in coordinating efforts to implement Part C of the Individuals with Disabilities Education Act (IDEA). Through an Interagency Agreement with DSHS, DCTED, the Department of Services for the Blind, and OSPI, DOH agrees to work proactively with these partners to assure a comprehensive statewide system of early intervention services for eligible infants and toddlers (birth to three years) with disabilities and their families.

Statewide integration and coordination of efforts are addressed at bi-monthly interagency meetings with DOH, ITEIP, and OSPI, the State Interagency Coordinating Council; and at the CSHCN Communication Network meetings. OMCH encourages contractors in local communities (local public health, family organizations, early intervention centers) to promote local coordination and integration of services by participating on local Interagency Coordinating Councils and developing working partnerships.

Through a Data Sharing Agreement with DSHS, the CSHCN Program provides data on children (0-3 years) served by local CSHCN programs to ITEIP for their annual Birth to Three Count Report.

### **DSHS's Division of Vocational Rehabilitation (DVR)**

Through a contract with the Adolescent Health Transition Project (AHTP) at the University of Washington Clinical Training Unit, Center for Human Development and Disability, the CSHCN program continues to provide and share information with DVR to address health and other issues related to the transition of children with special health care needs from adolescence to adulthood. The AHTP staff continues to provide materials for regional DVR Transition activities and events, such as job fairs hosted by DVR for adolescents with special needs.

## **DSHS's Medicaid Dental Program**

OMCH Oral Health Program continues to collaborate with the Office of Medical Assistance's Medicaid Dental Program on issues related to the lack of access to dental services for Medicaid children. DSHS provides input on Medicaid billing for dental sealant programs and other preventive oral health services. Over the coming year, interagency planning will take place to create even closer collaboration on oral health initiatives.

## ***OMCH Relationships with Other Agencies/Programs***

### **Managed Care Plans**

CSHCN staff, in partnership with Children's Hospital and Regional Medical Center (CHRMC) staff, are meeting with five health plans to determine shared interests regarding quality assurance for the CSHCN population. CSHCN staff also work closely with various state partner agencies who, via grant funding, are addressing data, quality assurance, and consumer information issues related to children with special needs in managed care.

### **Hospitals And Other Specialized Services**

*Children's Hospital and Regional Medical Center (CHRMC)* works with OMCH and the CSHCN Program, through a contract with the Center for Children with Special Health Needs and Chronic Conditions, to provide data and information to families, providers, and policy makers regarding health care issues for children with special health care needs and their families. CHRMC assists OMCH in implementing the CSHCN Assessment Plan, and provides training and resources to health care providers to improve their capacity to work with this population (e.g., "parents as partners in health care," and "Critical Elements of Care" for chronic health conditions). In partnership with CSHCN, CHRMC assists in developing a family leadership plan to facilitate family participation in state and local level policy decisions.

*Mary Bridge Children's Hospital and Health Center (MBCH)* assists CSHCN in developing and disseminating guidelines for the care of the high-risk infant and child. Through a CSHCN Program contract with the High Risk Follow-up Clinics at MBCH and the University of Washington, the Neonatal Intensive Care Units at both hospitals include "Critical Elements for the Low Birthweight Neonate" as part of their discharge plan sent to the child's primary care provider. Additionally, MBCH is the site of one of the 14 MCH supported Neurodevelopmental Centers.

*Seven (of Twelve) Regional Genetics Clinics*, located throughout the state, are funded to provide clinical genetic services for all MCH populations as well as provide educational outreach to the communities. Data generated by the regional genetic clinics are used for program planning and policy development. A Genetics Resource Line, initially established and supported by OMCH to provide education and referral services to health and social service providers on issues related to Genetics (1-800-562-GENE), is run through the University of Washington Medical Genetics Program.

*Four Regional Perinatal Programs*, also located throughout the state and under contract with OMCH, provide consultation and training to health care providers on specialized care for high risk pregnant women and neonates. The Statewide Perinatal Advisory Committee (PAC), staffed by OMCH, brings together representatives from tertiary care centers, professional organizations, consumer groups and state agencies to review and assess perinatal health issues and assist in developing policies and practices to improve perinatal outcomes.

*Community Health Clinics (CHC)* play a major role in providing access to direct health services as LHJs continue to move toward core public health functions and away from providing in-depth personal health care services. Most CHCs are also First Steps MSS providers and participate in First Steps education updates sponsored by OMCH and MAA. Community Health Clinic Dental Clinics participate with the Oral Health Program to collaborate on community based preventive oral health programs such as school sealants and as a referral base for WIC and Headstart Children.

*Fourteen Neurodevelopmental Centers* are supported, in part, by MCH funding to maintain the capacity to provide evaluation, diagnosis, coordinated treatment planning, and specialized therapy to children 0-36 months of age with a variety of developmental or neurodevelopmental conditions. Data generated from these centers contribute to a yearly statewide count of infants and toddlers enrolled in Washington State public services and to CSHCN Program Assessment Data.

### **Universities and Libraries**

OMCH collaborates with several training programs through the University of Washington (UW), including a Pediatric Pulmonary center Training Grant (CSHCN), Leadership Education in Neurodevelopmental Disabilities Training (CSHCN), and the CSHCN Nursing Leadership Training Grant.

Other collaborative projects with UW include:

- 1) A contract with the School of Nursing at UW focuses on assessment and planning for education and training for public health professionals. Currently, this includes training and support for five David Olds Home Visitation Pilots located at LHJs throughout the state.
- 2) OMCH Nursing Consultants provide mentoring to School of Nursing Leadership Training Grant Trainees, and OMCH staff teach classes to UW graduate students on topics such as: maternal child health, Title XIX, Welfare Reform, SSI and outcome measures for state programs.
- 3) OMCH has contracts with several programs within the Clinical Training Unit, Center on Human Development and Disability (CHDD) within UW, funded by MCHB, to extend and enhance MCH priorities. These include:
  - A contract to assist with the development and implementation of CHILD Profile and to coordinate the evaluation of CHILD Profile;
  - A contract to promote the availability of quality, community-based nutrition and feeding team services for children with special health care needs;
  - A contract to promote quality care for children at risk for health and developmental concerns. This contract develops, distributes, and promotes use of guidelines for primary care providers, provider training and consultation to community providers and families, and promotes the medical home concept through education and training, and by creating and maintaining linkages with a network of medical home training teams throughout the state.
  - A contract to provide a statewide resource for health transition issues for adolescents with special health care needs, their families, and providers.

OMCH's Immunization Program contracted in 1998 with the UW for a survey of knowledge, attitudes and practices of immunization providers.

In addition to coordinating work with universities, OMCH contracts for services with two library systems. Washington State Library is contracted to provide books of interest to families with children with special health care needs via the public library system. The Evergreen State College Library contracts for loaning OMCH related videos to First Steps Providers.

### **Parent Peer Support Networks**

OMCH supports the Washington State Fathers' Network (WSFN) in providing information, outreach, and support to fathers of children with special health care needs as well as consultation to the CSHCN Program and other state and local organizations. The Network supports 14 regional sites to promote fathers' issues and provide information and peer support on a personal basis. Special emphasis is placed on promoting access to information to Spanish-speaking fathers. The Network supports a newsletter and the WSFN Website which are available in English, Spanish, and outreach activities specifically targeted to Spanish-speaking fathers in communities in eastern Washington. WSFN also promotes ethnic outreach through Steering Committee membership representing the Chinese, Native American, African-American, and Hispanic communities.

Washington Parent-to-Parent is also supported through an MCH contract. This organization provides 1) information, outreach, and support to families who have children with special health care needs; 2) local and state level training to assist parents in accessing services; 3) consultation to the CSHCN Program; and 4) consultation on a variety of local, state, and national groups and initiatives. Parent-to-Parent also incorporates a variety of efforts statewide, to promote access to information, peer support, and consultation opportunities to minority populations.

Through these relationships, the CSHCN program is able to obtain statewide parent perspective and input on issues related to families of children with special health care needs.

### **Healthy Mothers, Healthy Babies Toll-Free Line**

OMCH continues to contract with HMHB Toll-free telephone line for consumer information and referral for maternity care and other maternal and child health concerns. As a part of this service, HMHB markets the toll-free line and conducts outreach to the community. The ASK line (Answers for Special Kids Toll-free line) was initiated in 1998 to address issues related to children with special health care needs also through the HMHB contract. HMHB is equipped to assist families of older children, as well as young children. OMCH staff convene and facilitate a team approach in managing this contract to assure coordination among OMCH, Immunization, Family Planning, WIC, and MAA programs related to HMHB activities.

### **Partnership with Centers for Disease Control and Prevention (CDC)**

For the past six years, OMCH had an agreement in place with the federal CDC, Division of Reproductive Health to provide a MCH Medical Epidemiologist to be stationed in Washington

State. The primary focus for the assignee was assessment capacity development for all areas of OMCH and especially for the Immunization Section. Specific work has recently been accomplished in assessing playground safety at selected schools and day care centers, determining physician immunization practices and participation in immunization registries, and local capacity development for assessing childhood immunization.

## II. Requirements for the Annual Report

### 2.1 Annual Expenditures

The accounting system used by the State of Washington and the Department of Health is called the Agency Financial Reporting System (AFRS). Data from AFRS is used for all direct program expenditures for the reporting year. To the direct program expenditures, overhead costs taken from the agency cost allocation system (system submitted to and approved by DHHS – Region X) are added to account for the total expenditure for the reporting year.

The total expenditure data is summarized onto Excel spreadsheets which distribute the expenditure data across reporting forms and categories based on percentage allocations determined by program managers and staff.

Significant variations are described below:

1. Between fiscal year budgeted and expended funds.
2. Between fiscal year expended funds column.

### ***Form 3: State MCH Funding Profile Variations Explained***

Category	FY99 Budgeted Minus FY 99 Expended Variance	Explanation
1. Federal Allocation	(328,520)	FY99 expended is higher than FY99 budgeted due to the following: (1) 99 block grant award received was higher than block grant application; (2) some second year 98 block grant expenditures were paid in FY99.
2. Unobligated Balance	0	
3. Total State Funds	(2,242,774)	FY99 expended is higher than FY99 budgeted due to unanticipated additional vaccine expenditures.
4. Local MCH funds	0	
5. Other Funds	0	
6. Program Income	0	
7. Subtotal	<u>(2,571,294)</u>	

Category	FY99 Budgeted Minus FY 99 Expended Variance	Explanation
8. Other Federal Funds	729,494	FY99 expended is less than FY99 budgeted due to less immunization grant funding received than projected.
9. Total	<u>(1,841,800)</u>	

Category	FY99 Expended Minus FY 98 Expended Variance	Explanation
1. Federal Allocation	492,841	FY99 expended is higher than FY98 expended budgeted due to the following: (1) 99 block grant award received was higher than 98 block grant award; (2) some second year 98 block grant expenditures were paid in FY99.
2. Unobligated Balance	0	
3. Total State Funds	2,397,602	FY99 expended is higher than FY98 expended due to unanticipated additional vaccine expenditures.
4. Local MCH funds	(19,900)	
5. Other Funds	0	
6. Program Income	<u>0</u>	
7. Subtotal	2,807,543	
8. Other Federal Funds	(964,320)	FY99 expended is less than FY98 expended due to (1) a significant reduction in Immunization grant expenditures; (2) loss of one SPRANS grant (Linkages and Outcomes for Children grant).
9. Total	<u>1,906,223</u>	

**Form 4: Budget Details by Types of Individuals Served  
Variations Explained**

Category	FY99 Budgeted Minus FY 99 Expended Variance	Explanation
a. Pregnant Women	348,476	FY99 budgeted is higher than FY99 expended due to budget projections being too high for this category.
b. Infants <1 year old	(1,952,504)	FY99 expended is higher than FY99 budgeted due to: (1) implementation of new child death review program activity; (2) higher vaccine expenditures than originally projected.
c. Children 1 to 22 years old	(1,312,171)	FY99 expended is higher than FY99 budgeted due to (1) implementation of new child death review program activity; (2) higher vaccine expenditures than originally projected.

Category	FY99 Budgeted Minus FY 99 Expended Variance	Explanation
d. CSHCN	830,001	FY99 budgeted is higher than FY99 expended due to budget projections being too high for this category.
e. All Others	120,265	FY99 budgeted is higher than FY99 expended due to budget projections being too high for this category.
f. Administration	(605,361)	FY99 expended is higher than FY99 budgeted due to unanticipated increase in direct program spending, primarily in vaccine expenditures also requiring administrative expenditures.
<b>g. Subtotal</b>	<b>(2,571,294)</b>	

Category	FY99 Expended Minus FY 98 Expended Variance	Explanation
a. Pregnant Women	278,048	FY99 expended is higher than FY98 expended due to Local Health Jurisdictions (LHJs) reporting higher expenditures in this category compared to the previous year (20% in FY99 versus 16.1% in FY98).
b. Infants <1 year old	1,296,840	FY99 expended is higher than FY98 expended due to: (1) implementation of new child death review program activity; (2) higher vaccine expenditures than originally projected; (3) LHJs reporting higher expenditures in this category as compared to the previous year (17% in FY99 versus 12.3% in FY98).
c. Children 1 to 22 years old	641,821	FY99 expended is higher than FY98 expended due to (1) implementation of new child death review program activity; (2) higher vaccine expenditures than originally projected.
d. CSHCN	335,514	FY99 expended is higher than FY98 expended due to LHJs reporting higher expenditures in this category as compared to the previous year (37% in FY99 versus 28.9% in FY98).
e. All Others	(192,621)	FY99 expended is less than FY98 expended due to LHJs reporting less expenditures in this category as compared to the previous year (1% in FY99 versus 4% in FY98).
f. Administration	510,941	FY99 expended is higher than FY98 expended due to increases in direct program spending, primarily in vaccine expenditures, which are subject to administrative expenditures through the cost allocation system.
<b>g. Subtotal</b>	<b>2,807,543</b>	

**Form 5: State Title V Programs Budget and Expenditures by Type of Service Variation Described**

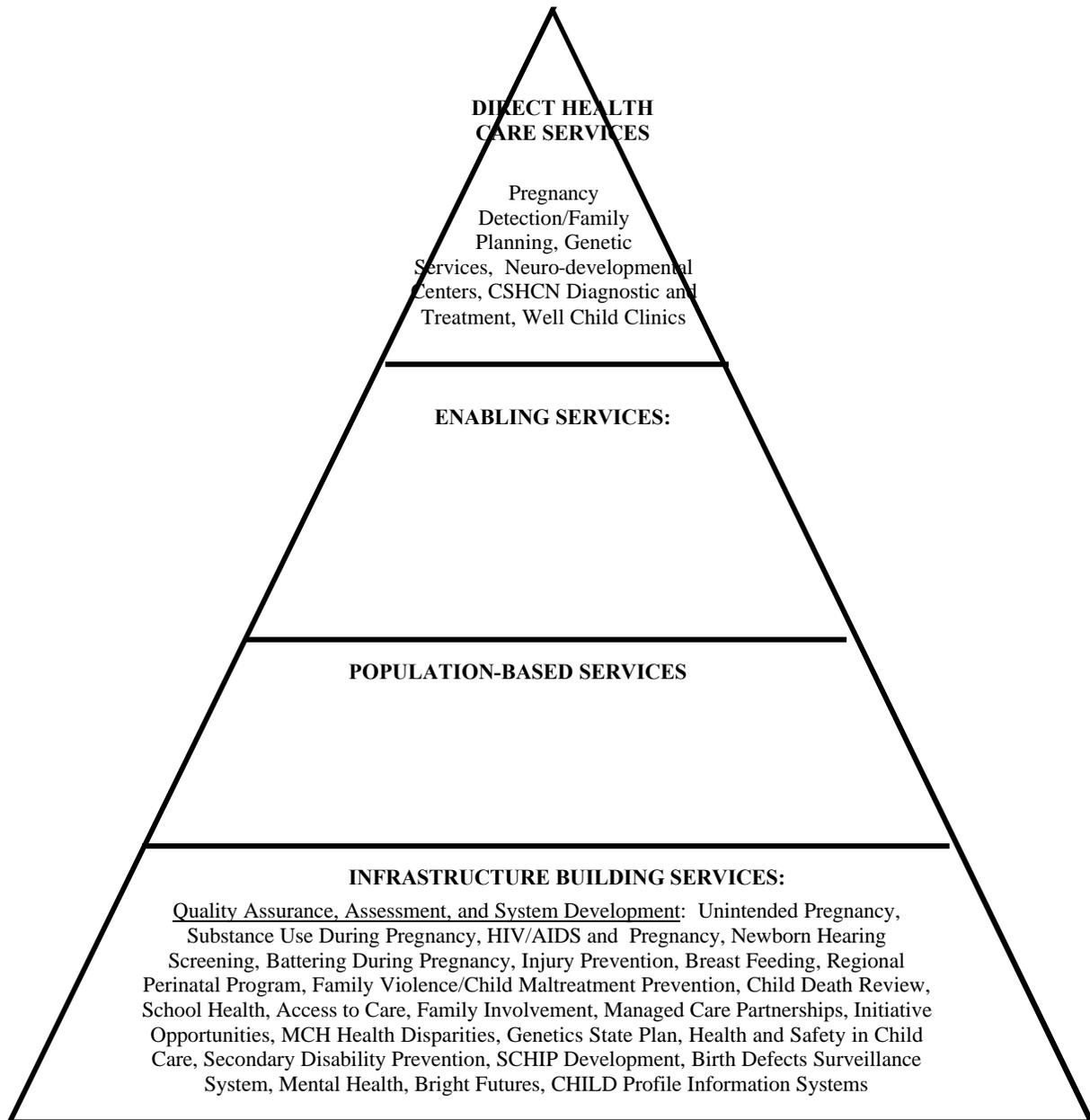
Due to further discussion and analysis of the proper placement of expended funds by the categories on this form, significant variation between fiscal years materialized. Discussion of these variations by category are stated below:

Category	FY99 Budgeted Minus FY 99 Expended Variance	Explanation
I. Direct Health Care Services	770,230	
II. Enabling Services	321,206	
III. Population-Based Services	(5,892,852)	
IV. Infrastructure Building Services	2,230,122	
V. Federal-State Total	(2,571,294)	<p>FY99 expenditures are higher than FY99 budgeted due to increase in vaccine expenditures in the Immunization Section and the implementation of the Child Death Review program.</p> <p>Variances by category between budgeted and expended are primarily due to refinements in the placement of services by category over the initial three years of reported budget information by category.</p>

Category	FY99 Expended Minus FY 99 Expended Variance	Explanation
I. Direct Health Care Services	(33,249)	
II. Enabling Services	1,842,234	Variance due to the following: (1) reclassification of the following activities from category III: Teen Pregnancy Prevention, Abstinence Education, and the Healthy Mothers Healthy Babies contract; (2) increase in LHJ expenditures reported in this category (from 36.8% to 43%) over prior year.
III. Population-Based Services	(204,203)	Higher vaccine expenditures in this category are more than offset by reclassification of expenditures to categories II and IV and a decrease in LHJ expenditures reported for this category.
IV. Infrastructure Building Services	1,265,761	Variance due to increasing the percentage of expenditures for CHILD Profile, reclassifying expenditures from category III for Oral Health,

Category	FY99 Expended Minus FY 99 Expended Variance	Explanation
V. Federal-State Total	2,870,543	<p>and new unanticipated expenditures for Child Death Review.</p> <p>FY99 expenditure increase over FY98 is due to increased expenditures for vaccines in the Immunization Section and the implementation of the Child Death Review program.</p>

## 2.1 Core Public Health Services Delivered by MCH Agencies



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

See Forms 6, 7, 8

## **2.3 State Summary Profile**

See Form 10

## **2.4 Progress On Annual Performance Measures for 1999 and Detailed Activities**

For a discussion of progress made on each performance measure, see Section 3.4.2.4, starting on page 154. The following is a detailed report of FY 1999 OMCH activities and accomplishments. In Section 2.4.1, references follow each of the narrative descriptions of the activities/ accomplishments. These references tie the activity to the related population served, service level, performance measure, & priority as listed in the 2000 application submitted in July of 1998. The code for these references is as follows:

- Population Served
  - MIH – Maternal Infant Health
  - CAH – Child & Adolescent Health
  - CSHCN – Children with Special Health Care Needs
- Service Level (Pyramid)
  - DHC – Direct Health Care
  - ES – Enabling Service
  - PBS – Population Based Service
  - IBS – Infrastructure Building Service
- Performance Measure
  - SP – State Performance Measure
  - NPM – National Performance Measure
- Priority
  - PRI - Priority

Several of the priorities and state performance measures were modified and/or improved in 1999 and again this year as a result of feedback from Reviewers, accomplishments during the interim period, or findings from the Five Year Needs Assessment.

In cases where the activity relates to a performance measure identified for 1999, the SP number is 1-9. In cases where the activity relates to a performance measure identified for 2000, the SP number is 11-16. In cases where the activity relates to a new performance measure identified for 2001, the SP number is 17-21. For a complete list of all performance measures, past & present,

see Figure 4 on pages 150-153. The revised priorities and state performance measures will be used in the Annual Application for FY 2000 (see page 167.) The set of national performance measures and federal outcome measures remain the same for both the report and the application.

***State OMCH Priorities (Pri.) (Identified in 1997 Report and 1999 Application, Submitted July of 1998)***

- Pri. 1. Reduce unintended pregnancy rate.
- Pri 2. Improve access to preventive health care for children and adolescents including preventive oral health care.
- Pri 3. Improve the health and safety of child care.
- Pri 4. Improve the health of the school age child.
- Pri 5. Improve Washington state capacity to assess the prevalence of CSHCN and monitor health status and quality of services for CSHCN.
- Pri 6. Reduce family violence and child maltreatment.
- Pri 7. Reduce the prevalence of smoking and drinking among pregnant women, teens and school age children.
- Pri 8. Improve capacity for surveillance and assessment of adolescent health.
- Pri 9. Improve quality assurance of health services for maternal child health populations, including children with special health care needs.

***State Performance (SP) Measures for 1999 as Identified in the 1997/99 Application***

- SP1. The proportion of mothers who achieve minimum recommended weight gain in pregnancy.
- SP2. Agreement will be reached between DOH and OSPI on a tool and process(es) to collect data for the surveillance of adolescent health behavior. A survey instrument will be in place for use in 1999.
- SP3. Increase to 100 percent the number of Washington's local health jurisdictions connected to the CHILD Profile central immunization registry.
- SP4. The percent of pregnancies (live births, fetal deaths, abortions) that are unintended.

- SP5. The percent of pregnant women abstaining from smoking.
- SP6. The development/implementation of activities which will promote universal counseling and voluntary testing for all pregnant women and increase availability of therapeutic interventions to HIV positive women who choose to undergo treatment.
- SP7. The percent of pregnant women abstaining from alcohol.
- SP8. Percent of women who receive counseling from the prenatal health care provider on tests for identifying birth defects or genetic disease.
- SP9. Community systems for identifying and monitoring young children at risk for health and development problems will be assessed, and recommendations for increasing communities' ability to promote the health of this population will be developed.
- SP10. The establishment of an assessment plan for children with special health care needs.

### ***National Performance Measures (NPM)***

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.
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.
3. The percent of Children with Special Health Care needs (CSHCN) in the State who have a "medical/health home."
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).
5. Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertusis, Haemophilus Influenza, Hepatitis B.
6. The birth rate (per 1,000) for teenagers aged 15 through 17 years.

7. Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
8. The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.
9. Percentage of mothers who breastfeed their infants at hospital discharge.
10. Percentage of newborns who have been screened for hearing impairment before hospital discharge.
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.
12. Percent of children without health insurance.
13. Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.
14. The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.
15. Percent of very low birth weight live births.
16. The rate (per 100,000) of suicide deaths among youths 15-19.
17. Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
18. Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

### ***Federal Outcome Measures (OM)***

1. The infant mortality rate per 1,000 live births.
2. The ratio of the black infant mortality rate to the white infant mortality rate.
3. The neonatal mortality rate per 1,000 live births.

4. The postneonatal mortality rate per 1,000 live births
5. The perinatal mortality rate per 1,000 live births
6. The child death rate per 100,000 children aged 1-14.

## **2.4.1 Program Activities By Levels Of The Pyramid, By Population, Related To Performance Measures And Priorities**

### **Direct Health Care Services**

#### ***Pregnant Women and Infants***

**Genetics.** Due to the increased demand for genetic specialty services and poor reimbursement for these services, the Genetic Services Section of OMCH contracted with twelve genetics clinics throughout the state. The purpose of this activity was to identify individuals and families at risk for genetic disorders and birth defects and provide them with information about possible interventions. As a result of this activity, 2,158 clinical genetics patients and 5,813 prenatal genetics patients, for a total of 7,971 patients, received genetic counseling in 1998. While the number of overall patients served decreased from the previous year, the number of genetics patients seen increased over 8%. The prenatal genetics patients decreased almost 10%. The program is exploring the possible reasons for these changes. (All populations, DHC, SP8, Pri.2)

**Pregnancy Detection.** OMCH funding was used by six LHJs to provide pregnancy detection and family planning services. This activity was designed with a two fold purpose: first, to detect pregnancy early and second, to refer to family planning services for those who test negative to prevent unintended pregnancies in the future. LHJs that provided these services included: Adams, Asotin, Columbia, Skagit, Walla Walla and Whitman. The population targeted for this activity is women of child bearing age in these rural communities where other family planning resources are not as readily available. (MIH, DHC, SP4, Pri.1)

#### ***Children and Adolescents***

**Teen Pregnancy Prevention.** One direct health care service provided through OMCH's teen pregnancy prevention program is teen clinic family planning service. This service helps fund comprehensive family planning clinical services to sexually active teens. Teen Clinics have been

very successful in attracting and serving teens and are working over capacity, with approximately 6,500 teens using these clinics in FY 1999. The literature supports the need for clinical family planning services to augment education and skill building being implemented by the teen pregnancy prevention (TPP) projects. OMCH was the lead on this activity with partners including: Family Planning agencies, Planned Parenthood, and LHJs. (CA, DHC, NPM6, Pri.1)

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

**Diagnostic and Treatment Funds.** OMCH maintains a diagnostic and treatment fund that can be used for children who have no other means of funding or payment for medically necessary services. This fund allows children to receive services that would not be funded by any other source. This activity is provided through the CSHCN coordinators in the LHJs and monitored by OMCH. This activity will continue because feedback from families and local CSHCN Coordinators still indicates that not all medically necessary services are available or financially covered by other programs or funding sources. For example, funding for nutrition supplements, hearing aid batteries and daily living tools may be provided through this fund. (CSHCN, DHC, SP9, NPM2, Pri.4)

**Neurodevelopmental Centers (NDCs).** OMCH also provides some funding to Neurodevelopmental Centers to help them maintain the capacity to provide specialty services for children with special health care needs, including occupational, physical, and speech therapies. In 1999, 14 NDCs received funding and provided the state with data on 2,651 children with special health care needs served. This activity was undertaken because MCH has an ongoing role in assuring access to statewide early intervention services. OMCH is the lead on this activity with support from MAA, ITEIP, DDD, and LHJs. (CSHCN, DHC, SP9, NPM2, Pri.2)

## **Enabling Services**

### ***Pregnant Women and Infants***

**Genetics.** The Genetics Education Plan was developed in 1997 in response to the lack of coordination among groups providing genetic education. OMCH played the lead in coordinating several partners including: the University of Washington, Pacific Northwest Regional Genetics Group, OSPI, the March of Dimes, and the Fred Hutchinson Cancer Research Center. In 1999, the Genetic Services Section began implementation of the Genetics Education Plan. Some target audiences include: health care professionals, teachers, adoption workers, insurance providers,

and the general public. Provider education was implemented through training sessions entitled, “Genetics and Your Practice.” OMCH collaborated with medical geneticists and genetic counselors to provide 41 trainings to health care providers throughout the state. (All populations, ES, SP8, Pri.9)

**Medicaid Outreach.** Another enabling service involving Medicaid outreach was developed based on data that indicated that a significant number of uninsured families/children might be eligible for Medicaid but unaware of the program. In these projects, families were linked to Medicaid eligible services through the HMHB toll-free line and through MSS. In addition to routine linkage activities performed by HMHB, they also assisted clients in applying for Medicaid. The purpose of these activities was to increase the number of families eligible for Medicaid enrolling in Medicaid, and assist Medicaid clients in getting the health services they need.

During CY 99, 3014 families were assisted in applying for Medicaid through the HMHB client outreach project. During SFY99, over 35,000 pregnant and post partum women received Maternity Support Services through First Steps. OMCH provides the program management for this activity, with partners including MAA, HMHB, and MSS Providers. (MIH, ES, NPM13, Pri.2)

## ***Children and Adolescents***

**Teen Pregnancy Prevention.** Teen pregnancy, was identified as a priority through the OMCH five year needs assessment process. The Legislature, as well as DOH, continue to support the teen pregnancy prevention program. In response, OMCH maintained numerous enabling services to reduce teen pregnancy. OMCH supports 10 comprehensive teen pregnancy prevention projects in 14 counties in Washington State. These projects are designed to reduce teen pregnancy through a variety of interventions and activities including youth development, comprehensive sexuality education, skill building, client advocacy/support, mentoring, and parent-child communication, as well as clinical family planning services. During FY '99, approximately 9,500 youth received teen pregnancy prevention services, including clinical family planning services targeting teens 11-19 years of age. OMCH was the lead on this project with partners including: Planned Parenthood, DSHS, OSPI, the LHJs, and youth serving agencies and advocacy groups. (CA, ES, SP4, NPM6, Pri.1) OMCH also provided training to LHJs on the parenting education curriculum, “Make Parenting a Pleasure,” and assisted with the development

of educational materials for LHJs regarding public health nurse home visiting for parents of infants and young children.

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

**Care Coordination.** In 1999, care coordination was provided to more than 7,400 children with special health care needs through local public health nurses. Families continually tell us that care coordination is needed. Care coordination was also identified as a priority during the five year needs assessment process. This service is provided to promote access to the total array of services, support families, and to assure information sharing among all participants; so that children with special needs and their families can reach their full potential. As a result of these activities, families were provided needed information and assistance to access services in their community. (CSHCN, ES, NPM2, Pri.5)

**Medical Home.** Another enabling service undertaken by OMCH in 1999 was to promote the concept of securing a medical home for all children with special health care needs. OMCH promoted the medical home concept by sponsoring 15 statewide medical home leadership teams (which included parents as integral members); supporting an annual statewide conference; developing a care coordination notebook; creating a website and bulletin board; and through development of “Child Health Notes,” a newsletter template for use in communities to provide information to providers and families of children with special health care needs. In addition to promoting the medical home concept, these activities were designed to address the knowledge barriers faced by primary care providers and public health providers, and to increase access to quality primary care services for children with special health care needs and their families.

As a result of these activities, primary care providers and public health providers gained knowledge about service provision and resources available; the medical home concept was promoted; collaboration among partners was improved; and additional resources and input in the area of early identification and early intervention were provided (relates to SP 9). These activities were undertaken in recognition of the importance of a medical home in quality provision of care. Additionally, this provides information for the data requirement of NPM 3. These activities targeted children with special health care needs ages 0-21 and their families throughout the state. OMCH was the lead on the project. Partners included the University of Washington’s CHDD, the Medical Home Leadership Network, the Washington Chapter of the American Academy of Pediatricians (AAP), families, providers, Parent to Parent, Father’s Network, local CSHCN Coordinators, and CHRMC. (CSHCN, ES, NPM3, Pri 9)

## **Population Based Services**

### ***Pregnant Women and Infants***

**CHILD Profile.** OMCH included a message about birth spacing and family planning in the CHILD Profile health promotion letter sent to all parents through CHILD Profile. The goal was to provide a population based health education message about birth control and spacing so women achieve planned pregnancies that are spaced for optimal outcomes. The message was placed in two letters (the 30 day and the 3-4 month letter) and were sent to 79,000 parents. Another message regarding spacing was developed for the 5 month and 11 month health promotion letters. This activity targeted women of child bearing age who have delivered a baby in the State of Washington. OMCH is the lead on CHILD Profile health promotion materials. (CA, PB, SP4, Pri.1)

### ***Children and Adolescents***

**Child Profile.** The CHILD Profile Program, which targets all Washington children ages 0-6 years of age, is a major population based service led by OMCH, with two major components: health promotion and immunization tracking. The CHILD Profile Health Promotion project continued statewide expansion in 1999, sending the materials to all parents of children born in CY99. Immunization tracking expansion also continued with health plans, private providers, and LHJs contracting to participate. One goal of these activities was to send health promotion materials (reminders for well-child exams and immunizations) to the parents of all children born so that children will be more likely to get exams and immunizations. A second goal was to increase provider participation in the statewide immunization registry.

In 1992, a task force identified the need for a system to improve utilization of preventive health care, including immunization rates and EPSDT. Therefore, increased efforts have been made in OMCH, through the CHILD Profile Program, to promote immunization practices and other preventive services. As of December 31, 1999, 287,291 families are receiving health promotion materials and the contracts are in place with the following providers to ensure participation in the immunization registry: eight health plans, one tribal health clinic, 16 private providers, 24 LHJs and ten community migrant health centers.

OMCH, DOH, Public Health – Seattle and King County, Snohomish Health District, MAA, Washington Health Foundation, and WSALPHO are all partners in these activities. (CA, PB, SP15, Pri.2)

**Bright Futures.** OMCH continued to develop its work with Bright Futures. The Bright Futures (BF) workgroup met on a regular basis to coordinate state and local activities regarding Bright Futures tools and concepts. Focus groups were conducted in Whatcom County to identify challenges and opportunities to implementing BF concepts and materials at a local level. OMCH has an Interagency Agreement with the UW to continue implementing BF at a local and state level. These activities were undertaken due to a need identified by the OMCH QA Team, the 5 year needs assessment process, and the input from key stakeholders at the state and local level. While initially targeting Whatcom County, OMCH plans to expand the use of BF across the state. OMCH is the lead on this activity. (CA, PB, SP9, Pri. 4)

**EPSDT.** OMCH participated on MAA's EPSDT Improvement Team. The purpose of this Team is to increase the number of children receiving EPSDT screens and to improve the quality of the EPSDT screens. OMCH has been very involved in providing input regarding both the content and structure of the chart insert tools — which is an insert for providers to use during well child check-ups 0 to 18 years — that meets EPSDT standards. OMCH continues to increase collaboration with MAA through the EPSDT Improvement Team as well as developing relationships with managed care organizations. This activity was undertaken because it helps achieve one of the priorities identified in the five year needs assessment process, early identification, diagnosis and intervention. This project targets Medicaid clients throughout the state. (CA, PB, SP14, Pri.2,9)

**Abstinence Education.** Another major population based service led by OMCH was the Title V Abstinence Education Program, designed to reduce teen pregnancy. The implementation plan was developed and undertaken in response to feedback from community meetings, written input from residents, and a review of literature. Ten contracts were developed and monitored by DOH for conducting abstinence education activities. These contracted agencies provided programs, quarterly deliverables and documentation of program results including, number of youth served and in-kind match received. A total of 12,813 individuals ages 10 to 24 years participated in abstinence education activities. The programs targeted youth ages 10-19 years of age in 7 communities. Partners included: OSPI, the University of Washington's Experimental Education Unit, the University of Washington's Washington Institute; and the Legislative Oversight Committee. The contracting portion of this project was an infrastructure building activity, with the programs being population based activities. (CA, PB, SP4, NPM6, Pri. 1)

**Teen Pregnancy Prevention (TPP).** OMCH provided other population based services through its TPP. OMCH led and/or arranged several trainings for TPP providers in order to increase awareness, skills, and expertise in teen pregnancy prevention and adolescent health. During 1999, three trainings were provided on such topics as adolescent development, media literacy, emergency contraception and evaluation. In addition, providers attended two contractor meetings. These sessions are essential for ongoing coordination and communication. (CA, PB and IB, SP4, NPM6, Pri.1)

**Oral Health.** In response to the 1994 Smile Survey, OMCH supported and implemented an Oral Health Program to reduce caries in infants, children, and adolescents. This program includes screenings and referrals for treatment. OMCH funds 19 of the state's 34 of the LHJs to operate oral health activities that help to reduce dental caries in infants, children and adolescents. In 1999, as a result of this effort, over 7,500 second graders received dental sealants. Additionally, over 15,000 second graders were screened and referred for treatment.

In 1999, a federal CISS grant funded support for 15 oral health coalitions to enhance community-wide involvement in addressing the major unmet need for greater access to preventive oral health services. For example, the coalitions have initiated successful fluoridation campaigns, increased support for clinic/referral systems, increased oral health education efforts, and increased the infrastructure and capacity to provide dental services.

A major conference was convened in March of 2000, entitled, "Power Up! Tools for Community Coalitions," This conference was designed to equip participants with tools needed to carry out community based coalition initiatives, and focused on promoting good oral health and increasing access to dental care for underserved and at-risk populations. A document, "Community Roots – Guidelines for Successful Coalitions" was produced and distributed to state and local entities. (CA, PB, NPM7, Pri.2,4)

In 1999-2000, OMCH revised, published, and disseminated the Washington State Sealant Guidelines in order to provide an updated and comprehensive quality assurance tool. These guidelines will assist local communities in planning, implementing, and evaluating community-based sealant programs. As a result of this effort, 250 copies of the guidelines were distributed to assist local communities across the State. The need for an updated version of these guidelines was identified as a priority by the Washington State Oral Health Coalition, the Washington Sealant Work Group, and local sealant programs. (CA, PB, NPM7, Pri 9)

**Injury Prevention.** OMCH also provides funding to DOH's Injury Prevention Program which provides technical assistance to locally based Safe Kids Coalitions, and injury prevention groups, most of which focus on motor vehicle injury prevention. This activity increases the quality and amount of effective injury prevention activities across the state. In 1999, two new coalitions were formed and a statewide planning group, comprised of local coalitions, was formed. This activity targets all Washington children 0-18 years of age statewide. (CA, PB, NPM8, Pri.4)

OMCH coordinated with the DOH Injury Prevention Program to oversee the implementation and evaluation of the three components of the population based suicide prevention project: gatekeeper training, crisis system enhancement and public education. These activities were designed to increase student awareness and participation in youth suicide prevention, and resulted in student developed media campaigns and increased school and community involvement in youth suicide prevention activities.

These activities were undertaken in response to a legislative appropriation to implement the youth suicide prevention plan. This plan targets youth ages 11-24 throughout the state. The Injury Prevention Program in DOH is the lead on this activity, with support from OMCH, the University of Washington, local school districts, and local crisis response agencies. (CA, PB, NPM16, Pri.4)

**Immunizations.** OMCH's Immunization Section provides free vaccines, technical assistance, training and educational materials as well as statewide media campaigns. The goal of these activities is to raise immunization rates. As a result of this work, school entry immunization rates remained high. These activities are federally mandated and funded through Section 317 of the Public Health Service Act. In addition, two new immunization requirements were implemented: school entry and Hepatitis B requirements and a second dose of MMR for sixth grade school entry. Education efforts about these changes were conducted through OSPI, LHJs, WIC, HS/ECEAP, Childcare Resource and Referral, Due by Two Newsletter, CHILD Profile Health Promotion Materials and the media. School based Hepatitis B clinics were held at schools in at least 19 LHJs. (CA, PB, NPM 5, Pri 2,3).

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

**Early Identification.** Broad efforts to reach children with special health care needs are focused on early identification activities, including statewide newborn screening and birth defects surveillance. Progress is also being made in the adoption of early hearing screening for all newborns. (CSHCN, PB, SP9, NPM4, 10, Pri. 8)

**Transitions.** Through a contract with UW Division of Adolescent Medicine and the Adolescent Health Transition Project (AHTP) education and information through a variety of media and forums is presented to providers, educators and families about health and life transitions for youth with special needs. Health consultation services are also available to health practitioners and families statewide through a contract with CHRMC. (CSHCN, PB, Pri. 2)

## **Infrastructure Building Services**

OMCH sees the role of its state office as being primarily focused on infrastructure building, to enable the LHJs and other contractors to provide the direct, enabling, and population based services. Therefore, numerous infrastructure building activities took place in 1999 for each of the three target population.

### ***Pregnant Women and Infants***

**Nutrition.** OMCH provided nutrition education and support to low-income pregnant women including routine use by MSS providers of a weight gain grid. MSS chart reviews by OMCH staff revealed that many clients are either over or under weight and the percent of MSS nutrition visits was lower than desired. The need for these activities relates to the fact that appropriate weight gain in pregnancy promotes optimal birth weight. The purpose of these activities was to increase the routine utilization of weight gain grids to monitor weight gain patterns and to increase the percent of MSS nutrition visits. This goal was partially achieved as demonstrated by the fact that MSS nutrition visits increased from 15% in SFY 97 to 17% in SFY98 and sustained at almost 17 percent in 1999.

Also noted in 1999, more nutritionists attended regional meetings and the “ABC’s of First Steps” training than in previous years. These workshops include nutrition overviews including promoting the use of the weight gain grid. These activities targeted Medicaid eligible pregnant women, statewide. OMCH was the lead on this activity, and DSHS/ MAA, MSS providers and WIC were partners. (MIH, IB, SP1, Pri.9)

**Unintended Pregnancy.** DSHS used PRAMS, birth records, abortion and Medicaid data to enhance state and local assessment capacity and knowledge regarding unintended pregnancy and birth spacing. These activities serve to increase awareness, monitor trends, and promote activities designed to reduce unintended pregnancy. The result was the development of County and CSO profile reports by DSHS which were distributed to 250 providers and CSO administrators. In

addition, presentations were made to DSHS Regional Administrators and WorkFirst Coordinators and at six community meetings. (MIH, IB, SP4, Pri 1)

**Tobacco Use.** Tobacco use was identified as one of the key priorities through the Five Year Needs Assessment Process, with a focus on use by pregnant women and teens. Data indicate that there are high smoking rates among Native American women, teens, and Medicaid clients. Low birth weight rates are higher for smokers than non-smokers regardless of socio-economic status. Due to these facts, OMCH engaged in several activities to address the issue of tobacco use by pregnant/parenting women.

OMCH monitored tobacco use by pregnant women and infant exposure via PRAMS and the First Steps Data Base in order to provide on-going surveillance of tobacco use during pregnancy and to determine the impact of interventions on the levels of tobacco use. OMCH shared this data with DOH's Tobacco Prevention Control Program for their Tobacco Use in Washington State Report which was distributed widely to policy makers and health care professionals statewide and was also placed on a DOH web page. Part of the purpose of this sharing of data was to raise awareness and increase commitment to expand tobacco cessation efforts.

OMCH also shared county data on this issue with First Steps providers, and requested volunteers to participate in an MSS tobacco cessation performance measure development project. The purpose of this activity was to begin the development of an MSS performance measure on smoking cessation during pregnancy/postpartum and reduction of second hand exposure to children. As a result of these activities, over 500 First Steps providers received information on smoking during pregnancy by county; new questions were developed for phase four of the PRAMS survey; and agencies were identified who would participate in a tobacco pilot project. This activity is led by a joint partnership of MAA, OMCH, and the Tobacco Prevention and Control Program (TPCP). Other partners involved include MSS providers, MCM providers, and the American Cancer Society.

OMCH also collaborated with TPCP to ensure that prenatal/postpartum smoking and environmental exposure were included in the CDC Tobacco grant and the State Tobacco Plan. This effort assured interventions aimed at pregnant/parenting women. (MIH, IB, SP5, Pri. 7)

**Pregnancy and HIV.** OMCH and the HIV/AIDS office monitored prenatal HIV counseling and testing via PRAMS and the HIV/AIDS survey: "Knowledge, Attitude, Beliefs, and Behavior"(KABB). PRAMS Survey data for 1998 shows that 49% of the women responding

recall their prenatal provider addressed how to avoid HIV, while 83% of these women recalled their provider suggesting they test for HIV. KABB data from 1995 indicate that of the 114 women responding that had received prenatal care, 40% were tested for HIV during their pregnancy. In the 1998 KABB survey group, 50% of the 115 women who got prenatal care, tested for HIV.

OMCH collaborated with the Office of HIV/AIDS, the Regional Perinatal Programs, and Medicaid to foster effective policies and programs for the prevention of perinatal HIV transmission. The goal of these activities was to increase universal HIV counseling and testing for all pregnant women, and promote the availability of therapeutic interventions to HIV positive pregnant women who choose to undergo treatment. As a result of these activities, the Northwest Regional Perinatal Program distributed 6,000 copies of "Update on Screening and Management of Maternal HIV infection." Over 500 health care providers attended 10 regional perinatal educational events focused on HIV screening and management of pregnant women.

OMCH, the HIV/AIDS Office, and DSHS continued to support the OMCH/HIV community advisory group of providers and women who are HIV positive. This group provides regular input regarding the prevention of perinatal HIV and service needs for HIV positive women and children. This year the group provided input on HIV testing following sexual assault and started to develop a set of recommendations on this topic. This group is important because regular, direct input for HIV positive women is crucial for developing strategies for reducing perinatal exposure, the primary source of transmission of HIV to newborns. Intervention during pregnancy reduces perinatal transmissions by two thirds. Also, at this time, some providers are not encouraging all pregnant women to be tested for HIV. (MIH, IB, SP6, Pri. 2)

**Substance Use During Pregnancy.** Drug affected infants continued to be a legislative priority. As reported last year, the legislature passed HB 3103 in 1998. This bill directed DOH to develop screening criteria to identify women who use alcohol/drugs during pregnancy; develop a training protocol to improve provider ability to identify women who use substances during pregnancy; and explore the feasibility of newborn testing for drugs or alcohol. The report was completed and presented to the Legislature in January 1999 and was distributed to over 500 stakeholders statewide as well as posted on the DOH website. This activity developed systems recommendations focused on improving provider screening and identification of women using alcohol/drugs during pregnancy.

Additional outcomes included a booklet for providers entitled, “Guidelines for Screening for Substance Abuse During Pregnancy,” which was distributed statewide to 1,100 health care professionals. A speakers list was developed to assist organizations in providing professional training, and presentations were made on the HB 3103 report to stakeholder groups to gain endorsement for universal screening by interview as a practice standard.

These activities targeted providers throughout the state to build necessary infrastructure. OMCH played the lead with numerous other partners including DSHS, the Regional Perinatal Programs, providers, and professional organizations.

DOH received additional money from the Legislature to increase provider training and workshops, site visits, provider outreach and consultation. These services were contracted in January of 2000 to Regional Perinatal Programs with the expected outcome of improved provider screening practices. These activities were undertaken based on concerns by MCH, stakeholders, and the Legislature about alcohol and drug affected infants. On-going skill building opportunities were identified as an integral step for increasing alcohol/drug screening and referral of pregnant women.

In order to track rates of alcohol use by pregnant women in the state, OMCH monitored alcohol use via PRAMS and First Steps data base. Results of this activity show that in 1998, 3.9 ( $\pm 1.3\%$ ) of mothers surveyed acknowledged alcohol use in the third trimester of their pregnancy. In 1997, 4.9 ( $\pm 2.0\%$ ) of non-Medicaid funded mothers vs. 2.4 ( $\pm 1.4\%$ ) of Medicaid mothers reported using alcohol during their third trimester.

The Legislature also provided additional funding for services to chemically dependent pregnant women. OMCH participated on a DSHS Committee (MAA, DASA, CPS, and the Research and Data Analysis (RDA) of DSHS) to implement three pilot programs designed to provide comprehensive services to pregnant and postpartum women with substance abuse issues. Pilot programs have been established in Snohomish, Whatcom, and Benton-Franklin Counties and target Medicaid funded pregnant and post partum women. This activity will improve the service delivery system available to pregnant and post partum women with drug and alcohol use in order to reduce the number of drug affected infants. Services will be available through pregnancy and up to the child’s third birthday. For this activity, OMCH participated on the state implementation team providing consultation to DSHS including development of application materials, review of community providers’ applications, and development of contractor expectations.

OMCH will continue to be involved in activities to reduce the use of alcohol by pregnant women. For 2001, a new performance measure (SP 17) was developed. This performance measure includes a number of risk factors, including alcohol use during pregnancy. See SP 17 for more information on plans for this measure in 2001.

In November 1998, 95 persons attended the Methadone Breastfeeding Summit in Seattle, co-sponsored by WIC, Perinatal Regional Centers, MSS, and OMCH. The Summit was organized in response to feedback from providers who were uncertain how to counsel women on this issue. At this conference, an update on the effects of methadone maintenance treatment on the safety of breast feeding for their infants was discussed. There was confusion and lack of uniformity among medical providers on whether or not women on methadone should breastfeed. This group initiated a process to develop a set of guidelines for medical and public health providers to use in working with women who have given birth, want to breastfeed, and are continuing on methadone maintenance treatment. This activity was completed in 1999. (MIH, IB, SP7, SP17, Pri.9)

**Domestic Violence.** In 1999, OMCH continued to monitor domestic violence rates via PRAMS, BRFSS and First Steps data bases in order to monitor trends and assess the impact of trainings provided on the prevalence. In 1999, the BRFSS data was collected and is under review. It will be developed into a report. This activity was undertaken because having adequate data is crucial to monitoring progress and assessing prevalence. Family violence including child abuse and domestic violence were identified as priorities through the five year needs assessment process. This activity targets pregnant women throughout the state. OMCH is the lead, with DSHS's First Steps Program and DOH Assessment Unit as partners. (MIH, IB, SP11, 18, Pri.6)

Even prior to the identification of domestic violence as a performance measure in 2000 (SP 11), OMCH responded to this data finding by collaborating with DSHS, the Perinatal Advisory Committee, the Washington State Coalition Against Domestic Violence (WSCADV), medical professional groups, WIC, and other stakeholders to reduce the incidence of battering pregnant women. The purpose of this statewide Perinatal Partnership Against Domestic Violence (PPADV) is to: develop a training curriculum; increase training capacity for perinatal providers; train providers at an awareness level and skill based level; and evaluate results based on PRAMS data.

As a result of these collaborations, one grant was written and funded by DHHS Office of Community Services, and a second grant was funded which will provide \$150,000 per year for

improving systems of care for pregnant post partum women in the Asian Pacific Islander community. The grant is placed at International Community Health Services Clinics in Seattle with the focus on: 1.) Training medical providers who serve pregnant post partum women (first and second goals); 2.) Developing a community response to domestic violence in the Asian Pacific Island community; 3.) Developing a model for replication by community health care clinics in Washington State.

The collaborations also resulted in 12 presentations to professional groups and six exhibits at professional meetings, consultation was provided to trainers, and the curriculum was updated. Additionally, six advisory meetings were held to decide on marketing tools and marketing plans for training. These activities were undertaken because training in domestic violence had been identified as a need by First Steps workers, in OMCH community meetings, and in national priorities. The Perinatal Advisory Committee indicated that the data on screening practices had not been collected. Consequently, questions about screening for incidence of domestic violence were added to PRAMS. (MIH, IB, SP 7, Pri 9)

OMCH promoted training for perinatal providers statewide by: providing curriculum materials, sponsoring a Train the Trainers Workshop to 25 Perinatal Regional Providers statewide (a total of 50 trainers were trained), marketing the training to professional groups, and distributing the curriculum. The purpose of this training was to increase the screening of pregnant women for domestic violence so that more women will be identified and provided assistance. The desired end goal is to reduce domestic violence and create more safety for women. As a result of these efforts, 950 perinatal providers were trained at the “awareness level.” Trainers (25 pairs) continue to work to develop new training opportunities. OMCH was the lead on this activity with support from DSHS’s Procedures and Policy Office, Washington State Coalition Against Domestic Violence (WSCADV), First Steps, WIC, DOH Community and Rural Health, Washington State Public Health Nursing Directors, Evergreen Health Care, Washington State Medical Association, Association of Nurse Midwives, Providence Health Care System, Region X Federal Women’s Health, Washington State Obstetrical Association, American Nurses Association, and Swedish Medical Center. (MIH, IB, SP 11, 18, Pri. 6)

**Breastfeeding.** In order to increase the percent of MSS clients that initiate breastfeeding and increase the duration of breastfeeding, OMCH sponsored training in breastfeeding assessment and counseling for MSS staff through the “ABC’s of First Steps” training. In these three ABC’s

trainings, 225 providers were trained, which included 18 new MSS Registered Dieticians who received training in prenatal and postpartum issues including breast feeding.

This project was undertaken in response to WIC data on duration of breastfeeding, indicating a need to promote longer breastfeeding. Site visits and chart reviews with MSS providers indicate good initiation rates, but early discontinuation of breastfeeding. WIC has reported that in 1998, 67% of WIC mothers initiated breastfeeding, with only 53% continuing for at least four weeks. This project targets Medicaid eligible pregnant and postpartum women throughout the entire state. OMCH works closely with DSHS's Medical Assistance Administration on this project. This training is an infrastructure building activity. (MIH, IB, NPM9, Pri.9)

**Perinatal.** In 1999, an assessment of education and training needs of health care providers was completed by all four regional perinatal programs. All four programs reviewed hospital-specific birth outcome data to monitor perinatal regionalization and identify areas for follow-up. Regional maternal and neonatal transport systems were maintained to promote appropriate levels of care. Data available for July-December of 1999 identified 503 maternal transports and 298 neonatal transports for the contracted regional perinatal centers.

OMCH continued to support regional perinatal systems of care through funding of regional perinatal centers to provide consultation and education to obstetrical and pediatric providers. The purpose of these activities is to improve maternal and birth outcomes by assuring opportunities for education and consultation for obstetrical and pediatric providers. (MIH, IB, NPM 15, Pri 9)

During July-December of 1999, 245 educational offerings were sponsored by regional perinatal programs. Over 3500 health providers, including 1700 RNs and 1143 MDs/midwives, attended. Topics covered and the number of providers receiving training in each area during July-December of 1999 include:

<u>Topic:</u>	<u>Number of provider participants*:</u>
Assessment and Management of at Risk Pregnancies	1713
Fetal Assessment	1250
Assessment & Management of at Risk Newborns	1149
Neonatal stabilization	980
Alcohol & Illicit Drugs	379
Domestic Violence	280
HIV/AIDS Screening	395
Tobacco	282

\*Numbers of attendees may be duplicative due to attendance at educational offerings with multiple topics.

OMCH provided consultation to the formation of a Home Birth Oversight Committee, a Perinatal Advisory subcommittee. The purpose of this group is to implement the DSHS Planned Home Birth Program. OMCH provided input to Policy and Billing Instructions Program policy manual including risk criteria and referral requirements. DSHS is the lead for this activity, with OMCH playing a support role. (MIH, IB, NPM17, Pri.9)

OMCH continued to manage MSS and monitor the utilization and the quality of prenatal care services. Access to first trimester prenatal care has improved from 79% in 1991 to 83% for all women. Access for women on Medicaid has improved from 61.9% in 1991 to 72.9% in 1998.<sup>7</sup>

These activities were undertaken to address the problem of decreased access to prenatal care for low income women during the early 1980's, and the continued disparity in first trimester utilization rates for low income women. These activities target Medicaid eligible pregnant women throughout the state. This project is co-sponsored through a partnership between OMCH and DSHS's MAA Program. (MIH, IB, NPM18, Pri.2)

OMCH will continue to support and maintain the PRAMS survey primarily funded by a CDC grant. In FFY99, the PRAMS survey provided key data on areas such as unintended pregnancy, tobacco use, and domestic violence which were utilized for major program initiatives in these areas.

## ***Children and Adolescents***

**Health Assessment for Youth.** Assessment activities continued to be a focus of infrastructure work for the child and adolescent population in 1999. The Joint Survey Committee, comprised of OSPI, DASA, DSHS, CTED, FPC, and DOH's Offices of OMCH and Non-Infectious Epidemiology, met regularly to develop a plan for a joint survey targeting public school students. This plan was initiated because all of these state programs need data on a variety of topics, and schools have been approached by several state agencies, resulting in confusion and the appearance of duplicated effort. This project will continue to be developed because data from

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<sup>7</sup> These figures may overestimate gains made in first trimester prenatal care over this period. The percent of births with unknown prenatal care doubled over this period from 4.9% to 9.7% of all live births. As live birth with unknown prenatal care are excluded from the denominator prior to calculating the rate, the change reported also reflects the increase in unknown prenatal care, because the denominator may be artificially low. An evaluation of birth certificates reporting found that seven of 93 delivery facilities had over 20% of deliveries with unknown prenatal care. Several of these facilities had among the largest number of deliveries in the state.

this survey is crucial to understanding the needs of the adolescent population for assessment purposes. (CA, IB, SP2, Pri.8)

**CHILD Profile.** As a quality assurance infrastructure activity in 1999, OMCH administered a parent satisfaction survey to a random sample of parents receiving CHILD Profile Health Promotion materials to evaluate the materials and determine the need for changes. The survey was completed and the analysis is underway in 2000. The results will provide answers to the following questions: the percentage of parents who read the materials; the percentage who find them useful; how easy or difficult the information is to understand; the usefulness of specific materials; whether the parents think the materials help them get their child's immunizations on time, etc. OMCH is the lead for this activity, with partners including Public Health - Seattle and King County, Snohomish Health District, WSALPHO, and MAA. (CA, IB, SP15, Pri.9)

Due to continued difficulties with securing funding and provider participation, the CHILD Profile Program initiated a strategic planning process to evaluate the CHILD Profile Immunization Registry in the context of the current environment. Based on this evaluation, CHILD Profile is developing program objectives and operational plans to address upcoming program issues and position this project for sustainability over the long-term, including a plan for funding and increased provider participation. In 1999, this process was begun and a contractor was secured to facilitate the process and develop a business plan. The partners involved in this effort include: Public Health – Seattle and King County, Snohomish Health District, MAA, WSALPHO, the Washington chapter of AAP, the Washington Health Foundation, and the Washington Immunization Action Coalition. This activity will be completed in 2000 and, therefore, was deleted as a performance measure for 2000. (CA, IB, SP3, NPM 4, Pri.2)

**Teen Pregnancy Prevention.** In order to evaluate the effectiveness of the intervention being used in the Teen Pregnancy Prevention Community Projects (TPP), process and outcome evaluations were conducted. This evaluation used random assignment methodology in several of the projects. An article addressing the evaluation of Washington State's Teen Pregnancy Prevention Program will be published in mid 2000. OMCH is the lead on this activity with the TPP community projects as partners. (CA, IB, NPM6, Pri.1)

**Abstinence Education.** A literature review revealed a lack of research and evidence regarding the effectiveness of abstinence only education interventions, so OMCH undertook an evaluation design of abstinence programs and activities. In order to ensure the development and

implementation of a rigorous evaluation design for the Abstinence Programs funded through MCH, OMCH contracted with evaluators from the University of Washington. OMCH has conducted 21 site visits to funded projects to monitor compliance with the program evaluation requirements, trouble shoot, and collaborate with the local evaluators. Quarterly meetings and teleconferences were conducted with the Principal Evaluator, the Washington Institute. All seven community-based projects have an evaluation design in place. These abstinence only education activities targeted youth ages 10-19 years who were served in Bellingham, Port Angeles, Seattle, Walla Walla, and Kennewick. OMCH was the lead in these activities, with other partners including: University of Washington's Washington Institute, school administrators, seven community-based projects, and parents of youth receiving services.

OMCH continues to analyze data at the state level related to teen pregnancy and teen births in order to monitor trends, evaluate impacts of projects, discern needs in various locations, and to improve program planning. Data was used to target activities for FFY 1999-2001. This assessment activity targets the entire state. (CA, IB, SP4, NPM 6, Pri. 1)

**Oral Health.** In 1999, OMCH began the infrastructure building process of developing an inter-agency strategic oral health plan that mirrors the national Oral Health Initiative. The purpose of this work is to decrease dental disease and to increase access to preventive services for underserved populations. This planning process will be completed by summer of 2000 with implementation to take place in 2001. This project was undertaken as a result of the large unmet need for prevention and intervention oral health services in the state of Washington, particularly among low income and high risk populations (as determined by SEO factors, exposure to fluoridated water systems, etc.). With OMCH as lead, public partners include, DOH, DSHS, Health Care Authority (HCA), the University of Washington School of Dentistry. Private sector partners include: the Washington State Oral Health Coalition, Washington State Dental Association, Washington Dental Service Foundation and numerous other oral health advocates. (CA, IB, NPM7, Pri.2)

Another infrastructure building activity related to oral health was the Smile Survey 2000 implemented by OMCH in 1999-2000. This survey was designed to obtain statewide estimates of dental caries prevalence in children. Two statewide cohorts of young children were targeted: 1.) Headstart and Early Headstart children, 0-5 years old; and 2.) school children, 6-8 years old. OMCH was the lead on this survey. To assure that data was comparable with data from other states, protocols from the Association of State and Territorial Dental Directors and CDC were

used. Analysis of the data set will take place in 2000 and will allow DOH to develop program plans, monitor disease trends, and evaluate program effectiveness. This survey was undertaken because the previous Smile survey was done in 1995 and more recent data was needed for planning, evaluation, monitoring, and responding to MCHB data requests. Partners included: University of Washington Office of Epidemiology, OSPI, LHJs, Washington State Oral Health Coalitions, and Indian Health Services. (CA, IB, NPM7, Pri.2))

**Injury Prevention.** OMCH provides funding to support an FTE in the Community and Family Health's Injury Prevention Program (IPP) within DOH. This funding supports the maintenance of the statewide data base (surveillance), which provides information for use in monitoring trends, identifying of needs, evaluating of the impact of interventions, and program planning. This activity is essential for assessment purposes and targets all children in Washington State.

Through OMCH's support of the Injury Prevention Program, IPP also works with the Washington Traffic Safety Commission (WTSC) which provides state leadership in the prevention of motor vehicle collisions, injuries, and deaths. Information from is shared by WTSC with OMCH through the IPP liaison to WTSC. This liaison work will continue in 2001. (CA, NPM8, Pri. 4)

**Quality Assurance.** In 1999, the OMCH Quality Assurance Team coordinated QA activities and developed a QA Plan for OMCH in order to establish a framework for OMCH QA roles and activities, especially related to managed care. A plan describing current OMCH activities and identifying recommendations for future QA activities was developed. This activity was initiated through the 97-99 SSDI grant. The initial focus of this work was on publicly funded managed care organizations (MAA and HCA) in their involvement with families throughout the state. OMCH was the lead for this activity with MAA, HCA, and DOH's Office of Planning and Policy as partners in this work. (CA, IB, NPM12, Pri.9)

**Child Death Review.** In 1999, OMCH negotiated with DSHS to develop and maintain a common Child Death Review System (CDR), an important infrastructure building assessment tool that is a nationally used tool for assessing deaths of children. The goals of the CDR system are: to create a shared system to prevent duplication of effort, to yield richer data, and model collaborative work towards the common goal of decreasing child deaths; to create a statewide system of community review of unexpected child deaths; to maintain lines of community between CDR and the death investigation system; and to provide DOH with consistent data which will

identify opportunities for preventing future deaths of children. OMCH also provided technical assistance to LHJs to develop multi-disciplinary CDR Teams. In order to maintain a link to the death investigation network in Washington State, CDR staff attends all meetings of the State Forensic Investigations Council. A CDR database was developed and disseminated.

In 1999, DOH and DSHS signed an Interagency Agreement to increase regular communication between CDR staff at both agencies. OMCH's provided technical assistance in the establishment of LHJ led multi-disciplinary teams that review all unexpected deaths of the target population, Washington children ages 0-18. To date, 28 teams have been formed statewide and orientation has been provided to team members. Data collection began January 2000 and aggregate information will be available in Summer 2001. (CA, IB, NPM16, Pri 8, OM1, 2, 3, 4, 5, 6).

**Child Care.** OMCH increased the number of LHJs providing health consultation to child care providers from 8 to approximately 24. The purpose of this work was to build statewide infrastructure system to promote health and safety in child care. Over 160,000 children per day are in licensed child care in Washington State. Many more children are cared for through informal channels, such as friends, family, neighbors. These informal channels have increased due to the pressures of TANF and WorkFirst families struggling to identify child care.

OMCH increased its capacity to promote health and safety in child care in 1999 through two main mechanisms: first, providing technical assistance and training to LHJs through OMCH's "Healthy Child Care Washington" program funded by a federal CISS grant/Healthy Child Care America; and second, providing funding directly to LHJs for building capacity through Washington State's DSHS/Office of Child Care Policy's federal child care block grant.

OMCH also sponsored the Annual Health and Child Care Partnership Symposium, attended by 200 providers, including public health nurses, child care providers, resource and referral network staff, licensors, surveyors, early child hood educators, HeadStart and ECEAP professionals, nutritionists, environmental health staff, oral health, and parents of children with special health care needs. (CA, IB, SP 13, Pri 3)

**Immunizations.** The Immunization Section has put forth a continuous effort to improve statewide children's immunization rates. This has been evidenced by a steady increase in coverage levels reported in the National Immunization Survey. The most recent data, from 1998, shows a 4:3:1 rate of 81.1% and 4:3:1:3 rate of 80.8%. Through Section 317 Health Services Act funding, the Immunization Program has implemented a variety of assessment methods that have

identified areas for program emphasis and development. One of these methods utilized the Clinical Assessment Software Application (CASA) program in all 34 LHJs and 21 Community Migrant Health Centers to improve clinic immunization practices. Another method provided education and related materials for medical professionals, school and childcare personnel and parents. The third method was partnering with geographically specific LHJs to conduct immunization coverage surveys for two-year-olds. OMCH was the lead on these activities with the overall goal to increase coverage rates for two-year-olds. (CA, IB, NPM5, Pri 2,4,9)

**Student Health Initiative.** OMCH has a lead role in assuring implementation of DOH's Student Health Initiative's three action plans that will:

- Address the lack of trained and available personnel to meet student health care needs.
- Improve the data that describe the health needs of the school age population.
- Increase the funding received by schools to meet student health care needs.

OMCH's primary partner in this initiative is OSPI which has worked with the Nursing Commission on the action plan to increase availability of trained personnel who can meet students' health care needs in the school setting. A staffing model with four staffing levels based on the severity of students' health needs was developed through stakeholder meetings, and is being released as a joint DOH/OSPI document. Additionally, the Legislature approved a plan to establish a school nurse corps to provide additional school nurse support through increased numbers of nurses at schools without adequate student/nurse staffing ratios and nurse supervisors at Educational Service Districts (ESDs) statewide. The Legislature also funded a data initiative that will put computer programs in every school building to track student health records and information. OSPI is also piloting a health services management software program which could provide statewide data on nursing services in schools. Data are an important element to determine needs and gaps. An interagency group led by DOH is developing a joint adolescent health survey which will be administered in 2002. An oral health assessment of school children in 2<sup>nd</sup> and 3<sup>rd</sup> grade, "Smile Survey 2000," is being implemented in 1999-2000. This is a cooperative effort between OSPI and DOH with DOH as lead agency. (CA, IB, SP 2, NPM7, Pri4)

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

**Fetal Alcohol Syndrome.** In 1998, a three year plan was developed to address Fetal Alcohol Syndrome (FAS). A major component of this plan involved DOH representation on the FAS

Interagency Workgroup (FAS-IAG). FAS-IAG is now coordinating FAS activity for state agencies and sponsors an annual conference. The purpose of this activity was to develop state-wide interagency assessment, intervention and educational activities to prevent FAS.

DSHS/DASA is the lead on this activity, with support from OMCH, DASA, DVR, Corrections, OSPI, and the University of Washington's FAS Clinic. (CSHCN, IB, SP8, Pri.2,4)

**Early Identification.** OMCH provided training and technical assistance to family practice physicians, pediatricians, nurses, family resource coordinators, and managed care representatives, on topics of early identification and management of infants and children at risk for health and developmental problems. The purpose of these activities was to (a) increase physician and provider awareness of the need for identifying children at risk and the availability of early intervention services and (b) to provide training on early identification and management of these infants and young children.

As a results of these efforts, CSHCN coordinators report: the number of referrals to early intervention services has increased; the referrals have become more timely (younger age); a resource guide was developed for physicians and community members; interest in future trainings and consultations was expressed; and awareness of screening tools, numbers of hearing screening and neuromotor screening were increased.

These activities were undertaken due to a need for training and technical assistance identified by Adams County in Eastern Washington and through the 0-3 Interagency Coordinating Council. A need for training was also identified by participants (physicians, public health nurses, and family resource coordinators) in the Medical Home Training Project. The activities targeted Adams County in Eastern Washington and the entire state through a statewide meeting.

OMCH was the lead on these activities, with the University of Washington, LHJs, medical home trainers, and Part C – Infant Toddler Early Intervention Project. Even though this performance measure was deleted in 2000, these activities will continue to take place in 2001 because early identification, diagnosis and intervention services are a state priority. (CSHCN, IB, SP9, NPM3, Pri.2)

**CSHCN Assessment.** In 1999, the CSHCN Assessment Plan was fully developed and implementation began. The goal of this project was to create a systematic approach to developing and using data for children with special health care needs. OMCH is currently developing strategies to determine the prevalence of CSHCN and address national performance measures.

This project was intended to address concerns from stakeholder surveys, community health assessments and other reports that indicated a serious lack of quantitative information regarding children with special health care needs. It was later identified as a priority through the five year needs assessment process and additional stakeholder input.

Extensive work has gone into the development of a means of determining the prevalence of children with special health care needs, and promoting their inclusion in state and local health assessments. OMCH succeeded in adding a question module to the statewide BRFSS survey that will provide information about child health insurance, medical home, and prevalence for children with special health care needs. The survey will begin in late January or early February 2000, and be completed in December of 2000. In addition, the Questionnaire for Identifying Childhood Chronic Conditions-Revised (QuiCC-R), a tool to identify childhood chronic conditions, has been included in a statewide BRFSS-like survey that is being conducted concurrently with the BRFSS.

OMCH has also created a model for identifying children with special health care needs in hospital discharge data, and are developing some outcome measures from these data. The programming associated with this assessment will be included in VISTA, a desk top software package that is available in every LHJ in the state in 2000. Additional work is being done to explore the potential for using hospital discharge data to identify quality assurance issues and/or systems benchmarks, which includes such items as differences in length of stay, hospitalization rates, and repeat hospitalizations between children with chronic conditions who are served through Medicaid vs. private insurance.

OMCH is working closely with MCHB and CISS Grantees, and contractors to explore ideas for using existing secondary data sets to extract data and information about the health, and health system impacts on children with special health care needs. In partnership with the Center for Children with Special Needs and Chronic Health Conditions, models and protocols for coordinating state and local level assessment and data gathering activities are being developed. OMCH is the lead on this project, with partners including the Center for Children with Special Needs and Chronic Health Conditions (CCCHC) at CHRMC, MAA, DOH/CSHCN, OSPI, LHJs, Foundation for Accountability, MCHB, and the University of Washington. (CSHCN, IB, SP9, 10, SP 16, Pri. 5)

**Birth Defects.** In order to create a systematic approach to improving current birth defects surveillance in Washington State, a Birth Defects Surveillance Enhancement Plan was developed.

As a result of this activity, enhancements were outlined and prioritized. This plan continues to be implemented. Nine structural birth defects (i.e., anencephaly, spina bifida, cleft lip with/without cleft palate, cleft palate, 2° and 3° hypospadias, limb reduction defects, gastroschisis, omphalocele, and Down Syndrome) and three complex disorders (i.e., autism, cerebral palsy, and fetal alcohol syndrome) were added to the notifiable conditions regulation (new under review). OMCH staff are consulting with CDC, the March of Dimes and the National Birth Defects Prevention Network and local neurodevelopmental experts to explore issues of case ascertainment, data quality and validity, and reporting. These activities target women of child bearing age and children with special health care needs.

**Data Sharing.** To assure that SSI applicants under the age of 16 are aware of their community's system of supports, a data sharing agreement is in place between Disability Determination Services (DDS) of DSHS and OMCH. Diskettes containing all applicants for SSI under age 16 are sent to OMCH by the DDS office; county specific lists are sent to LHJs who contact families. During the Five Year Needs Assessment Process, care coordination for children with special health care needs was identified as a priority. This activity provides a means of connecting children and families with local service systems. The population targeted for this activity includes SSI applicants 0-16 years of age throughout the state. The lead on this activity is OMCH, with partners including: DDS and Local Health Jurisdictions.

**Adolescent Transition.** In 1999, OMCH staff established a link with the Division of Vocational Rehabilitation (DVR) and the DVR Transition Team, the group of Transition Coordinators statewide who work with students with disabilities in transition process from school to work. The goal of creating this link was to increase awareness of the health transition issues of youth with special needs and to provide DVR staff with information resources including the Adolescent Health Transition Project's (AHTP) website and materials. As a result of creating this linkage, AHTP provided information packets to all DVR Transition Coordinators and provided materials for Adolescent Transition information fairs in two regions of the state. OMCH staff met with DVR staff and consulted on materials being developed by DVR for teens with disabilities.

CSHCN engaged in these activities in response to the lack of information parents could access to help in planning for their children's transition to adult work, health and living situations. This activity targeted adolescents with special needs and their families throughout the state. OMCH was the lead, working through contract staff at the AHTP and partnering with DVR. (CSHCN, IB, NPM1, Pri.2)

**Nutrition.** OMCH provided two semi-annual workshops to members of the CSHCN Nutrition Network and one annual workshop for feeding teams. The purpose of these activities was to provide opportunities for education, networking and technical assistance for community-based nutritionists and feeding teams to enhance their capacity to provide specialty services statewide to children with special health care needs. Approximately 60 nutritionists attended each nutrition workshop and 16 feeding teams (approximately 75 people) attended the feeding team workshop.

These activities were initially begun as a result of a needs assessment that assessed the availability of community based nutritionists and feeding teams and the needs for ongoing education and technical assistance. The workshops targeted community based nutritionists and interdisciplinary feeding teams who serve children with special health care needs throughout the state. OMCH was the lead on this activity with the University of Washington's Center of Human Development and Disability (CHDD) program serving as partner via a contract. (CSHCN, IB, NPM2, Pri.2,9)

**CSHCN Outreach.** OMCH contracts with LHJs included asking LHJ to engage in outreach and link children with special health care needs to insurance sources, primarily Medicaid. The purpose of these activities were to provide information to families and input to MAA that would help families access needed covered services. OMCH also supported community systems development such as LHJ staff participation on community based health care coalitions, i.e., Healthy Options Oversight Committees with MAA. These contracted activities resulted in improved awareness for families of availability of Medicaid services with resulting increased access to care and an improved understanding by MAA of medical coverage issues for children with special health care needs. These activities were undertaken when feedback from providers and parents and enrollment data indicated that information on Medicaid coverage was not reaching families. OMCH was the lead for contracts and DSHS/MAA was the lead for coverage issues. Other partners included the LHJs. (CSHCN, IB, NPM11, Pri.5)

**Family Leadership.** In 1999, OMCH promoted the involvement of families in leadership roles through numerous activities. OMCH, together with Children's Hospital and Regional Medical Center, sponsored a Family Leadership Summit which involved twenty families from around the state. Families participated in one and a half days of focused discussions and brainstorming about key areas to be addressed in the health policy and personal support arenas. Families also had opportunities to develop personal networking systems with other families and organizations.

Prior to the five year needs assessment retreat for children with special health care needs and genetics, OMCH provided training to parents, to enable them to fully participate in the prioritization process. OMCH also conducted a focus group with parents prior to this retreat in order to identify areas of concern and priorities from a family perspective. Parents of children with special health care needs participated in both the initial prioritization retreat targeted at the SHCN population as well as at the final prioritization retreat. (CSHCN, IB, NPM14, Pri. 9)

Other ways in which OMCH involved families in leadership include: provided training to parents on cultural competency and workshop methods; assisted parents financially to attend the AMCHP conference; provided funding and support for the Statewide Parent to Parent organization and the Washington Fathers Network; provided assistance in identifying parent speakers to present case histories at the WorkFirst/Public Health/CSHCN Initiative Trainings, developed a script and assisted/mentored 10 parent speakers; involving 2 parents in the development of EPSDT chart inserts, representing children and adolescents with special health care needs; and involving three parent representatives in the bimonthly Issues Investigation Group meetings convened by CSHCN. The above activities were coordinated by the Family Consultant hired by CSHCN, whose hours were increased to full time in 1999.

The results of these activities include the following: 20 family members convened at the family leadership Summit in June; families provided recommendations for future activity and focus; families developed a framework for the family leadership plan; family perspectives were clearly heard while setting priorities during the five year needs assessment process; family perspectives were provided at WorkFirst trainings; DOH contracts continued to support Parent to Parent, the Fathers Network, and CHRMC provided information and support to hundreds of families statewide; valuing families was established as the number one priority which is to inform all other efforts undertaken by CSHCN program. OMCH is the lead on these activities, with partners including: Families, CHRMC, Parent to Parent, Fathers Network, Family Voices, Medical Home, DSHS/ITEIP, OSPI, MAA. (CSHCN, IB, NPM14, Pri.9)

**CSHCN Assessment.** In 1999, the CSHCN Assessment Plan was fully developed, and implementation began. The goal of this project was to create a systematic approach to developing and using data for children with special health care needs. Initial strategies determining the prevalence of CSHCN and to address national performance measures are currently being implemented. OMCH is the lead on this project, with partners including Center for Children with Special Needs and Chronic Health Conditions (CCCHC), MAA, OSPI, LHJs, Foundations for

Accountability (FACCT), MCHB, and the University of Washington. (CSHCN, IB, SP 10, 16, Pri 5)

## **Sample of LHJ Activities from 1999 Reports**

OMCH continued to encourage flexibility in the use of Title V funds on the local level so local MCH programs could respond to their own community's needs as identified through their assessment activities. Since each LHJ use funds differently, collecting and summarizing information regarding activities and results from LHJs continue to be a challenge. During this past year considerable effort has been made to simplify the reporting process.

Last summer, OMCH developed a method to work with LHJs on possible changes to the existing statement of work and year end report for the Consolidated Contract between DOH and LHJs. The Public Health Nursing Directors identified LHJ representatives to participate in this project. This group met with OMCH staff for two days to develop a tool that would benefit all parties. This tool includes a list of possible activities for the contract reduced from 134 items to 72, cost estimate information necessary for "Federal MCH Reports 1-4", public health issues the activities would address, and expected results. The tool was piloted by two LHJs (one urban, one rural) with favorable results, then presented and discussed at all MCH Regional Meetings. Feedback indicated that these tools will be helpful planning documents for LHJs, will provide more accurate and current information to OMCH regarding planned activities, and will assist LHJs in developing their reports at the end of the year. This Activity Plan/Year End Report is being implemented for the 2001 contract year so implementation results will be presented in next year's block grant.

In the meantime, in order to provide the following information, OMCH staff reviewed Year End Reports for 1999 activity from LHJs and noted the following information as a few examples of the work being done by LHJs to demonstrate the types of services funded through Title V dollars at the local level. This summary includes examples from large and small LHJs at various locations throughout Washington. This list is by no means inclusive of all activities, nor reflective of all LHJs.

### ***Direct Health Care Services***

During 1999, 6 out of 29 (21%) LHJs provided public health nursing interventions not provided through other programs. In several districts, these services were provided to high risk newborns

in need of special care and monitoring, including home visits. Seven out of 29 (24%) LHJs provided pregnancy testing via Title V funds, supplementing the additional dollars they received for Family Planning from other funds to fill gaps and/or provide additional services. (MIH, DHC, NPM2, Pri 1, 5, OM 1, 2, 4)

### ***Enabling Services***

During 1999, 29 out of 33 (88%) LHJs used Title V dollars to provide care coordination for children with special health care needs, a clear priority service for LHJs. An additional 21 of 29 (72%) used this source of funds to provide public health nursing services that focused on linking Title V populations with needed resources such as prenatal care, transportation, food, shelter, etc. (CSHCN, ES, NPM 2)

### ***Population Based Services***

In 1999, SIDS counseling and education are a focus of 20 out of 33 (60%) of the LHJs. In Spokane, a “Back-to-Sleep” program has contributed to a reduction in SIDS deaths, from 12 deaths in 1996 to 6 deaths in 1999. Bremerton-Kitsap provided a training on SIDS for 85 people. Pamphlets on health hazards were distributed in 16 out of 32 (50%) of the LHJs. Seattle-King County has developed and distributed over 100 different types of brochures in several languages. Many LHJs distributed brochures and other educational items in creative ways including: booths at fairs and festivals, town meetings, distribution to child care providers and schools. Topics of these brochures included: parenting, breast-feeding, oral health, immunizations, lice, bicycle helmets, etc. Approximately one-third of the LHJs used Title V funds to promote oral health through screenings and the use of the Smile Mobile.

Another major focus of at least half of the LHJs was innovative health delivery and outreach. Seattle-King County worked with the Center for Multi Cultural Health, small businesses, child care to enroll eligible children for Medicaid. They targeted Russian, East African, Cambodian, Korean, and Latino populations. As a result of this work, public health staff in Seattle-King County assisted 5,400 Medicaid eligible individuals in completing a Medicaid application. In addition to this effort, Sea-King provided education to Spanish speaking clients through in-house Spanish speaking staff, which increased the advocacy on behalf of clients and increased the comfort level of clients in seeking services. Seattle-King County also engaged in street outreach on the issues of substance use, HIV, homelessness, and hunger through People of Color Against

AIDS Network (POCAAN). Sea-King also did outreach to teens and developed after school walk-in family planning clinics for teens.

Smaller communities also engaged in outreach and innovative health delivery through interacting with people at fairs and festivals, coordinating services with WIC satellite days in isolated areas, and partnering with schools and other agencies. For example, Lewis County provided 4,000 immunizations at WIC sites and at schools. Lewis also worked with the UW School of Dentistry to bring senior students dentistry to conduct oral health screening. Okanagon County screened 91 children with their Smile Mobile. Several communities are moving to make evening clinic hours available for families who work during the day. (MIH, CAH, PB, SP 3, 4, 9, Pri 1, 2, 4)

### ***Infrastructure Building***

In 1999, 22 out of 32 (69%) of LHJs in Washington used Title V funds to provide training to their staffs. Because of limited funding, training opportunities are often limited, so a majority of LHJs have utilized MCH funds to enable their staff to keep their knowledge and skills up to date.

Clallam County sent staff to the University of Washington learn how to get child care workers licensed. Grays Harbor trained their entire staff (including support staff) on domestic violence issues and cross cultural awareness. Grays Harbor staff also provided “Make Parenting a Pleasure” using a train the trainer format, to enable participants to use this model throughout the community. They also trained staff in Early Brain Development. Columbia, another rural community, used WSU Extension Courses on several topics including: Early Brain Development, Violence, and Child Care. Jefferson, Snohomish, Chelan/Douglas, Seattle and King County health districts’ staff were trained in the David Olds Home Visiting Model.

The majority of LHJs also used Title V funding to build collaborative relationships by participating in coalitions, workgroups, and sharing data with other child/family agencies. Most of the LHJs are involved in the MAA Healthy Options Oversight committees in their communities in order to ensure access to primary health services for their populations. It is also clear from a review of the reports from LHJs that they are developing prevention activities, and for the most part, with community partners, in response to the data they have gleaned in their assessment work.

Bremerton-Kitsap worked with schools to develop a special teen parent housing project, which included writing protocols for the use of the housing and parenting education for the teens living in the house. They also worked with a legal aid agency to present a workshop to service

providers on patient rights under welfare reform. Pacific County worked with a local tribe, the school district, and law enforcement to secure a domestic violence prevention grant. They also provided data that led to a drug lab clean up project. Mason County wrote newsletters for child care providers, parents, and providers of children with special health care needs about immunizations, normal development, and communicable disease. Benton Franklin staffed a van with a public health nurse to provide outreach throughout the community. They also worked with a hospital on discharge planning for high risk children. Clallam County used these funds to form a dynamic, broad based coalition which sponsored a home visiting summit and worked to prevent child abuse and neglect and youth violence.

In 1999, 10 out of 31 (32%) of the LHJs used Title V funds to increase their involvement in child death reviews in their communities. In Seattle-King County, where 67 children died, the Health Department is exploring prevention strategies and has already developed a program to prevent drowning and a Back to Sleep program to prevent SIDS deaths. In Okanogan, where no child deaths occurred in 1999, the LHJ is participating in DCFS's Child Protective Services team to intervene in high risk families to prevent serious injury and death. Pacific County provided data and information to the school district on teen suicide prevention. Pacific County and several other LHJs in southwest Washington are working on an education project to promote the use of pea gravel in play areas. Spokane, which had a major back-log of 203 cases of child death from the past three years, eliminated this back-log during 1999 and was able to provide technical assistance to other LHJs to develop teams and review criteria and protocols.

Another focus of infrastructure building by LHJs in 1999 using Title V funds, was providing information regarding children with special health care needs to various entities within their communities. Cowlitz County provided information on the needs of these children to policy makers with examples of how public health nursing interventions had improved outcomes for these children. Benton-Franklin coordinated outreach with the use of teams including a pediatric nurse practitioner, the CSHCN coordinator, a parent representative, and a family services coordinator. They also developed a referral chart and distribute "County Health Notes," a health news bulletin. Garfield sponsored a special dinner event on early brain development research, which was attended by 75 parents, grandparents, and providers. Grays Harbor County presented information about the CSHCN program to the Parent to Parent Group, where they shared information and a fact sheet on CSHCN community resources. (CAH, CSHCN, IB, SP 9, 11, 13, Pri 2)

## ***Clients Served by Method***

To provide a more precise indication of the number of individuals served and methods chosen by LHJs, the following chart shows the top seven methods based on the number of clients served as reported by LHJs in their 1999 reports.

<b>Activity Chosen by LHJ (checked off on report form)</b>	<b>Number Served</b>
Provide public health nursing services, especially for high risk or vulnerable populations.	45,608
Provide or promote care coordination services for children with special health care needs, and other at risk populations.	13,331
Activities to reduce the incidence of oral health problems, including BBTB, Caries, Smokeless Tobacco, use of fluoride, etc.	7,110
Parenting Skills	7,517
Oral health screenings and referrals for at-risk children	7,110
School health programs	5,338
Collaborate with community-based organizations to develop and/or provide intervention with high risk families, including screening, assessment, education, counseling, and referral (such as Minnesota Parenting Inventory, Region X Standards).	3,981

## **2.5 Progress on Outcome Measures**

For a detailed description of the progress on each outcome measure, see Form 12 and Section 3.3.3 starting on page 164. The following is a summary of how the performance measures and OMCH's activities under each relate to the outcome measures.

Several national and state performance measures are directly or indirectly associated with infant mortality (OM 1). The most strongly associated factor is NPM 15, VLBW births, with the risk of neonatal death 200 times greater among VLBW infants than among normal weight infants. Other performance indicators that may be associated with infant mortality are NPM 17, VLBW infants delivered at facilities for high risk deliveries and neonates; NPM 18, late prenatal care; and SP 4, unintended pregnancies; SP 5, abstaining from smoking during pregnancy, and SP 17, provider screening during pregnancy.

The black/white infant mortality ratio (OM 2) is largely a function of higher rates of prematurity and other causes of VLBW deliveries among African Americans (NPM 15). Higher VLBW rates

among African Americans may be influenced by lower rates of first trimester prenatal (NPM 18) and unintended (especially unwanted) pregnancies (SPM 4).

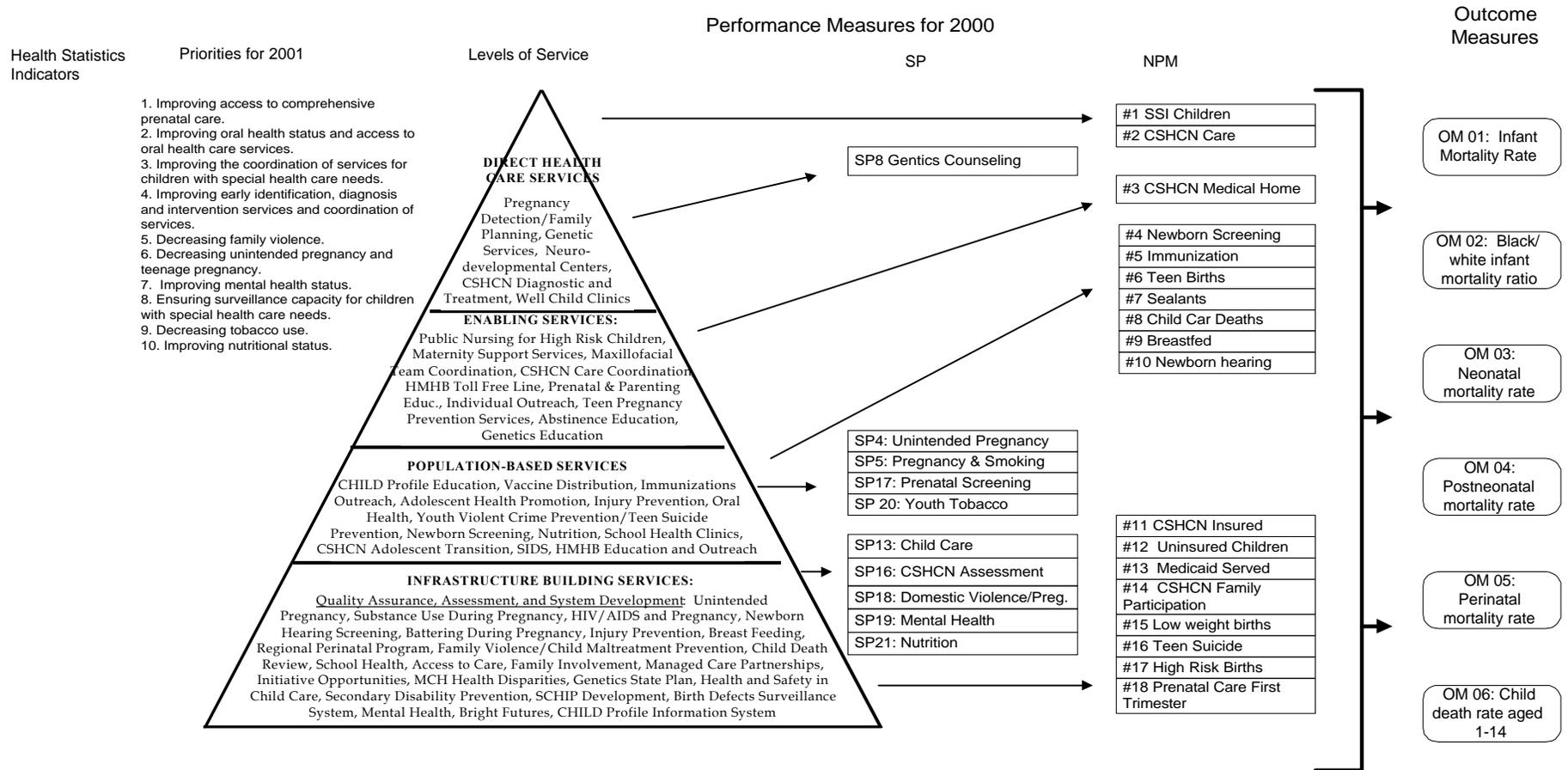
The two leading causes of neonatal mortality (OM 3) are birth defects, and factors related to prematurity and low birth weight. Performance measures associated with these issues are VLBW births (NPM 15), perinatal regionalization (NPM 18), genetic testing (SPM 8), abstinence from smoking (SP5), provider screening (SP 17), and late prenatal care (NPM 18).

Sudden infant death syndrome (SIDS) and congenital anomalies are the most common causes of postneonatal (OM 4). The SIDS component of postneonatal mortality may be influenced by abstinence from smoking (SPM 5), if it continues postpartum. Prenatal counseling about genetic testing (SPM 8) may reduce the prevalence and severity of birth defects.

The fetal death component of perinatal mortality (OM 5) may be influenced by abstinence from smoking (SPM 5), provider screening (SP 17), genetic testing (SPM 8), and by reducing unintended pregnancies (SPM 4), which occur more often at the age of extremes of fertility, as do fetal deaths.

Deaths to children age 1-4 (OM 6) clearly related to NPM 8, motor vehicle deaths to this age group. Increasing immunizations (NPM 5 and SPM 15), health insurance coverage (NPM 12), genetic testing (SP 8), mental health services (SP 19), food security (SP 21), and improved safety in child care settings (SP 13) may help to reduce childhood deaths.

Figure 3.  
Title V Block Grant Performance Measure System



## **III. Requirements for Application**

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

#### **3.1.1 Needs Assessment Process**

##### ***Background***

Since the submission of the previous Five Year Needs Assessment in 1995, OMCH has undertaken numerous efforts to improve the collection, management and reporting of data, and to use data in OMCH program planning and priority setting. The goal has been to establish an on-going needs assessment process which cycles between data analysis, priority setting, program planning, and evaluation. Since 1995, an assessment section has been created, available data have been inventoried, needed improvements in data collection, management, and reporting have been identified, and several improvements have been implemented, such as the collaboration with OSPI and DSHS on the joint adolescent health survey. OMCH has also begun to enhance birth defects surveillance data, develop several reports using Pregnancy Risk Assessment Monitoring System (PRAMS) data, and implement strategies for identifying the population of children with special health care needs.

Because of the abundance of data available in Washington State, OMCH decided to focus the current Five Year Needs Assessment on priority setting. This was necessary to develop a more focused agenda for the next five years, to facilitate data-driven decision making, and to enhance the use of data for communication and evaluation. In 1998, OMCH established a Needs Assessment Steering Committee comprised of representatives from different programs in OMCH, the DOH local assessment coordinator, and a representative from the LHJs. This committee, chaired by the manager of the OMCH Assessment Section developed a plan to: 1) gather and review health status data; 2) gather and review information on the Washington State health system; and 3) involve local and state stakeholders in identifying priority needs for the MCH population.

To gather and review health status data, a list of health status indicators and health behavior indicators pertaining to mothers, infants, children, adolescents or children with special health care

needs was developed. This list was reviewed by several OMCH and DOH staff and stakeholders to identify data sources and indicators that were not identified. Data were then compiled by the OMCH Assessments section. Included were the overall rate for Washington for each health indicator, the most recent U.S. data, and the Healthy People 2000 target, if applicable. Data were stratified by age, race/ethnicity and Medicaid status and trend information was provided. Data sources included Washington State birth, death, abortion, and fetal death statistics, PRAMS, the Comprehensive Hospital Abstract Reporting System (CHARS), Medicaid data, the Survey of Adolescent Health Behaviors, the oral health Smile Survey, the Pediatric Nutrition Surveillance System, and sexually transmitted disease surveillance data. Comparative data for the U.S. were obtained from National Center for Health Statistics reports. These data were used in a series of prioritization retreats described below.

Information on Washington's health system was compiled through an extensive literature review of state and local trends, data and related information on all aspects of the current health system. OMCH also collaborated with the Office of Community and Rural Health (which oversees the Primary Care Grant in Washington) in conceptualizing and describing the health system, environmental influences, and system needs. A survey of nursing directors in LHJ was conducted in Spring 1999 to identify LHJ priorities for the maternal child health population based on local needs assessments. Facilitated discussions were also conducted through the spring and summer of 1999 at each of five OMCH regional meetings. These facilitated discussions emphasized service system assets, gaps, and impacts of policy on the maternal child health population. Information gleaned from these activities was incorporated into issue papers used in the final prioritization retreat and is reported in this document.

Several data sources were used in the Needs Assessment Process, including vital statistics, PRAMS, Youth Risk Behavior Survey, population data from the Washington State Office of Financial Management, Smile Survey, hospital discharge data, and program data from DOH and DSHS. Data from PRAMS, Youth Risk Behavior Survey and the Smile Survey are all estimates of the population based on a statistical sample. Ninety-five percent confidence intervals are included with these estimates to indicate the range within which the true population value likely lies. The hospital discharge data cover all discharges from Washington State hospitals except military hospitals. Data are based on billing records and may be slightly biased to reflect diagnostic codes with higher charges. Program data are collected using several different methods and reporting may not always be consistent. Often these data are a better indicator of general patterns rather than exact numbers of clients served.

Data addressing these indicators were sent to participants prior to each retreat. In addition to health outcome data, population data, a summary of Healthy People 2010 draft objectives, and a summary of local health priorities from a survey taken in 1995 were distributed to participants. Along with the data packet, each participant was given a written orientation to a modified version of the Hanlon-Pickett prioritization method<sup>1</sup>. This method was followed during each retreat. It involves rating the size, seriousness, intervention effectiveness, and political/economic/logistical ability to address the health problem in order to rank and prioritize health problems.

### ***Public Input***

To involve local and state stakeholders in identifying priority needs for the MCH population. Four prioritization retreats was planned. Initially, three day-long retreats were held, each focusing on one of the three Title V populations: mothers and infants (November, 1998), children and adolescents (April, 1999), and children with special health care needs (August, 1999). Each retreat included approximately 40 participants including content experts from DOH, LHJs, state universities, advocacy groups, epidemiologists, parents, other state agencies, and other stakeholders. Focus groups and other forums were held with parents of children with special health care needs to gather their input on potential indicators and to prepare them to participate in the prioritization retreats.

In preparation for each retreat 20 to 30 population specific key health status and health behavior indicators were selected from previously identified indicators. Participants were also given an opportunity to identify additional indicators at each retreat. At each retreat, participants discussed the health indicators, the data, and their own perspectives in facilitated groups of 6-8 people. Each individual was asked to prioritize the set of health indicators using worksheets corresponding to the Hanlon-Pickett method. Worksheets were collected and a preliminary rank order of the priorities was developed. The group then came together in one large facilitated group and reviewed the preliminary rank order; discussed the health indicators, data, and any new identified health indicators; and refined the list to the 7-10 priority health needs for that population group. (See pages 145-147 for a list of the priorities identified.)

In November 1999, a final retreat was held to refine the 25 population-specific priorities identified to a list of 15 state OMCH priorities. Similar to the prior retreats, participants included content experts from DOH and the stakeholder groups previously mentioned, several of whom

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<sup>1</sup> Pickett G. and Hanlon J.J. *Public Health Administration and Practice, 9<sup>th</sup> edition*. Times Mirror /Mosby

participated in earlier retreats. In preparation for this retreat, participants received issue papers outlining the size, seriousness, current health system components and service gaps related to each identified priority. The process was similar to previous retreats, including small group facilitated discussions, individual ranking of priorities, preliminary group ranking, and a large group facilitated discussion to select the 15 priorities.

Following this retreat, managers and staff selected 10 of these 15 priorities to be submitted for the MCH Block Grant (see pages 145-147). Criteria used to select the 10 block grant priorities included: 1) MCH block grant dollars as a major source of funding for activities related to the priority; 2) OMCH as the only DOH office or a leading DOH office addressing the priority; and 3) OMCH plays a primary (vis-à-vis supportive or collaborative) role in statewide efforts to address this priority. OMCH, however, plans to continue to track data on and address all 15 priority issues identified using other funding and opportunities.

### ***Ongoing Process***

Over the coming five years, OMCH plans to further systematize data review, priority identification and planning. Using funding from a State Systems Development Initiative, OMCH is designing an annual data report which will initially be targeted to OMCH and DOH program staff. This report will include health status, behavioral and health care systems indicators and will facilitate review of existing data and assessment of the status of OMCH designated priorities. Fact sheets will be developed from the data report and disseminated to stakeholders and policy makers. As new indicators are suggested by the data, stakeholders and policy makers, the Assessment Section will collect and review available data. New indicators will be presented to OMCH staff and stakeholders for discussion and identification of data or system needs. On an annual basis, state performance measures will be re-aligned with existing OMCH priorities and activities as well as with DOH planning and priorities. At this time the need for new priorities will be reviewed, any new state performance measures will be created if necessary, and program needs identified.

Limitations of the information gathering process include the lack of routine sources of data on several health status measures and health systems indicators, especially given the changing practices subsequent to the increase in managed care. Models for describing and evaluating health care systems under managed care are not readily available but would have been very useful for

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College Publishing. Boston, 1990.

describing culturally competent care. Also of note, although not a current limitation, are additional data requirements and/or limitations on data release, such as those being introduced under the Health Insurance Portability and Accountability Act (HIPAA). Such requirements fiscally and logistically hamper future data collection efforts as the implications of complying with new state and federal requirements regarding privacy and data release are implemented.

## **3.1.2 Needs Assessment Content**

### **3.1.2.1 Overview of the MCH Population's Health Status**

The following is an overview of MCH fertility rates followed by the major morbidity and mortality issues facing the MCH population in Washington State. With the exception of low birth weight, the topics discussed were identified as priorities for the maternal, infant, child, adolescent or children with special health care needs population during the preliminary prioritization retreats. For discussion of the MCH population distribution, see Section 1.4.

It is important to note throughout this needs assessment that the data presented on health status for racial/ethnic populations must be viewed with a recognition of the fact that cultural values and influences impact a number of the health outcomes and behaviors discussed. In addition, complex issues such as lack of access to culturally appropriate health care, socio-economic factors, racism, and language barriers contribute to the disparities highlighted in this document. Space limitations do not allow for in-depth interpretations of this data. Therefore, any analysis and program decisions made on the basis of this information must include significant input from the populations involved to allow for more accurate interpretations and culturally appropriate interventions.

#### ***Fertility and Pregnancy rates***

Washington's pregnancy rate (live births, fetal deaths and abortions) was 85.0 per 1000 women 15-44 years in 1998, down 11.5% since 1990. The reason for this decline is not well understood. Scrutiny of the rate trend, however, reveals a 7.9% increase in the number of women of reproductive age in Washington State and a 16% decrease in the numbers of abortions over this period. Women between 20 and 29 continue to have the highest age-specific pregnancy rates. Although still a small proportion of all pregnancies, the rates to women over 35 have been increasing since 1990. These women are at increased risk of several adverse pregnancy

outcomes. As the numbers of women of reproductive age increases, the number of pregnancies is also expected to increase, although substantial changes to the pregnancy rate are not anticipated.<sup>2</sup>

The fertility rate (live births) in 1998 was 64.1 per 1000 women 15-44 years, resulting in 79,640 births. The fertility rates of African American and American Indian women are about 10% higher than those of white women. The rates of all three groups have declined since the early 1990's and have been stable over the past several years. Hispanics, however, have both an increasing and already much higher fertility rate at 135.4 births per 1000 Hispanic women 15-44. These factors are contributing to the growing diversity of the state.

### ***Unintended and Adolescent Pregnancy***

Unintended pregnancy refers to pregnancies that are unwanted or mistimed at the time of conception. When pregnancies are undertaken without planning or intent, there is less opportunity to prepare for an optimal pregnancy. Long term family health and economic stability may be compromised by: 1) Absence of preconception risk identification and management, 2) insufficient birth spacing between children, 3) family sizes larger than desired, and 4) lack of preparation for parenthood. In addition, the mother is less likely to seek early prenatal care, less likely to breastfeed, and more likely to expose the fetus to alcohol and tobacco. The infant is at greater risk of low birth weight, being abused, and dying in the first year.

Additional social risks include: reduced education and career attainment of the parents, welfare dependency, divorce and domestic violence.<sup>3</sup> Unintended pregnancy has economic costs as well. At an average of \$5,639 for prenatal care and delivery, the cost to the government for the approximately 17,000 unintended Medicaid births is estimated to be \$95.8 million.<sup>4</sup> The related Healthy People 2010 goal is to increase to at least 70 percent the proportion of pregnancies that are intended.

In 1998, 38.1% ( $\pm 3.3\%$ <sup>5</sup>) of live births and 53.1% ( $\pm 3.3\%$ ) of all pregnancies<sup>6</sup> were estimated to be unintended based on PRAMS data and vital statistics. This is approximately 30,000 live births

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<sup>2</sup> Washington State Office of Financial Management. *Forecast of the State Population by Age and Sex. 1990-2020. Technical Notes.* Olympia, 1999.

<sup>3</sup> US Department of Health and Human Services. *Healthy People 2010 Objectives: Draft for Public Comment.* Washington, DC: US Government Printing Office, 1998.

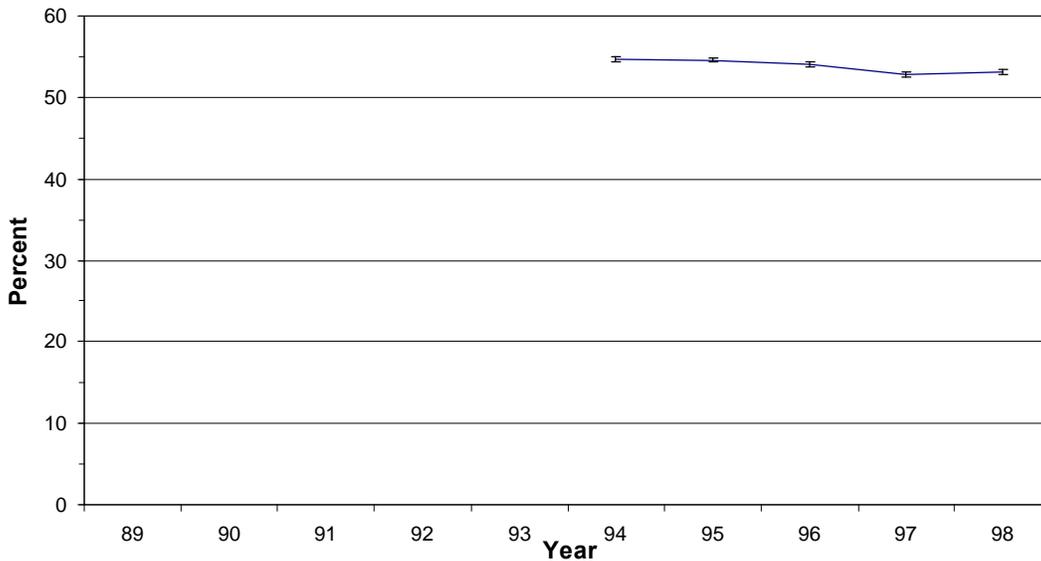
<sup>4</sup> Washington State Department of Social and Health Services, First Steps Program Data, 2000.

<sup>5</sup> This designates the approximate 95% confidence interval.

<sup>6</sup> The PRAMS survey is administered to women who have recently given birth. Estimates based on this survey are representative of the population of women delivering live births, and not necessarily all pregnant

and 25,000 abortions each year. Washington has been monitoring unintended pregnancy since 1994 and has seen no significant reduction in the percent of births or pregnancies that were unintended over this period. The numbers of induced abortions, however, has declined as noted above.

### Washington State Unintended Pregnancies 1994- 1998



Source: Washington State Pregnancy and Induced Abortion Statistics 1998, Table 2; Washington State Dept. of Health, Center for Health Statistics, PRAMS Survey, 1994-1998. Unintended pregnancy is calculated as follows: [% Pregnancies Unintended from PRAMS\*(WA Resident Live Births +Resident Fetal Deaths)]+WA Reported Abortions/# of WA Resident Pregnancies

Analyses of unintended live births reported in PRAMS data reveal that women on Medicaid, African American women, and young women reported the highest rates of unintended births in 1998. Among women receiving Medicaid coverage for their delivery, 53.0% ( $\pm$  4.9%) reported their births as unintended at the time of conception, compared to 28.1% ( $\pm$  4.1%) of women not on Medicaid. African American women reported 52.8% ( $\pm$  5.1%) of births as unintended compared to 36.7% ( $\pm$  4.3%) of births to white women. Similarly, 74.8% ( $\pm$  8.4%) of births to women under 20 years were unintended, compared to 44.5% ( $\pm$  6.7%) of births to women 20-24 and 29.9% ( $\pm$  3.7%) of births to women 25 and older. Despite these increased risks, unintended births to white women and to women ages 20-34 account for most of the unintended births in the state because they comprise the majority of births in the state.

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women. When describing unintended pregnancies, two estimates can be made: the number of live births which were reported as unintended at the time of conception and the number of all pregnancies which are unintended. The first estimate is derived directly from PRAMS survey data. The second estimate is a composite measure. It is calculated as follows:  $[(\text{PRAMS unintended birth rate}) * (\text{livebirths} + \text{fetal deaths})] + [\text{number of abortions}] / \text{livebirths} + \text{fetal deaths} + \text{abortions}$ .

Although women under 20 years have the highest rates of unintended births in the state, not all births to women in this age group are unintended. However, for adolescents, the problems with unintended pregnancy can be more serious. Adolescent pregnancy has been related to a variety of social consequences including decreased high school completion rates, educational attainment, employment and job opportunities, and increased dependence on welfare and public assistance. The infants of adolescent mothers are at increased risk for several adverse pregnancy outcomes including low birth weight; infant mortality; sudden infant death syndrome; and possibly child abuse, neglect, and behavioral problems.<sup>7</sup> In 1998, approximately 88% of adolescent births in Washington were covered by Medicaid. The cost of providing the prenatal care and delivery services was estimated at \$14.5 million.<sup>8</sup> Adolescent pregnancy also results in several long term societal costs largely as a result of the social consequences previously mentioned.

In 1998, the adolescent pregnancy rate in Washington was 42.6 pregnancies per 1000 women 15-17 years old, lower than the Healthy People 2010 goal of no more than 46 pregnancies per 1000 women. Fifty-six percent of the 5,110 pregnancies resulted in live births, a rate of 24.0 births per 1000 women. Similar to national trends, adolescent pregnancy and birth rates in Washington have been declining since peaking in the late 1980's. Since 1990, the adolescent pregnancy rate has declined 26% and the adolescent birth rate has declined 19%. Nevertheless, high adolescent pregnancy rates continue to challenge several rural counties and race/ethnic subgroups. Thirteen counties, representing 26.9% of Washington's 15-17 year old female population have pregnancy rates above the Healthy People 2010 goal. Many of these counties have substantial Hispanic populations, and the adolescent birth rate for Hispanic adolescents is 73.9 per 1000 women 15-17, more than three times the rate of non-Hispanic adolescents. Statewide birth rates among American Indian adolescents (55.9 per 1000) and African Americans (36.8 per 1000) were also much higher than among Whites (22.9 per 1000). (Pri. 6, SP4, NPM6)

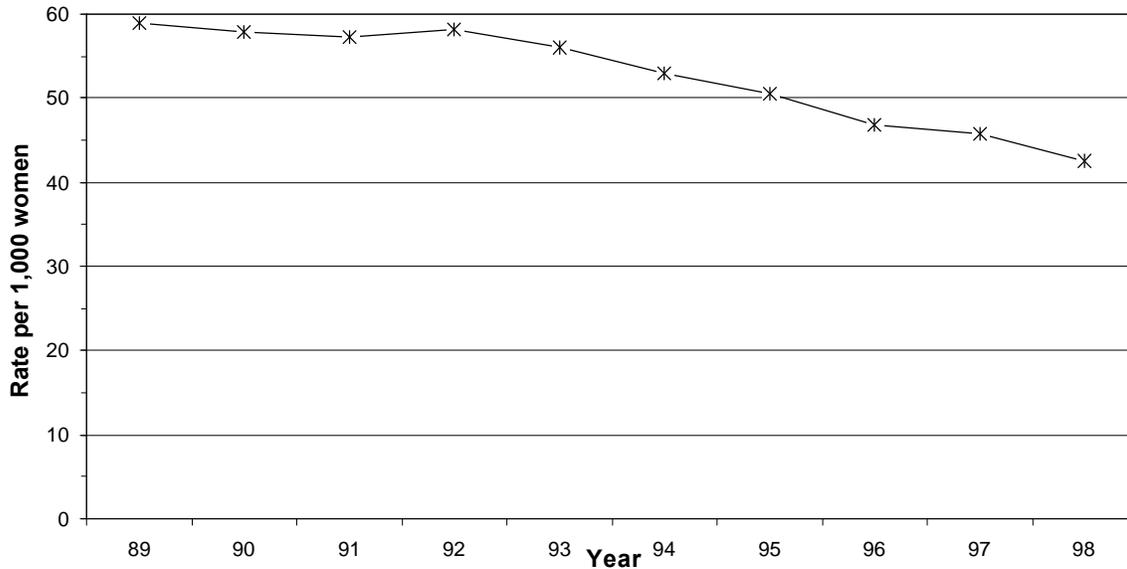
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<sup>7</sup> US Department of Health and Human Services. *Healthy People 2010 Objectives: Draft for Public Comment*. Washington, DC: US Government Printing Office, 1998.

Washington State Department of Health. *The Health of Washington State*. Olympia: 1996.

<sup>8</sup> Washington State Department of Social and Health Services, First Steps Program Data , 2000.

### Washington State Teen Pregnancies, Age 15-17 1989-1998



Source: Washington State Pregnancy and Induced Abortion Statistics 1998, Table 3. Abortion and pregnancy rates for 1992-1995 include 173, 173, 185 and 188 estimated abortions that were unreported these years.

### ***Substance Use during Pregnancy: Tobacco, Alcohol, Illicit Drugs***

Health educators have referred to pregnancy as providing a window of opportunity for behavior change because of the motivation to provide a safe and healthy environment for the infant, and the frequent contact with the health provider. This opportunity relates to support for decreasing the use of tobacco, alcohol and illicit drugs, all of which have been associated with adverse pregnancy outcomes. The use of tobacco during pregnancy has been related to intrauterine growth retardation, sudden infant death syndrome, and spontaneous abortions. Furthermore, while not a direct result of smoking during pregnancy, exposure of children to secondhand smoke has been related to asthma and lower respiratory tract infections.<sup>9</sup> Among the strongest risk factors for smoking are low income and lower educational attainment.<sup>10</sup>

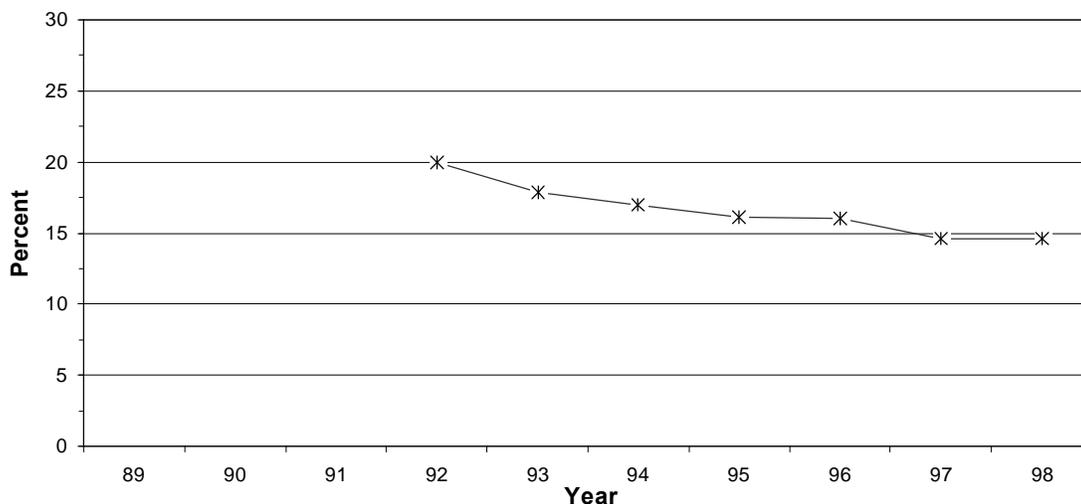
In 1998, 14.6% of women delivering live births reported smoking sometime during pregnancy. These women tend to be daily smokers who consume almost half a pack per day (9.8 cigarettes per day). While the rate of smoking reflects a 26.6% decline since 1992, it still represents over 11,000 women. The smoking rates of women on Medicaid have also declined (approximately

<sup>9</sup> US Department of Health and Human Services. *Healthy People 2010 Objectives: Draft for Public Comment*. Washington, DC: US Government Printing Office, 1998.

<sup>10</sup> Washington State Department of Health. *Tobacco and Health in Washington State*. Olympia: 1999.

14%); however, smoking during pregnancy continues in women on Medicaid compared to women not on Medicaid. In 1998, 23% of women on Medicaid reported smoking during pregnancy. Similarly high rates were reported by American Indian women (25.5%) and women under 20 years (25%). Smoking during pregnancy also seems to be clustered geographically in Washington with high rates reported by women residing throughout the Olympic Peninsula and Southwest Washington.

### Washington State Pregnancy Smoking 1992-1998



Source: Center for Health Statistics, Birth Certificates, 1992-1998.

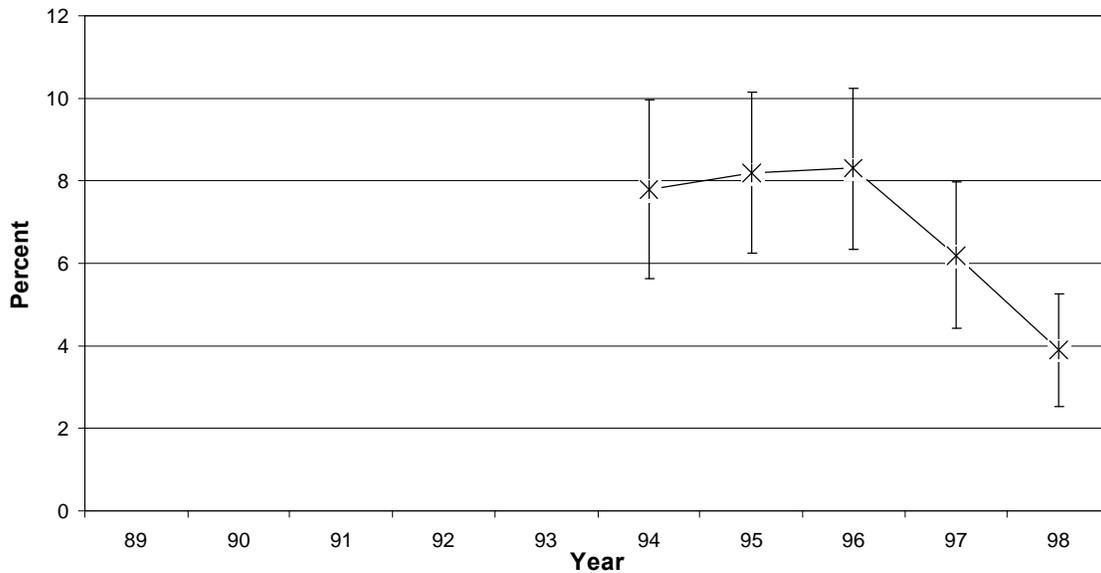
Reviewing the Pregnancy Risk Assessment Monitoring System (PRAMS) data demonstrates that many Washington women decrease their smoking while pregnant, but unfortunately rates increase again after delivery. In 1998, 26% ( $\pm 3\%$ ) of PRAMS respondents reported smoking in the three months prior to conception, 13% ( $\pm 2.3\%$ ) reported smoking in the last three months of pregnancy, and 18% ( $\pm 2.5\%$ ) reported smoking in the three months after delivery. The Healthy People 2010 goal is to reduce smoking during pregnancy to no more than 2%.

Alcohol use during pregnancy has been related to fetal death, low birth weight, fetal alcohol syndrome, and mental retardation.<sup>11</sup> In 1998, third trimester alcohol use was 3.9% ( $\pm 1.4\%$ ) as reported in PRAMS. This represents an approximate 50% decline in the past two years, and is

<sup>11</sup> US Department of Health and Human Services. *Healthy People 2010 Objectives: Draft for Public Comment*. Washington, DC: US Government Printing Office, 1998.

lower than the Healthy People 2010 goal of no more than 6% of pregnant women who report using alcohol in the past month. Women not on Medicaid, and women over 30 years continue to report higher use of alcohol during pregnancy.

**Washington State Alcohol Use in Pregnancy**  
1994-1998



Source: Washington State Dept. of Health, Center for Health Statistics, PRAMS Survey, 1994-

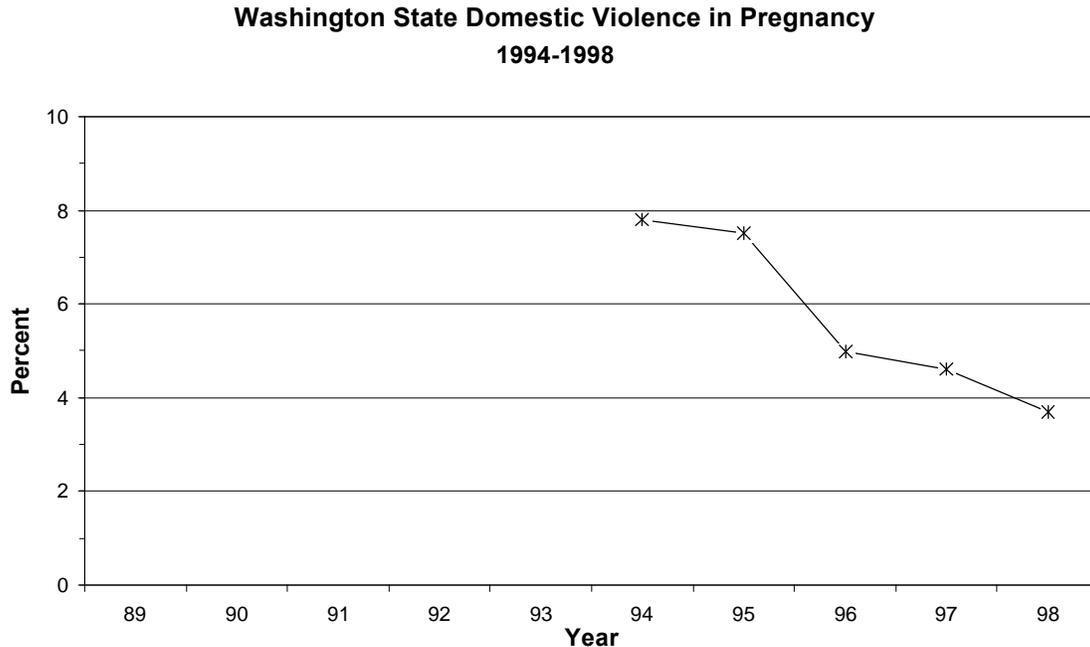
The effects of illicit drug use during pregnancy vary with the drug(s) used, but have been reported to include poorer maternal nutritional status, later onset of prenatal care and increased rates of preterm labor and placental abruption. Fetal effects include prematurity, intrauterine growth retardation, infant mortality, neurobehavioral problems, and child abuse and neglect.<sup>12</sup> Currently in Washington, population based data on illicit drug use in pregnancy are not available and ascertainment of illicit drug use in pregnancy is fraught with methodologic difficulties.<sup>13</sup> A review of several data sources on low income Medicaid women resulted in an estimate of 10-12% or 8,000 – 10,000 alcohol and/or drug exposed births in Washington per year. These infants were defined as drug or alcohol-exposed based on clinical reports of treatment for a drug or alcohol problem during pregnancy or up to two months after delivery. Most of these infants showed no measurable effects of drug exposure at birth. A small subset of these infants, estimated to be 1-1.2%, or 800-1000 infants were identified as drug affected based on a set of indicators reported

<sup>12</sup> Washington State Department of Health. *Report to the Legislature on HB 3103*. Olympia: 1999.

<sup>13</sup> Washington State Department of Health. *Report to the Legislature on HB 3103*. Olympia: 1999.

on birth certificates and Medicaid claims data.<sup>14</sup> The Healthy People 2010 objective is to increase to 98% the percent of pregnant women who abstain from drug use. (Pri. 1, 9, SP5, 19)

## ***Physical Abuse During Pregnancy***



Source: Washington State Dept. of Health, Center for Health Statistics, PRAMS Survey, 1994-1998.

Research has suggested that physical abuse of women may increase during pregnancy. Furthermore, children in families where the mother is being abused may also be at increased risk of physical abuse. The reported effects of physical abuse on pregnancy outcomes have been varied, including reports of low birth weight, fetal injury, miscarriage, maternal substance use, maternal stress, depression and late onset of prenatal care.<sup>15</sup> Because of this, Washington State PRAMS data has monitored physical abuse in pregnancy since 1994. In 1998, 3.8% ( $\pm 1.2\%$ ) of respondents reported they were physically abused during pregnancy. This represents over a 50% decline since 1994, but still represents almost 3000 women. The decrease may be real, or may reflect differential responses from a change in wording of the question in mid-1995. PRAMS data show several factors to be associated with increased rates of physical abuse in Washington including young maternal age, low income, and American Indian race. In an analysis of PRAMS data from 1996-1998, 11.3% ( $\pm 3.9\%$ ) of women < 20 years, 9.0% ( $\pm 3.7\%$ ) of women receiving

<sup>14</sup> Washington State Department of Social and Health Services. *Substance Use During Pregnancy: Prevalence, Effects, and Costs*. Olympia: 1997.

TANF, and 9.1% ( $\pm 1.4\%$ ) of American Indian women reported physical violence. In addition, two other factors were associated with physical violence and may be either a cause or consequence of the violence during pregnancy: 16.3% ( $\pm 4.3\%$ ) of women who were recently separated or divorced from their partner and 10.2% ( $\pm 2.9\%$ ) of women who reported a close friend with a drug or alcohol problem reported physical abuse during pregnancy. The related Healthy People 2010 goal is to reduce the rate of physical assault by current or former intimate partners to no more than 3.6 physical assaults per 1,000 persons age 12 and older. (Pri. 5, SP 18)

### ***Sexually Transmitted Diseases***

Unprotected sexual relations carry the risk of sexually transmitted diseases (STDs), and Human Immunodeficiency Virus (HIV). In addition to the acute infections themselves, STDs may result in reproductive health problems, such as pelvic inflammatory disease (PID) which can cause ectopic pregnancy, infertility, and chronic pain. STDs have also been associated with adverse perinatal outcomes, such as pre-term delivery and perinatally acquired infections of the newborn, and reproductive cancers. STD lesions also increase the risk of contracting HIV infection.<sup>16</sup> The most common STD reported in Washington is chlamydia. Most chlamydia cases in females are asymptomatic, and females are selectively screened because of the risk of PID if chlamydia is untreated. In 1999, there were 8,882 cases of chlamydia reported among women, an incidence of 307 per 100,000. The peak incidence was among adolescent women 15-19 years (1796.5/100,000 women). The rate among adolescent men 15-19 was 298.8 per 100,000. The overall state rate of chlamydia decreased 40% between 1988 and 1997. In the last two years, the incidence has been increasing in Washington, but much of the increase is believed due to more sensitive laboratory techniques. The highest chlamydia incidence rates are among African Americans, followed by American Indians. Hispanics also report elevated rates. Reported race/ethnic specific rates are not reported here because of a substantial proportion of missing data.

In 1999, there were 1,009 cases of gonorrhea reported among women, an incidence of 35/100,000. Similar to chlamydia, the peak incidence was among adolescent women 15-19 years (187.6/100,000). The rate among adolescent men 15-19 years was 50.8 per 100,000. Overall, gonorrhea incidence has declined 77.4% since 1988, although a slight increase was seen in 1999 due in part to an outbreak in Pierce County. Rates among African Americans have consistently

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<sup>15</sup> Washington State Department of Health. *Domestic Violence in Pregnancy*. Olympia: 2000.

<sup>16</sup> US Department of Health and Human Services. *Healthy People 2010 Objectives: Draft for Public Comment*. Washington, DC: US Government Printing Office, 1998.

been higher than other race/ethnic groups, although their incidence has decreased over 50% since 1993.

The statewide rate of primary and secondary syphilis in females was 0.1 per 100,000 in 1999. Since 1995, rates in females have fluctuated between 0.1 and 0.3 per 100,000. Rates in males have increased over the last two years due to an outbreak among men who had sex with other infected men in King County. Generally, syphilis is rare in Washington State.

Pelvic inflammatory disease (PID) is also currently a reportable condition in Washington. The statewide acute PID incidence rate for females was 10.3 per 100,000 in 1999, but is believed to be underreported. The Healthy People 2010 goal is to reduce the percentage of women requiring treatment for PID to no more than 5%.

### ***Perinatally-Acquired Infections***

Washington defines perinatally-acquired infections to include sexually transmitted diseases, HIV, hepatitis B, rubella, group B streptococcus, and other bacterial and viral infections. These infections can cause lasting impairment or death to infants. Identification of the risk status and/or infection in pregnant women is crucial for appropriate prevention or prophylaxis to be administered during pregnancy, labor and delivery, or postpartum. In 1999, there were 14 cases of chlamydia, 1 case of gonorrhea, 2 cases of herpes, and no cases of perinatally acquired HIV/AIDS, and an estimated 15 cases of perinatally acquired hepatitis B in infants under 1 year<sup>17</sup>. There were also an estimated 63 cases of group B streptococcus contracted when infants were less than 1 week old. There were no cases of congenital rubella.

### ***Low Birth Weight***

Low Birth Weight, the proportion of live births weighing less than 2500 grams, is a major cause of infant mortality and long term morbidity. Low birth weight consists of two subgroups: infants who are born small for their gestational age (intrauterine growth restriction) and infants born early (< 37 weeks) whose weight is appropriate for gestational age. The two subgroups have different outcomes and different risk factors. Intrauterine growth restriction has been associated with increased risk of neurologic problems including cerebral palsy, mental retardation and developmental disabilities. A major risk factor for intrauterine growth restriction is cigarette

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<sup>17</sup> Washington State Department of Health . Infectious Disease and Reproductive Health Office data. March 2000.

smoking during pregnancy. Other factors include substance use during pregnancy, maternal medical conditions such as hypertension and genetic disorders, low maternal weight gain and low pre-pregnancy weight for height. Infants born pre-term are immature and are at greater risk of immediate life-threatening conditions such as respiratory distress and infection. Risk factors include pregnancy complications such as *placenta previa*, *abruptio placentae*, and maternal infection.<sup>18</sup> It is often difficult to distinguish these two subgroups of low birth weight due to uncertainty about the infants' gestational age.

Tremendous improvements have been made in caring for low birth weight infants over the last three decades which have resulted in sharp declines in associated mortality. These improvements, however, are extremely costly, especially for very low birth weight (<1500 grams) infants. Additional non-medical costs associated with low birth weight infants include special education and other support services. Related Healthy People 2010 objectives are to reduce low birth weight deliveries to no more than 5% of live births and very low birth weight deliveries to no more than 0.9% of live births.

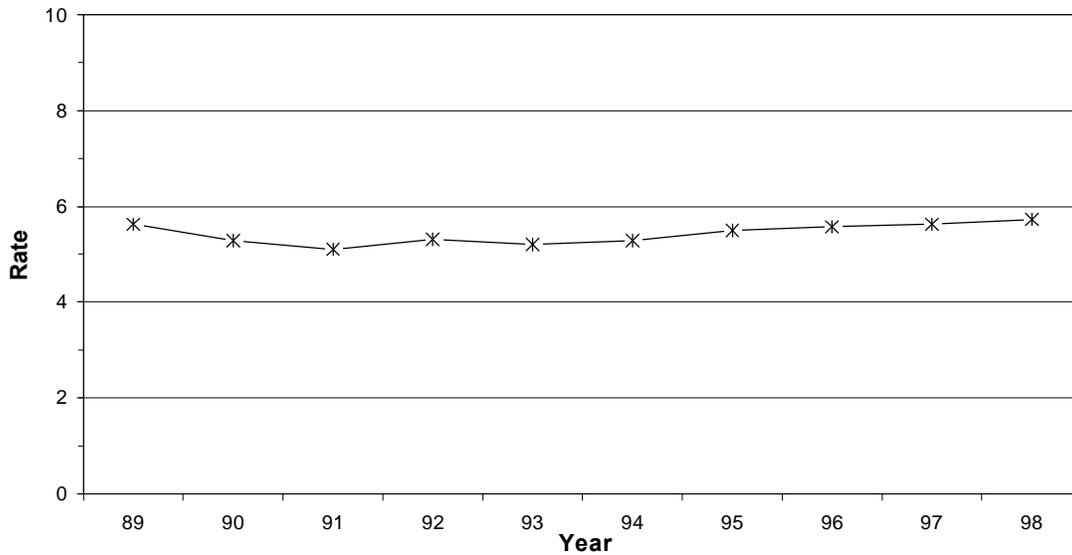
In 1998, there were 4,545 low birth weight infants born to Washington residents, a low birth weight rate of 5.7%. Of these, 860 infants were born very low birth weight, a rate of 1.1%. Review of data for the past 10 years reveals an 11.8% increase in low birth weight rates since the low point in 1991. Increasing low birth weight rates have also been reported nationally. Because multiple births are often low birth weight and the incidence of multiple births has been increasing, the rate of singleton low birth weight has been used to determine whether the increase in low birth weight is independent of the increase in multiple births. Washington data indicate singleton low birth weight rates have also increased slightly since the early 1990's. Currently, 4.5% of singleton births are low birth weight, and 0.8% are very low birth weight.

Low birth weight rates vary across Washington counties, but no particular patterns emerge. Race/ethnic disparities in low birth weight persist in Washington. The highest rate, 10.1%, is experienced by African Americans. This rate, however, has actually declined over 10% since 1991. Over the same period, the rate of American Indians has increased 48% to 7.7% while the rate for Caucasians has increased 12.5%. Rates for Asian/Pacific Islanders and Hispanics have also been increasing. Women on Medicaid also have higher low birth weight rates than women not on Medicaid, but the disparity in rates has decreased since the advent of First Steps. (Pri. 1, NPM15, NPM 17)

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<sup>18</sup> Washington State Department of Health. *Health of Washington State*. Olympia: 1996.

### Washington State Low Birth Weight 1989-1998



Source: Center for Health Statistics, Birth Certificates, 1989-1998

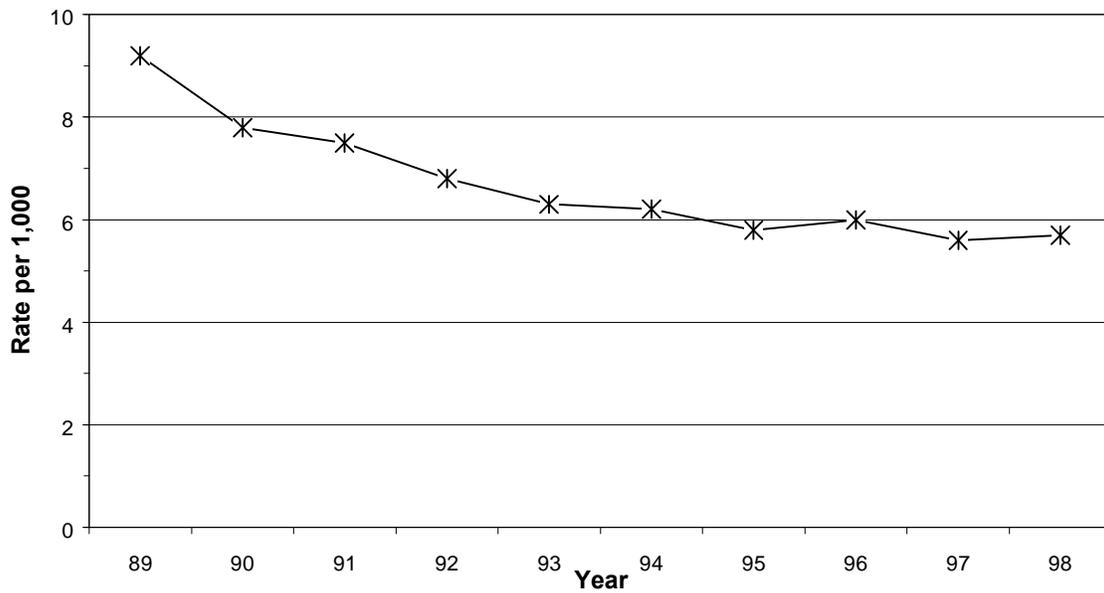
### ***Infant Mortality***

Infant mortality is an important public health indicator associated with health status and access to health services of both pregnant women and their infants. Infant mortality can be split into neonatal mortality, deaths that occur in the first 28 days of life and postneonatal mortality, deaths occurring between 29 and 364 days of life. Neonatal mortality is closely associated with prenatal conditions, pregnancy risk factors and birth complications while postneonatal deaths can also be due to conditions and care that develop after birth.<sup>19</sup> Approximately 39% of all infant deaths are due to conditions in the perinatal period (ICD-9 codes 760-779). This includes maternal diseases affecting the child, pregnancy complications, birth injuries and other conditions affecting the fetus/newborn. Another 27% of deaths are attributable to congenital malformations (ICD-9 codes 740-759), and 20% are attributable to Sudden Infant Death Syndrome (ICD-9 code 798.0). Related Healthy People 2010 objectives are to reduce infant mortality to no more than 4.5, neonatal mortality to no more than 2.9 and postneonatal to no more than 1.5 deaths per 1000 live births.

<sup>19</sup> Washington State Department of Health. *Health of Washington State*. Olympia: 1996.

In 1998, there were 452 infant deaths in Washington, 285 in the neonatal period and 167 in the postneonatal period. These deaths correspond to infant, neonatal and postneonatal rates of 5.7, 3.6 and 2.1 deaths per 1000 live births. Rates declined appreciably in the early 1990's, but have been relatively stable for the past 4 years. Despite the overall encouraging picture, race/ethnic disparities in infant mortality persist, and may be increasing for some groups. Currently, American Indians have the highest infant mortality rate at 11.2 per 1000 live births. While this rate decreased dramatically in the early 1990s, it has been increasing over the past 3 years, and is currently over twice the rate of Caucasians. The rate among African Americans, 10.4 per 1000 live births also remains over twice the rate among Caucasians, despite continuing to decrease throughout the decade. Infant mortality rates are also higher for babies born to younger mothers (< 20 years), older mothers (> 40 years) and women on Medicaid. (Pri1, SP8, OM 1-5)

**Washington State Infant Mortality  
1989-1998**



Source: WA State Vital Statistics, 1998, Table 1 'Live Births, Deaths, Infant Deaths, Maternal Deaths and Fetal Deaths, Washington Residents, 1910-1998', WA State Department of Health, Center for Health Statistics, November 1999

### ***Child Maltreatment***

Child maltreatment, behaviors which cause a child physical or emotional harm, refers to physical abuse, sexual abuse, neglect and emotional maltreatment. In addition to injuries, child maltreatment has been associated with a variety of adverse health outcomes including substance use, delinquency, depression, adolescent pregnancy, poor physical health and poor school

performance. Among the risk factors for child maltreatment are poverty, unemployment, young maternal age, unintended pregnancy, large family size and short interpregnancy interval.<sup>20</sup> The epidemiology and prevention of child maltreatment, however, has been hindered by difficulties in defining and consequently measuring the problem and the fact that child abuse is not always reported. Currently, accepted referrals to CPS is the best available statewide measure of child maltreatment. In 1998, 41,407 referrals (some involving multiple children) were accepted by CPS. These referrals involved 54,548 children 0-17, a rate of 35.6 per 1000 children. This rate reflects a decline since 1991, when the rate was 60 per 1000. This decline may be a true drop in the occurrence of child maltreatment, a shift in referral practices, a shift in acceptance practices or some combination of all three factors. (The Healthy People 2010 goal is to reduce child maltreatment to 11.1 per 1,000 children under 18.)

### ***Oral Health***

Dental caries is an infectious disease process that affects 84% of all children by age 18. Severe disease, however, is concentrated among relatively few children with 20% of children experiencing 80% of the caries. At highest risk are low-income children, children in rural communities, and Hispanic, Asian and American Indian children. The 1994 Washington State Smile Survey of low income populations found that 38% of Head Start/ECEAP preschool children, 46% 6-8 year olds and 57% of 14-16 year olds had experienced caries. Rampant caries (caries in 7 or more teeth) was most pronounced among the youngest children surveyed (11.2% of Head Start/ECEAP children). In addition, when examined for this study 7.2% of Head Start/ECEAP children were experiencing pain or had visible abscesses, and 21.2% needed restorative dental treatment. Childhood dental caries are preventable with appropriate care including access to fluoridated water systems, use of sealants and fluoride treatments. (NPM 7, Pri 2)

A follow up to the 1994 Smile Survey was administered in the fall of 1999 and data are currently being analyzed.

### ***Nutrition and Hunger***

Inadequate nutritional status is a risk factor throughout the life cycle for a number of preventable diseases, and contributes significantly to heart disease, diabetes, stroke and many cancers. Child-bearing women, infants and children are more vulnerable to the adverse effects of nutrient

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<sup>20</sup> Washington State Department of Health. *The Health of Washington State*. Olympia: 1996.

inadequacies. Moreover, they are more likely to be low income and therefore at greater risk of food insecurity. Food insecurity is defined as “limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways.”<sup>21</sup> In analyses of the Food Security Supplement to the Current Population Survey administered from 1996-1998, Washington was among 11 states with food insecurity and 6 states with hunger significantly above the national average. The percentage of households in Washington with food insecurity was 11.9 (± 1.42%) and 4.6% (±0.97%) of households were food insecure and hungry. The related Healthy People 2010 objective is to increase the prevalence of food security among US households to at least 94 percent of all households.

In addition to food insecurity, other indicators describe the nutritional status of the MCH population in Washington State. Initiation of breastfeeding appears widespread with 87.8% (± 2.2%) of PRAMS respondents reporting breastfeeding at any time. There is a substantial decline however, in breastfeeding for extended periods of time, with only 69.9% (± 2.9%) of respondents reporting breastfeeding at five weeks post partum. A similar decline is shown in 1998 WIC data for low income women. These data also reveal that 64.9% of clients initiated breastfeeding, however, only 52% were continuing to breast feed at five weeks postpartum. Many children and adolescents also have a diet that is poor or needs improvement. Data from the 1999 Washington State Youth Risk Behavior Survey indicate that only 22.7% of respondents reported eating 5 fruits and vegetables per day and 20.9% were either at risk for overweight (in the top 5-15% for body mass index) or were overweight (in the top 5% for body mass index). The Healthy People 2010 objective is for 75% of people over the age of 2 to eat at least five or more servings of fruit or vegetables every day. (Pri. 10, SP 21)

## ***Asthma***

Asthma is among the leading causes of chronic illness in children, resulting in missed school and activity limitations.<sup>22</sup> It is a leading reason for emergency room visits and has been highlighted as an indicator of health care access, as many emergency room visits and hospitalizations due to asthma may be avoidable through appropriate medical management. Data from the 1997-1998 Washington State Behavioral Risk Factor Surveillance System (BRFSS) ascertain the proportion

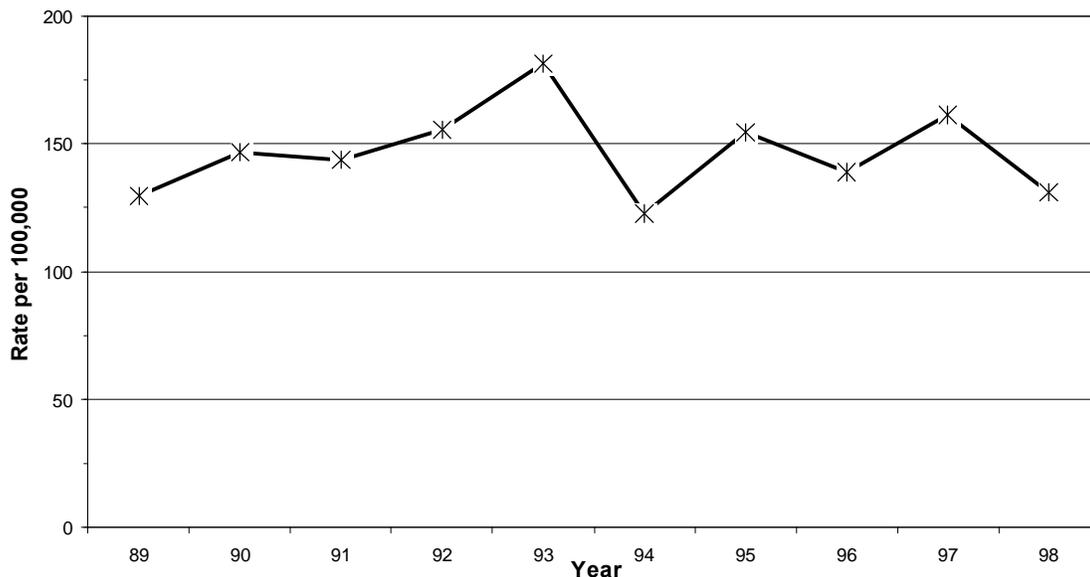
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<sup>21</sup> Nord M, Jemison K, Bickel G. *Measuring Food Security in the United States: Prevalence of Food Insecurity and Hunger, by state, 1996-1998*. Food Assistance and Nutrition Research Report Number 2. Washington, DC: United States Department of Agriculture, 1999.

<sup>22</sup> US Department of Health and Human Services. *Healthy People 2010 Objectives: Draft for Public Comment*. Washington, DC: US Government Printing Office, 1998.

of children ever diagnosed with asthma. Overall, 10.1% of children ever had asthma: 7.8% of children 0-4, 9.5% of children 5-12 years and 12.8% of children 13-17 years. This corresponds to an estimated 151,000 children with asthma.<sup>23</sup> In 1998 there were also 2,204 hospitalizations (13.1 per 10,000 children 0-19 years) with asthma listed as the primary diagnosis. Hospitalization rates were highest among those age 0-4 (29.4 per 10,000) and decreased dramatically with age. Adolescents, ages 15-19 had the lowest rate, 5.0/10,000. The younger children are more vulnerable to respiratory infections because they are often not diagnosed and therefore lack prevention and treatment plans. Trend data reveal a variable pattern in asthma hospitalizations over the last ten years. Data on emergency room visits in Washington related to asthma are not available. Nationwide, asthma is reported to disproportionately affect race/ethnic minorities and the poor, but Washington State specific data are not yet available.<sup>24</sup> The related Healthy People 2010 objective is to reduce the asthma-specific hospitalization rate to no more than 25 per 10,000 children under 5, and no more than 8 per 10,000 children and adults age 5-64.

**Asthma Hospitalizations (Primary Dx only)  
1989-1998: 0-19 yr olds**



Source: Washington State Department of Health, Office of Hospital and Patient Data, CHARS.

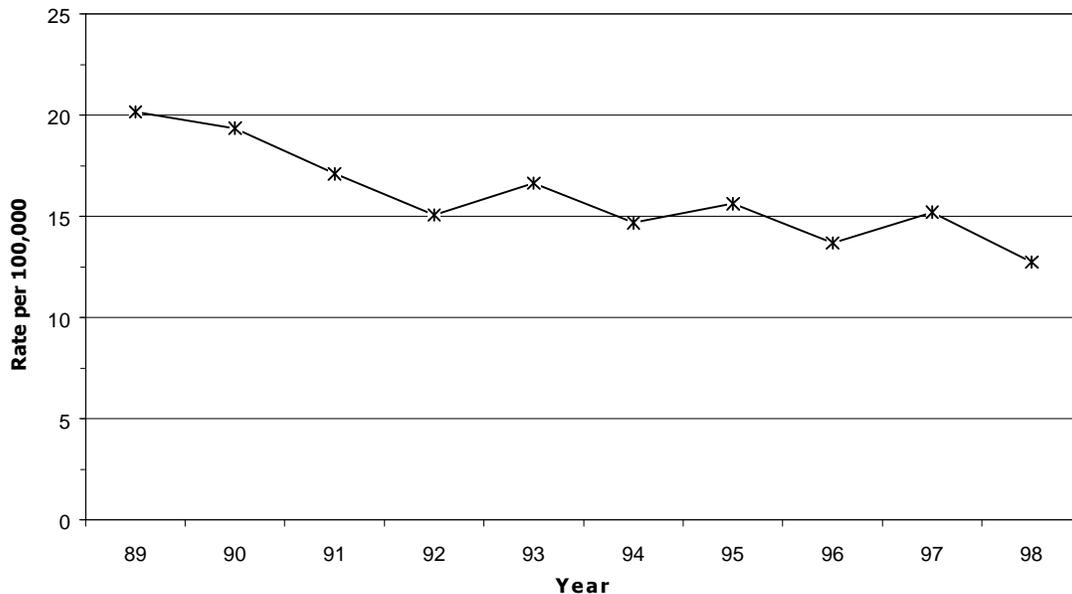
<sup>23</sup> Macdonald SC, Bensley LS, VanEenwyk J, Wynkoop Simmons K. *Self-Reported Asthma in Adults and Proxy-Reported Asthma in Children – Washington, 1997-1998*. Morbidity and Mortality Weekly Report 1998;48:918-920.

<sup>24</sup> US Department of Health and Human Services. *Healthy People 2010 Objectives: Draft for Public Comment*. Washington, DC: US Government Printing Office, 1998.

## Unintentional Injuries

In Washington injuries are classified by the manner or intent of the injury into four subgroups: unintentional, self-inflicted, assaults and other. Each of these groups can then be categorized by the cause of the injury, such as motor vehicle crash, fall, drowning or burns. Using this classification reveals that approximately 66% of injury deaths and 80% of nonfatal injury hospitalizations of children in Washington are due to unintentional injuries. For all children 0-19, the leading causes of injury deaths are motor vehicle crashes, drowning, pedestrian injuries and fires. For hospitalizations, the leading causes are falls, motor vehicle crashes, and being hit by or against objects. However, it should be noted that the causes of injury vary significantly by age. Suffocation and obstruction are the leading cause of unintentional death in infants, drowning for one year olds and motor vehicle crashes for adolescents. There are several Healthy People 2010 objectives related to unintentional injuries, including reducing the deaths related to unintentional injuries among the entire population, reducing emergency room visits, and reducing motor vehicle related injuries.

**Washington State Fatal Unintentional Injuries**  
1989-1998: 0-19 yr olds

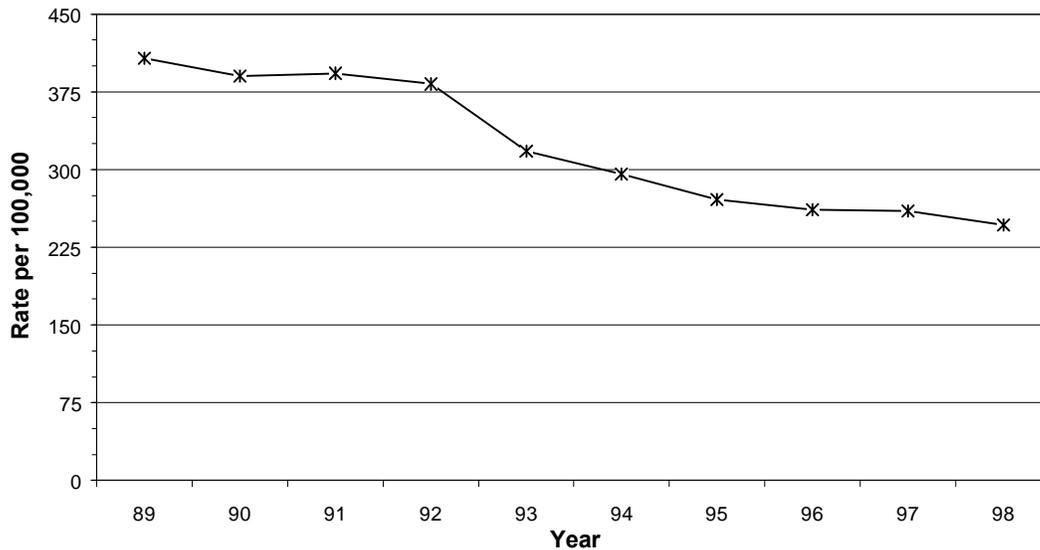


Sources: Center for Health Statistics, Death Certificates; Office of Hospital and Patient Data, CHARS; OFM, Forecast of the State Population by Age and Sex: 1990 to 2020, November 1999.

In 1998, there were 214 deaths due to unintentional injuries among children 0-19, a rate of 12.7 per 100,000 population. This rate has declined over 25% since the early 1990's. The

unintentional injury death rate was highest for 15-19 year olds. This rate was over twice that of infants less than one year old. As noted above a large proportion of unintended deaths are due to motor vehicle crashes. Motor vehicle death rates among all Washington residents have declined substantially over the past 20 years.<sup>25</sup> In 1998, the death rate due to motor vehicle crashes was 7.5 per 100,000 population 0-19. Substantial age variation in motor vehicle deaths is apparent in the rate differences of children 1-14 (2.8/100,000) and young adults 15-24 (26.4/100,000). Young adults are at highest risk of motor vehicle deaths and are over represented in traffic collisions generally. The Healthy People 2010 goal is to reduce the number of deaths caused by motor vehicle crashes to no more than 9 per 100,000 population.

**Washington State Non-fatal Unintentional Injury Hospitalizations**  
1989-1998: 0-19 yr olds



Sources: Center for Health Statistics, Office of Hospital and Patient Data, CHARS; OFM, Forecast of the State Population by Age and Sex: 1990 to 2020, November 1999.

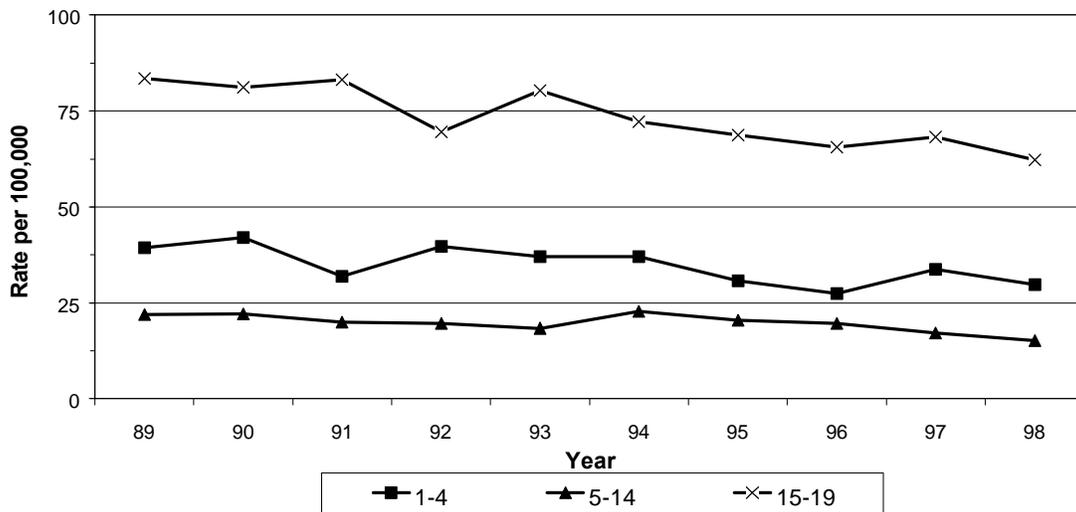
Hospitalization rates due to unintentional injuries have declined 40% over the last 10 years from 407 to 246 hospitalizations per 100,000 population 0-19. This trend is seen across all age groups except infants. The decline is largely due to the decrease in motor vehicle related injury hospitalizations over the same period. Despite this decline, the numbers of affected children and youth remain substantial. In 1998, 358 children 1-14 and 956 15-24 year olds were hospitalized due to injuries sustained in motor vehicle crashes. (NPM 8)

<sup>25</sup> Washington State Department of Health, *The Health of Washington State*. Olympia: 1996.

## Child and Adolescent Mortality

Deaths to children and adolescents in Washington have also declined over the past decade. Unintentional injury deaths account for approximately 44% of deaths to children 1-19 years. In addition, congenital anomalies in young children and neoplasms in older children are leading causes of mortality. By age 15, intentional injury becomes a leading cause of mortality. In 1998, suicide accounted for 16% and homicide accounted for 13.2% of the 250 deaths to 15-19 year olds. The suicide rate was 9.9/100,000 and the homicide rate 8.2/100,000. The related Healthy People 2010 objective is to reduce suicides to no more than 6.0 per 100,000 people of all ages. (Pri. 7, NPM 16, OM6)

**Washington State Child and Adolescent Deaths  
1989-1998**



Source: Numerator data comes from the WA State Death Files, 1989-98  
Denominator data for years 1-4 comes from OFM 'State Population by Age and Sex, 1970-2020, November 1999 Forecast (listed by individual years)

## Mental Health

The Healthy People 2010 draft document reports that “at least one in five children and adolescents may have a diagnosable mental, emotional, or behavioral problem that can lead to school failure, alcohol and other drug use, violence, or suicide.<sup>26</sup> While data on school dropout rates, violence, alcohol and drug use are available, data on the mental health status and service needs of Washington State children and adolescents are scarce. Hospitalization data are

<sup>26</sup> U.S. Department of Health and Human Services. *Healthy People 2010 Objectives: Draft for Public Comment*. Washington D.C.: US Government Printing Office, 1998.

available, however, these data reflect only the most serious of cases. Moreover, it is hard to know how the advent of managed care in the last ten years has impacted these hospitalizations.

Included as a mental health condition were hospitalizations with a primary diagnosis among ICD-9 codes 290-319. This includes depressive disorders, disruptive behavior disorders, anxiety disorders, adjustment disorders, psychotic disorders, impulse control disorders, bipolar disorders and other conditions. In 1998, there were 203.9 hospitalizations for mental disorders per 100,000 0-19 year olds. This is equivalent to 3,422 hospitalizations. About 60% of the hospitalizations are for adolescents 15-19 years old, and 30% for 10-14 year olds. Despite the small numbers, the hospitalization rate for mental disorders of 5-9 year olds appears to be increasing.

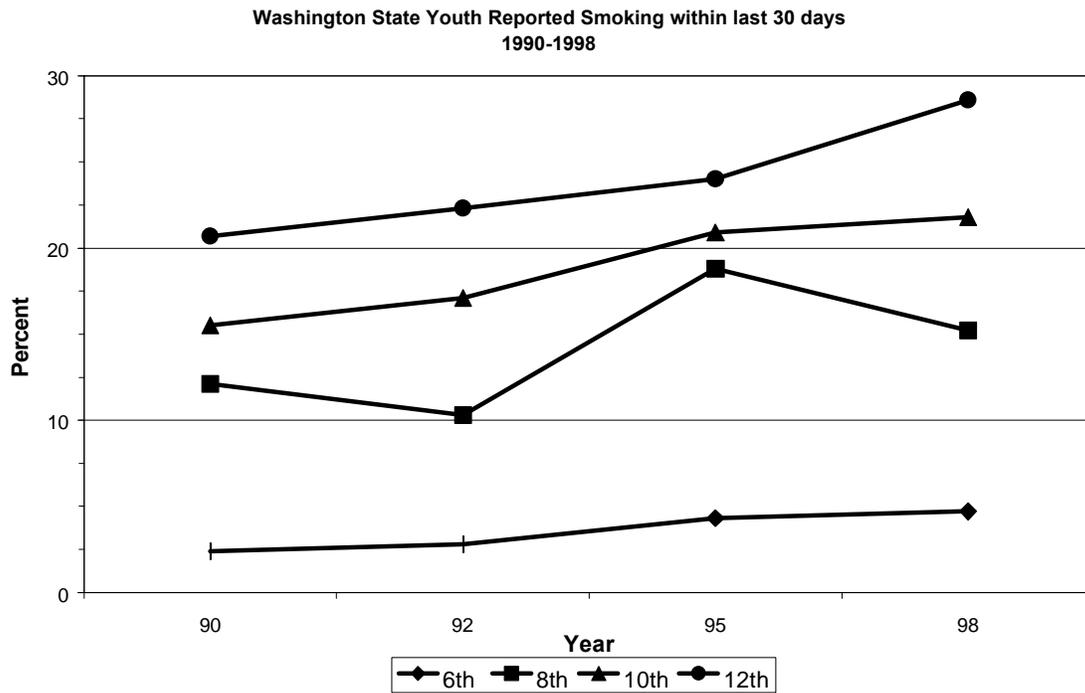
### ***Tobacco Use by Youth***

There is overwhelming evidence that cigarette smoking causes heart disease, cancer of the lung, larynx, esophagus, mouth and bladder, and chronic lung disease. Furthermore, research has shown that tobacco use is addictive, and that addiction often takes hold during adolescence.<sup>27</sup> The Washington State Survey of Adolescent Health Behaviors (WSSAHB) is a survey of the enrolled public school population in grades 6, 8, 10 and 12. Data from the WSSAHB for the years 1990 to 1998 show that the prevalence of smoking in the past 30 days increased for children in the sixth grade (from 2.4% to 4.7%), children in the tenth grade (from 15.5% to 21.8%), and children in the twelfth grade (from 20.7% to 28.6%) There was no discernible trend in smoking among children in the eighth grade. In 1998, there were no statistically significant differences in smoking prevalence across 4 broad regions of the state: Puget Sound, Northwest, Southwest and Eastern Washington. The survey was not designed to analyze finer geographic areas. The average age of smoking initiation was 12 years and over 25% of children in the sixth grade indicated they had experimented with tobacco. This proportion increased with age to 68% of children in the twelfth grade reporting they had ever smoked. By eighth grade, 3.4% of students already reported daily smoking, consuming at least 5 cigarettes a day. Among 10<sup>th</sup> and 12<sup>th</sup> graders, the proportion of daily smokers was 9.1% and 11.6%. Female students were more likely to report cigarette smoking than male students, although more adult men report smoking than women. Substantial race/ethnic differences in youth smoking were reported. The prevalence was highest among American Indian/Alaska Native students (27.2%), followed by Caucasian (16.9%) and Hispanic students (16.8%). The WSSAHB also collected data on use of smokeless tobacco. In 1998, 7.7% of students in grades 6 through 12 reported using smokeless tobacco at least once

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<sup>27</sup> U.S. Department of Health and Human Services. *Healthy People 2010 Objectives: Draft for Public Comment*. Washington D.C.: US Government Printing Office, 1998.

in the past 30 days. Similar to cigarettes, use increased with age. Over twice as many males (10.8%) as females (4.5%) reported smokeless tobacco use.<sup>28</sup> There are several related Healthy People 2010 objectives. They include reducing the proportion of young people in grades 9-12 who have used any tobacco product in the past month to 21%, cigarettes in the past month to 16%, smokeless tobacco in the past month to 1% and cigars in the past month to 8%. Other objectives are to increase by at least 2 years the average age of first use of tobacco products by adolescents, and to increase to 40% the proportion of young people in grades 9 to 12 who have never smoked. (Pri. 9, SP20)



Source: Washington State Survey of Adolescent Health Behaviors (1998), Chap. 3, Exhibit 3-4

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

Children with special health care needs have or are at risk for long term health or developmental problems that have lasted or are expected to last at least 12 months. These conditions result in activity limitations, ongoing treatments or interventions, and increased use of medical and other health services over and above the usual for children their age. Often, care for these children places greater demands on family and community resources. Inadequate care and services can result in a decreased quality of life and increased dependency for these children. Although there is tremendous variety among diagnoses within the population of children with special needs, as a

<sup>28</sup> Washington State Department of Health. *Tobacco and Health in Washington State*. Olympia: 1999.

group these children and their families face similar challenges in securing needed care. The variety of conditions affecting the group of children with special health care needs has made identification of this group difficult.<sup>29</sup>

Over the past five years, however, great progress has been made in identifying and implementing methodologies for routine statewide surveillance of this population. In 1993, the National Association of Children's Hospitals and Related Institutions piloted a methodology for identifying this group of children based on diagnostic codes. This study found that 18% of children under age 19 with a medical encounter had some type of special health need. Eleven percent of children had conditions of mild severity, such as asthma or ADHD, 6% had a condition of moderate severity, such as diabetes and 1% had conditions of high severity, such as leukemia.<sup>30</sup> This methodology is ideal for assessing the use of services and costs related to health care services. Using this methodology, researchers at the Center for Children with Special Needs and Chronic Health Conditions at Children's Hospital and Regional Medical Center in Seattle have charted the trends in hospitalization rates for children with chronic conditions compared to hospitalizations for non-chronic conditions. Hospitalizations for chronic conditions have declined 16.1% from 1987 to 1996. It is unclear to what extent this decline may be due to: 1) improvement in treatment; 2) a true decline in prevalence; or 3) decreased hospitalizations due to limited access and increased home care.

A second methodology, which uses screener questions for identifying children with special health needs has been developed for use in surveys. This methodology is better suited for assessing the quality of care received, health status, quality of life and utilization of services outside of the hospital. Researchers at the Foundation for Accountability in Oregon are currently piloting this methodology using the Consumer Assessment of Health Plans Survey (CAHPS) among Medicaid clients in Washington.

While data are currently not available, both methodologies will enable the comparison of data across geographic regions and by age of the child. The second methodology could also be used to study race/ethnic and socioeconomic disparities in the prevalence of children with special health care needs and the services they receive. (Pri. 3, 4, 8, NPM 1, 2, 3, 11, SP16)

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<sup>29</sup> Washington State Department of Health. *The Health of Washington State Supplement*. Olympia, WA, 1998.

<sup>30</sup> Washington State Health Care Policy Board. *Children with Special Health Care Needs*. Olympia, WA, 1997.

# Factors Influencing Access to Health Care

## ***Financial Access***

The Washington State Population Survey conducted by the Office of Financial Management (OFM) in 1998 estimated that 9.5% or approximately 540,000 Washingtonians were without health insurance. This is down from 12.2% in 1994. The survey also estimates 7.8% of residents under 18, about 125,000 children, lack health insurance.<sup>31</sup> Residents living east of the Cascade mountains, young adults 18-24 years, and Hispanics were more likely to be uninsured. Those living in poverty were also more likely to be uninsured. Among children, about 12.1% of those living in households under 200% of the federal poverty level (FPL) were uninsured compared to 4.2% of those above 200% of the FPL. This discrepancy is observed despite the availability of Medicaid coverage for children up to 200% FPL. Also of note, 85% of uninsured children lived in families with at least one full time worker.<sup>32</sup>

Those Washington residents who do have insurance receive it from a variety of sources including employers, individual plans and the government. Similar to national trends, employer based insurance premiums in Washington have risen over the past decade. Consequently, those with employer based coverage are being asked to contribute a greater percentage of premium costs, especially for family coverage. In addition, they are increasingly being required to pay out-of-pocket for services, either with deductibles or co-payments.

## ***Managed Care***

Pressure from large health care purchasers to control the rising cost of health care encouraged the growth of managed care in Washington in the 1980's and 1990's. Private sector insurance has seen shifts to managed care through the movement of large self-funded corporations moving to managed care. For example, in 1997, the Boeing Corporation greatly increased the proportion of its work force in managed care. At the same time, small and mid-sized employers have formed purchasing groups to increase their market power. Government purchasers have also shifted to managed care. In 1994, Washington's Medicaid agency began the shift from fee-for-service to managed care for its clients, and as of 1998, 61% of clients were enrolled in managed care

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<sup>31</sup> University of Washington Health Policy Analysis Program. *The Pulse Indicators: Taking the Pulse of Washington's Health System*, Seattle: 1999.

<sup>32</sup> University of Washington Health Policy Analysis Program. *The Pulse Indicators: Taking the Pulse of Washington's Health System*, Seattle: 1999.

plans.<sup>33</sup> Government purchased care for state employees and subsidized care for low income residents (Basic Health Plan) are also largely managed care. In 1997, it was estimated that approximately two-thirds of those with health insurance coverage in Washington were under managed care plans.<sup>34</sup>

### ***Individual Insurance Market***

Another issue regarding financial access to services in Washington is the lack of individual health insurance plans, a problem that intensified over the past year. Health insurance reforms implemented since 1993 imposed several requirements on the insurance industry. These requirements included: 1) prohibiting the denial of health insurance based on health status, 2) allowing no more than a three month waiting time for pre-existing conditions, 3) waiving the waiting time in certain instances, and 4) ensuring that once enrolled the same plan or similar benefits must remain available to the member. In addition, although maternity services were not required as a benefit, at least one of the plans offered had to include maternity services.

Between 1993 and 1995, the number of people covered in the individual market expanded by 40%. Carriers began citing losses which they claimed were caused by the health care reforms. Over the past year several carriers, including the three largest, discontinued offering individual insurance plans. Prior to legislation passed in the 2000 session, individual policies were not available in 31 of 39 counties. The new legislation changes the individual market so that: 1) carriers may now deny coverage to up to 8% of those who apply based on results of a screening questionnaire; 2) individuals may be subject to a pre-existing condition waiting period of no more than 9 months; 3) persons changing plans do not have to wait the full 9 months again, but can be asked to retake the screening questionnaire and be denied coverage; and 4) carriers must now include maternity coverage including prenatal care. Individuals denied insurance can enroll in the Washington State Health Insurance Pool (WSHIP) which has a six month waiting period, and offers fee-for service coverage at 150% of average rates or managed care at 125% of average rates. A catastrophic health insurance plan will also be developed by the Washington State Health Care Authority.<sup>35</sup>

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<sup>33</sup> Washington State Department of Social and Health Services. *1998 Washington State Medicaid Program Annual Report*. Olympia: 1999.

<sup>34</sup> University of Washington Health Policy Analysis Program. *The Evolution of Managed Care in Washington State*. Seattle: 1997.

<sup>35</sup> Washington State Legislature. *E2SSB 6067. Final Bill Report*. Olympia: March 2000.

## **Medical Assistance**

MAA provides health care services to low income people in Washington, primarily through the federal/state Medicaid partnership. Low income pregnant women with household incomes up to 185% FPL are eligible for services (a monthly income of \$2,629 for a family of four in 2000), and children in households with incomes below 200 FPL (a monthly income of \$2,842 for a family of four) are eligible up until their 19<sup>th</sup> birthday. In addition, members of families on TANF, people with disabilities, and low income elderly are also covered.

Over the past decade, the MAA program has changed from a welfare program to one that provides health coverage to working families with low-income children, persons with disabilities, and elderly persons. In 1992, 60 percent of the clients were in households receiving Aid to Families with Dependent Children (AFDC) assistance and 10 percent were children in households not receiving assistance on a monthly basis.<sup>36</sup> In 1998, 447,318 children ages 0-18 received health coverage through Washington's Medical Assistance programs (27 percent of the state's child population).<sup>37</sup> Of these children, approximately 35% were in households receiving TANF.<sup>38</sup> A major factor in this shift was the expansion of Medicaid coverage to children from 100% FPL to 200% FPL in 1994. Prior to enactment of SCHIP in 1997, Washington was one of only four states with Medicaid coverage at or above 200% FPL.

The services offered by Medicaid in Washington are extensive, including: inpatient and outpatient care, physician services, lab and x-ray, nursing facility services, family planning, home health and nurse-midwife services, additional medically necessary services, outpatient drugs, durable medical equipment, dental services, physical, speech and occupational therapy, preventive care and well-child visits.

Currently, MAA purchases both managed care and fee for service health care services for its clients. The managed care program is called *Healthy Options* and was phased-in statewide beginning in 1994. In 1999, MAA contracted with ten health maintenance organizations to cover services for the majority of clients. Clients with disabilities, in foster care, and in some rural areas of the state continued to receive fee-for-service coverage. Clients are not required to make any payments for health care services.

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<sup>36</sup> The Urban Institute. *Health Policy for Low-Income People in Washington*. Washington, DC: 1997.

<sup>37</sup> Department of Social and Health Services. Medical Assistance Administration data, 2000.

<sup>38</sup> University of Washington Health Policy Analysis Program. *Enrollment Trends for Children in Medical Assistance Programs, State and County Trends, 1995-1999*. Seattle: 2000.

## ***State Children's Health Insurance Program (SCHIP)***

In February 2000, Washington began accepting children into SCHIP. Eligible are an estimated 15,000 children 0-18 years in families with incomes between 200% and 250% FPL. In 2000, this amounts to a monthly income between \$2,948 and \$3,553 for a family of four. There is a single application process for Medicaid and SCHIP. If children are Medicaid eligible they must be enrolled in Medicaid. Covered services are the same as for Medicaid, however, clients must pay a \$10 per child/per month premium (maximum \$30 per family per month) and a \$5 co-pay for office visits (excluding well-child and immunization visits). There is an annual out-of-pocket maximum of \$300 per child or \$900 per family. SCHIP currently contracts with two managed care plans. In the three counties where both plans are available, clients must enroll in one of the plans. In the 29 counties where only one plan is available, clients can enroll in either managed care or fee-for-service. The seven remaining counties only have fee-for-service coverage available. As of April, 2000 there were 477 clients enrolled in SCHIP.

## ***Outreach***

Recent estimates show that there are 100,000 children in Washington who are eligible for Medicaid but uninsured. MAA contracts with 31 community based organizations including health districts, community social service agencies and American Indian tribes to identify and enroll uninsured children eligible for Medicaid. Contracts are also in place for SCHIP outreach.

## ***Basic Health Plan***

The Basic Health Plan is a state sponsored health insurance program in Washington for residents meeting income eligibility guidelines. The program is administered by the Washington State HCA, who contracts with nine health plans to provide services. Services covered include hospitalization, provider visits, emergency services, and prescriptions. Members pay a sliding scale premium based on income, age and the health plan selected. In December, 1999 there were approximately 128,000 people covered on the Basic Health Plan.

## ***Basic Health Plus***

Basic Health Plus is a program for children under 19 years old coordinated by Medicaid and the HCA. Children whose parents receive Basic Health Plan coverage receive expanded benefits that are the same as those available to Medicaid Healthy Options clients. Like the Healthy Options clients, no premiums or co-payments are required. In December, 1999 there were approximately

80,000 children covered on Basic Health Plus. These children are reflected in the 447,318 children listed above who are receiving health insurance coverage from the MAA.

### ***MAA/Health Care Authority Joint Purchasing Agreement***

Washington State has been innovative in using the combined purchasing power of the MAA and the HCA to negotiate contracts with managed care organizations. In addition to the Basic Health Plan, the HCA contracts for health coverage of all state employees. Thus, they are two of the largest purchasers of health care in the state, providing plans for approximately 20% of the state's population.<sup>39</sup> They have used this purchasing power to negotiate not only costs and benefits, but also quality and access standards.

### ***Health Impact of Welfare Reform***

WorkFirst is the Washington State welfare reform program which went into effect August 1, 1997. As of February 2000, the numbers of families receiving public assistance had dropped 38% since January 1997. Currently, 59,000 families are receiving assistance. In addition to assistance with job readiness and work placement, WorkFirst connects families to childcare providers and helps subsidize child care costs.

The Economic Services Administration of DSHS has conducted telephone surveys of families exiting welfare with the purpose of evaluating the program and addressing concerns regarding the status of families. The latest survey was administered between April and June 1999 to 572 people who had exited welfare in December 1998 and 453 people who had received welfare continuously for at least 6 months in April 1999. The overall response rate was 73%. At the time of the survey, 64% of TANF exiters were working compared to 32% of TANF recipients. Mean family cash income including child support and TANF grant was \$1,304 for TANF exiters and \$840 for TANF recipients. While the reported income was over 50% higher for TANF exiters, the average income of exiting families had dropped for the second time compared to the two previous surveys. Also of concern, TANF exiters self-reported more food insecurity and hunger than TANF recipients, 13% of exiters reported experiencing hunger compared to 8% of TANF recipients. In addition, 31% reported no health insurance for adults and 15% reported no health insurance for children compared to 2% and 1%, respectively, for TANF recipients.<sup>47</sup>

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<sup>39</sup> The Urban Institute. *Health Policy for Low-Income People in Washington*. Washington, DC. 1997.

The number of child SSI recipients decreased by 11% due to the Redetermination Project, which was an evaluation of SSI eligibility for each child based on new SSI criteria. The CSHCN Section has solicited feedback from community public health nurses and from family organizations to determine the impact the new criteria has had on families. There has been no indication that this event in itself has negatively impacted the population. MAA has been proactive in striving to inform providers and families of continued Medicaid coverage for these children no longer medically eligible for SSI.

To address food security and health insurance concerns of TANF exiters, DSHS has been conducting targeted food stamp and health coverage outreach. In addition, research to evaluate the long term impact of WorkFirst has just begun by the UW and Washington State University. They plan to track 3,000 former TANF families over five years.<sup>40</sup>

The Washington Welfare Reform Coalition, a statewide coalition of advocates, also conducted a study of 1400 low-income families (>50% on welfare) across the state between November 1997 and December 1998. Families identified at service delivery centers either self-administered the study or were interviewed in person. Efforts were taken to secure statewide participation. In addition to welfare, the survey asked about housing, health insurance, public and private assistance, employment, Work First, and child care. Comparing the group surveyed prior to July 1<sup>st</sup>, 1998 (n = 445) with that after July 1, 1998 (n=297) revealed that the percentage of uninsured changed from 30% to 45% and those without food for a day or more increased from 27% to 43%. In addition, parents identified problems finding convenient good quality child care during the times needed.

In another effort, DOH and LHJs are partnering with DSHS, WorkFirst Division. Public Health Nurses (PHN) visit families that are required to work under WorkFirst, but have children with special health care needs. The PHNs determine the impact of the child's special needs on the parent's ability to participate in a work activity. Following this assessment, the PHN makes recommendations to WorkFirst Case Managers that may include a modification of WorkFirst requirements or a deferral from WorkFirst requirements. Efforts are also made to coordinate with the local child care referral agencies regarding the availability of appropriate child care to meet the child's needs. Efforts are underway in a number of counties to broaden the public health role with WorkFirst to include work with other families, including the "Difficult to Serve" and

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<sup>40</sup> Department of Social and Health Services. Economic Services Administration. *Exit Survey Shows Work is Still Best Route Off Welfare*. Press release issued November 5, 1999.

“Pregnancy to Employment” categories. DSHS is also monitoring the status of women who were enrolled in TANF prior to and since the implementation of the Welfare Reform Act. DSHS is monitoring primarily for economic factors, such as employment, wages, and success in receiving child support; but also plan a future focus on the well-being of children. OMCH has been invited to participate in planning to re-focus the monitoring and is being kept apprised of current monitoring activities. (See also Section 3.2.2.2 and 3.2.2.3 of Needs Assessment.)

## ***Availability of Care***

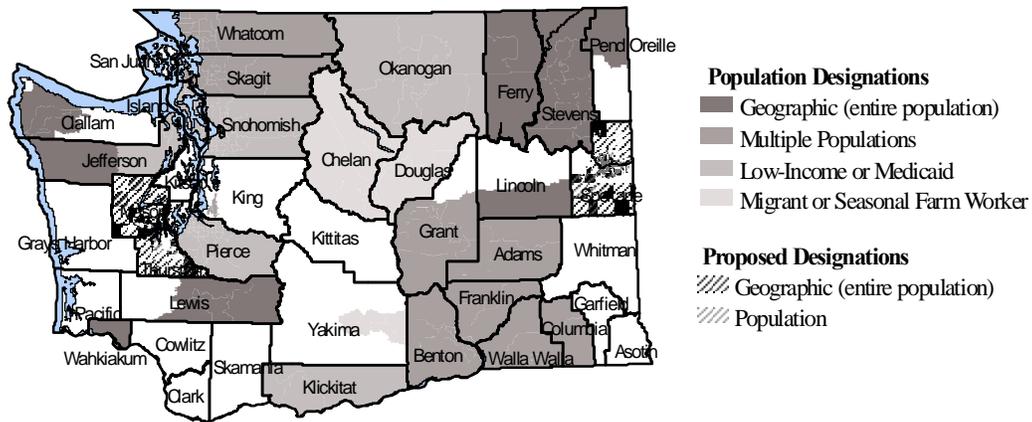
### **Availability of Primary Care**

The total number of primary care providers in Washington is increasing, and more physicians are choosing primary care specialties. In 1994, there was one primary care physician (family practice/general practitioners, pediatricians, and general internists) per 1,274 people. Currently, it is difficult to identify the true supply of licensed health practitioners. The number of licensed practitioners is available, but may not be an accurate reflection of the number of practitioners providing full time direct patient care. This is because licensed practitioners may be retired, practicing part time, practicing in a specific setting (such as prison or hospital), practicing out of state or in another county, conducting research, teaching, working as an administrator, working in the military, or voluntarily obtaining state credentials. Bearing this caveat in mind, the number of licensed health care practitioners in 1998 included 12,380 licensed physicians, 2,317 advanced registered nurse practitioners, 1,072 physician assistants, 3,652 dentists, and 3,072 dental hygienists. There was one primary care physician (family practice/general practitioner or general internist) for every 1,315 residents. The distribution of these practitioners across the state is not currently available. However, 1995 data show overall there were 22.6 physicians (MD/DO) per 10,000 population, with 14.5 physicians per 10,000 in rural areas and 24.4 physicians per 10,000 in urban areas. There were also 1.5 physician assistants (1.6 rural, 1.5 urban), 3.1 nurse practitioners (2.1 rural, 3.3 urban), and 6.6 dentists per 10,000 (4.7 rural, 7.0 urban).<sup>41</sup> While these data provide a general picture of the distribution of providers throughout the state, they present a rosier picture than current conditions because of impacts of managed care and the Balanced Budget Act of 1997.

While the state as a whole meets the provider to population standard of one primary care provider to 1500 people, there remains an insufficient number of providers in several areas of the state. As of February, 2000, 116 areas or facilities in Washington had federal Health Professional Shortage

Area (HPSA) designations.<sup>42</sup> These areas, identified on the following three maps, are designated as having a shortage of primary care physicians, primary dental care and/or mental health care. As the designation is used to target federal resources to improve access to health services, facilities providing services to people residing in HPSA designated areas, federally recognized tribes, and correctional facilities can also be designated as HPSAs. HPSA designation is a better indicator of where shortages exist rather than as an indication of the degree of shortage because the designation is voluntary and subject to change. Over time, there has been a shift in Washington from entire populations or geographic areas having inadequate health care access to smaller subpopulations within an area having inadequate access. Consequently, sub populations such as the low income residents of selected areas and migrant and seasonal farmworkers are increasingly being designated as HPSAs.

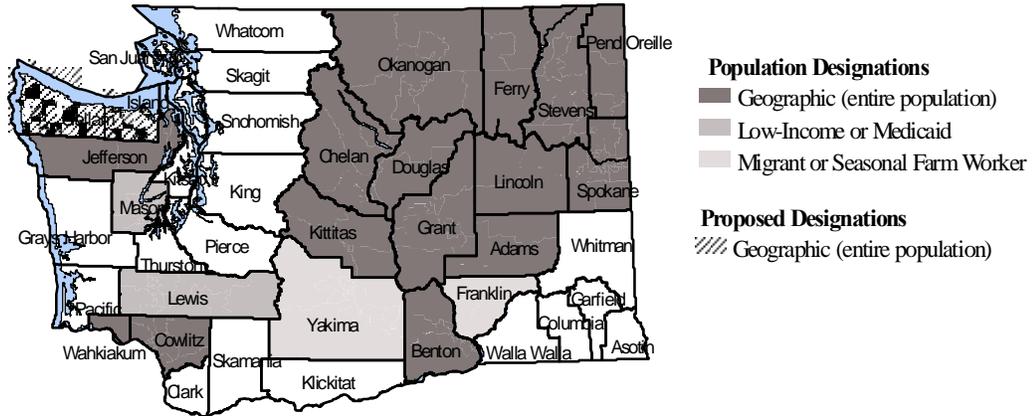
### Dental Care Map



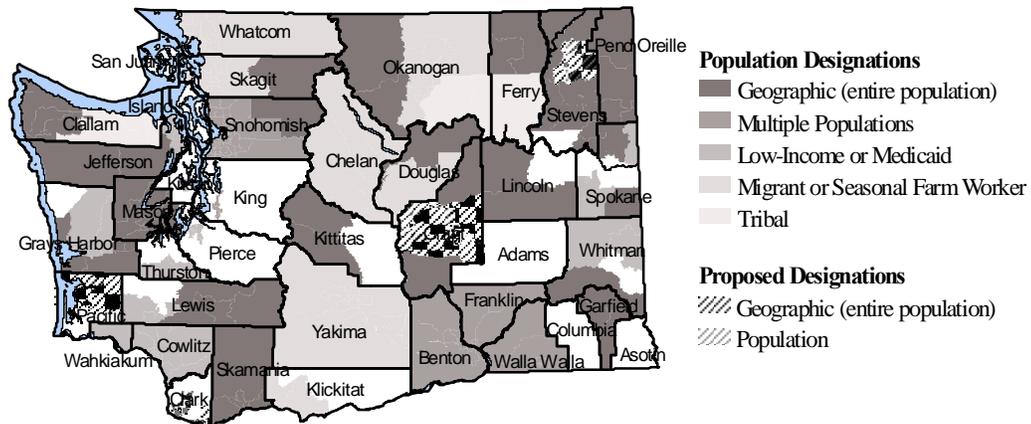
<sup>41</sup> Washington State Department of Health. *Rural Health Databook*. Olympia, 1997.

<sup>42</sup> Washington State Department of Health. Office of Community and Rural Health data, 2000.

## Mental Health Map



## Primary Care Map



There are currently 93 acute care hospitals in Washington, and an additional 6 birthing centers. Eight of the 44 rural hospitals do not provide obstetric services. The location of hospitals is closely related to the population distribution, and it is estimated that 98% of the population lives within 30 minutes of an acute care hospital. However, in 36 census divisions in 20 rural counties; the population lives more than 30 minutes from such services.<sup>43</sup>

In addition to the HPSAs, there are 34 Medically Underserved Areas or Populations (MUA/MUP) located in 27 counties. The MUA/MUP were first designated in the 1980s to receive ‘federal or Public Health Service’ Community and Migrant Health Center funding. Currently, there are 31 state and federally funded Community and Migrant Health Centers in Washington providing preventive and primary health care medical and dental services at 69 delivery sites. The estimated

275,000 migrant and seasonal workers depend on these centers for care. In 1998, 97,353 children (5.5% of all children 0-19 years) received medical services and 48,492 (2.7%) received dental services at Community and Migrant Health Centers. Children represented 38% of all medical service clients and 47% of all dental service clients at the centers. The numbers of rural health clinics doubled between 1995 and 1998 to 55 sites.<sup>44</sup>

There are also 24 Indian Health Service/Tribal Health Clinics located throughout the state and one urban Indian health clinic located in Seattle. Some of these clinics, however, have a limited scope of services available on-site.

Pharmacy services are generally available in urban locations, especially with the expansion of pharmacy services in retail chain-store outlets. Rural access, however, remains a problem. Forty-eight rural communities have only one retail pharmacy in town.<sup>45</sup>

While primary care services are available to the majority of Washington's children and women of reproductive age, access remains problematic for rural populations, underserved urban subpopulations, migrant and seasonal workers and American Indians and Alaska Natives. In addition, despite high rates of insurance coverage and geographic access, many people still lack access to primary care for a variety of reasons including lack of adequate transportation. This is especially true for the rural and geographically challenged areas such as mountainous areas. Other barriers include the declining reimbursement rate for primary care providers that are participating in managed care organizations. Although not yet a trend, Community and Rural Health staff fear this may be a disincentive for providers and pharmacists to contract with managed care organizations. Even though providers may be geographically available, anecdotal evidence indicates reluctance from both medical and dental providers to see additional clients, especially those enrolled in Medicaid.<sup>46</sup>

### **Availability of Specialty Providers**

Washington State has 31 health professions which require a license to practice in the state and 15 professions with voluntary certification. As noted above, the number of practitioners licensed does not equal the number of practitioners providing full time direct patient care. Also, for

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<sup>43</sup> Washington State Department of Health. *The Health of Washington State Supplement*, Olympia: 1998.

<sup>44</sup> Washington State Department of Health. *Washington Community and Migrant Health Center 1998 Medical Activity Report*, and *Washington Community and Migrant Health Center 1998 Dental Activity Report*. Olympia: 1999.

<sup>45</sup> Washington State Department of Health. *The Health of Washington State Supplement*. Olympia: 1998.

<sup>46</sup> Facilitated discussions with Local Health Jurisdiction Regional Assessment Coordinators, 1999.

licensed providers such as physicians and nurses medical specialties are not recorded in the licensing database. Furthermore, there is currently no way to determine if these providers are serving the MCH population. A licensing survey was administered along with the license renewal application in 1998 to determine medical specialty, practice hours and clients served.<sup>47</sup> Results from this survey of active license holders who were not medical residents, living and practicing in Washington state, and born between 1900 and 1980 are reported below. The identification of medical specialty was not complete for all license holders. For physicians and osteopaths, 15% of licensees were missing medical specialty information. The assumption was made that the distribution of medical specialty for physicians who reported medical specialty was similar to the distribution among physicians missing medical specialty information and the percentage of specialty providers were extrapolated to all 12,380 physicians. Among nurse practitioners, 36.2% of medical specialty information was missing. Because of this lack of reporting, no extrapolations were made and specialty providers reflect the 64% who reported the indicated specialty. Among physician assistants, 17.5% were missing medical specialty information. No extrapolations were made for this group because of the small number of MCH specialties reported generally among these providers. The medical specialty reported is the primary medical specialty or secondary medical specialty if the primary specialty was left blank. Targets for ratios of specialty providers to population were not available.

<b>Licensed Providers</b>	<b>Number</b>
<b>Physician</b>	<b>12,380</b>
Osteopath	24
Family Practice/General Practitioner	2482
Gynecology/Obstetrics	587
Neonatology/Perinatology	54
Pediatrics	617
Specialty Pediatrics	179
<b>Advanced Registered Nurse Practitioner</b>	<b>2,317</b>
Family Practice/General Practitioner	304
Midwifery	90
Gynecology/Obstetrics	171
Neonatology/Perinatology	12
Pediatrics	86
Specialty Pediatrics	19
<b>Physician Assistant</b>	<b>1,072</b>
Family Practice/General Practitioner	349
Gynecology/Obstetrics	21
Pediatrics	12
Specialty Pediatrics	2

<sup>47</sup> University of Washington Center for Health Workforce Studies, 1998 Washington State Health Provider Licensing Survey, 2000.

<b>Licensed Providers</b>	<b>Number</b>
<b>Dentist</b>	<b>3,652</b>
<b>Dental Hygienist</b>	<b>3,027</b>

There are also 12 regional genetics clinics throughout the state that provide specialty genetics services. A total of 2,158 families were seen for clinical genetic consults and another 5,813 individuals were seen for prenatal genetic counseling in 1998. OMCH provides state match funding to DSHS, MAA so that prenatal genetic counseling provided by a Master’s level trained and nationally certified genetic counselor can be covered as a Medicaid Service. Over the last few years, the number of clients receiving clinical genetic services has been increasing. The rise in clinical genetic services is primarily attributable to services increasingly being provided to cancer patients and their families. The number of clients receiving prenatal services declined in the past year. Data was not received from one clinic, which may explain this decrease. OMCH is currently working with the Statewide Genetics Advisory Committee to further explore the pattern and the need for services.

### ***Availability of Transportation and Translation Services***

MAA covers both transportation and interpreter services for Medicaid eligible clients. MAA contracts for transportation services with brokers to ensure access across the state. Interpreter services are also made available through contracts. Providers assist clients in accessing these services. OMCH trainings for new MSS and MCM providers review the policies and assist these providers with learning how to help clients access these services. In addition, OMCH uses the HMHB toll-free line to provide resource information to the public in several languages. HMHB has Spanish-speaking Resource and Referral Specialists who answer the phone, and HMHB contracts with AT&T to provide other interpreter services as needed. Educational materials distributed by OMCH are available in alternative formats, as needed.

### ***Consumer Satisfaction with Services***

Currently, there is limited statewide data available to assess patient satisfaction and quality of care in Washington State. The two data sources include the National Committee for Quality Assurance (NCQA) Health Plan Report Card, and the Consumer Assessment of Health Plans Survey (CAHPS). While NCQA is limited to evaluation of managed care plans, CAHPS results are provided for both managed care and fee for service plans.

NCQA is a private, non-profit organization, which has as its primary function, accreditation and performance measurement of managed care plans throughout the country. Using the Health Plan Employer Data and Information Set (HEDIS®) performance measures, NCQA evaluates how well health plans and providers perform in the key areas of: quality of care, access to care and member satisfaction. Six of the 11 (55%) health plans currently providing services to Washington residents are accredited through NCQA. Accreditation is given in 5 categories: 1) Access and service, 2) Qualified providers, 3) Staying healthy, 4) Getting better, and 5) Living with illness. The evaluation is conducted on-site by a team of trained health care experts. Results of the evaluation are combined with health plan records and consumer surveys. Points are given in the categories listed above and the total points in each area are assigned corresponding stars (4-0) to give an overall outcome rating for the health plan (i.e., Excellent, Commendable, Accredited, Provisional or Denied). For participating Medicaid plans, all received a 'commendable' rating by NCQA in 1999. This means that each health plan demonstrated a level of service and clinical quality that met or exceeded the NCQA requirements for consumer protection and quality improvement.

NCQA also evaluates health plans in which the individual consumer or employment group pays for coverage. In 1999, six health plans were accredited by NCQA with five receiving a 'commendable rating' and one health plan receiving an 'excellent' rating. In order for a plan to receive a rating of 'excellent' it must demonstrate levels of service and clinical quality that met or exceeded the NCQA requirements for consumer protection and quality improvement and must also achieve HEDIS® results that are in the highest range of national or regional performance.

The CAHPS survey provides a standardized way to evaluate health care programs from the consumer point of view. Survey questions are divided into five major areas of concern: Getting care quickly; Getting needed care; Doctors who communicate well; Courteous and helpful office staff and Customer service. While NCQA uses a regimen of performance measures to assign a rating to a plan, in Washington, CAHPS results are reported as a comparison of one plan against all the plans evaluated as a whole. Star ratings range from 1-3 with one star indicating the plan scored significantly worse than Washington State average for all the plans being evaluated; two stars indicates the plan wasn't statistically different from average; and three stars indicate the plan scored significantly better than the average. Where indemnity plans are evaluated, no comparison is made to managed care and a percentage rather than a star rating is reported. Both the Washington State Medical Assistance Administration (MAA) and the Washington State Health

Care Authority (HCA) use the CAHPS Survey results to ensure their clients make informed choices when selecting their health care options.

Survey results from the Medicaid population were reported in the 1999 Washington State Medicaid Client Satisfaction Survey. Results were separated by (Healthy Options Adult and Child) and (Fee for Service Adult and Child). In addition to the topics listed above, each respondent was asked to rate the overall quality of their health care and the overall quality of their health plan. For Adult Healthy Options clients, one out of nine (11%) plans scored significantly better than average for quality of health care received, with all other plans being average. For the evaluation of the health plan, two out of nine (22%) of plans scored significantly better than the Washington State average, and one (11%) health plan scored significantly worse than the Washington State average. Survey results for the Child Healthy Options clients indicated that two out of nine (22%) plans scored significantly better than average for quality of health care received, and two out of nine (22%) scored significantly worse than average for the same measure. When rating the overall quality of a health plan, one out of nine (11%) scored significantly better with all other plans being average. Fee for Service results were reported as percentages. For adult clients, 39% rated their health care as 'best care possible' and 37% rated their health plan as offering the 'best possible health coverage. Forty-six percent of the clients whose children participate in Fee for Service their health care rated their care as 'best care possible' and 40% of clients rated their health plan as offering the 'best possible coverage'. It must be noted that characteristics between Healthy Options and Fee for Service clients differ in health status, age, sex, and service utilization and may not be directly comparable.

The Washington State Health Care Authority uses CAHPS Survey results to assist state and local government employees and K-12 school district employees in health care selection. Ten managed care organizations (MCO) and one preferred provider plan are evaluated under this program. When asked to rate overall health care quality, two MCOs (20%) and the preferred provider plan scored significantly better than the average of all the plans combined, while another two MCOs (20%) scored significantly worse than average.

When rating the overall quality of the health plan five MCOs (50%) and the preferred provider plan scored significantly better than average, while three MCOs (33%) scored significantly worse than the average for all plans evaluated. In the future it may be possible to identify MCH populations within the survey respondents to better assess the quality of care and level of satisfaction obtained by this group in Washington State.

### **3.1.2.2 & 3.1.2.3 Direct and Enabling Services**

#### ***Direct and Enabling Services Specific to the Maternal and Infant Population***

##### **Family Planning Services**

A variety of family planning services are available across the state. For very low income residents, Medicaid covers family planning services for eligible men and women through managed care providers or fee for service by contract with 21 agencies across the state. Eligibility is currently limited to clients on general assistance (TANF), with incomes averaging about 60% FPL. Expanded Medicaid coverage for pregnant and postpartum women from 90% FPL to 185% FPL is available for one year postpartum through First Steps (See description below). As part of the state's welfare reform plan, Medicaid also provides family planning clinical services at eight Community Service (welfare) Offices (CSOs) through contracts with state funded family planning clinics. In addition, part time nurse practitioners offer information, referral and limited clinical services at 55 of the state's 65 CSOs.

Title X and state dollars provide public family planning services through contracts with 21 agencies that operate 73 clinics in 31 of the state's 39 counties. Services are free for clients with incomes less than 100% FPL, and on a sliding scale for those between 100% FPL and 250% FPL. The 21 agencies include six LHJs that receive Title V funds for pregnancy detection and counseling services. Two others of the 21 agencies are also Community Health Centers. In 1998, approximately 100,000 clients were served at these Title X agencies.

Public funding covers less than one-half the cost of providing public family planning services in Washington. Consequently, clinics have had to close, especially in rural areas, and services such as education and outreach have been curtailed. Only 7% of clients served at Title X clinics in 1998 had private health insurance, and that insurance didn't necessarily cover family planning services or supplies. Because funding is minimal, family planning services at some Community and Migrant Health Centers are not well promoted. Federal funding for family planning has not kept pace with other programs; it declined by over 50% between 1981 and 1991.<sup>48</sup> While state and local funding has increased somewhat, public clinics are facing higher costs and patients with more severe health problems. For example, more patients present needs for testing and treatment

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<sup>48</sup> Institute of Medicine. *The Best Intentions: Unintended Pregnancy and the Well-being of Children and Families*. Washington, DC: National Academy Press, 1995.

for STDs, breast and cervical cancer screening, and other wellness services, family planning clinics provide the service but are not reimbursed.

Special state funding has increased access to family planning services for men in Washington. In 1995, special legislative funding began providing no-cost vasectomies to men who were not Medicaid eligible and did not have insurance coverage. Over 1300 vasectomies have been provided to low income men through this project since 1995. In July 2000, an additional \$230,000 (approximately 690 vasectomies) will be available to the Vasectomy Project from DSHS' Work First Program.

Washington is in the process of requesting a 1115 waiver from the Health Care Financing Administration (HCFA). The waiver requests comprehensive family planning coverage for men and women with incomes through 200% FPL. Services would be available at Title X/state funded clinics and other agencies who meet the Medical Assistance Administration criteria for Medicaid fee for service reimbursement. Services would go into effect in 2001. In the interim, TANF reinvestment funds have been made available to fund family planning annual exams for women < 200% FPL.

Even residents with health insurance, however, have limited coverage of family planning services and methods. In June 1998, the Office of the Insurance Commissioner (OIC) conducted a survey of sixteen insurance carriers to ascertain reproductive health benefit coverage in health insurance plans available in Washington. Selected plans represented about 25% of Washington residents and represented managed care, preferred provider, point of service and indemnity plans. The survey found wide variation across plans in coverage of services. In most plans, routine gynecological, maternity, sexually transmitted disease diagnosis and treatment, and HIV/AIDS testing, treatment and counseling were covered. However, only 50% of plans covered contraceptive services at all and only 30% covered the five FDA approved reversible methods of contraception used exclusively by women (IUD, diaphragm, Norplant, Depo Provera and oral contraceptives)<sup>49</sup> while 77% of plans offered elective and medically necessary abortion coverage. The OIC has actively followed up these findings with presentations to the national office of the American College of Obstetrics and Gynecologists, the Washington State Human Rights Commission, and national conferences, and has used this information in testimony in support of legislation. The OIC is interested in repeating this survey to monitor trends.

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<sup>49</sup> Washington State Office of the Insurance Commissioner. *Reproductive Health Benefits Survey Report*. Olympia: 1999.

Efforts to increase the availability and access to family planning services are also part of a joint initiative to reduce unintended pregnancy undertaken by DOH and DSHS. Another strategy to reduce unintended pregnancy which is advocated by the Institute of Medicine is broadening the range of health professionals and institutions that promote and provide contraceptive services. Following a feasibility study, five state agencies initiated a novel pilot project in western Washington in 1998 to reduce unintended pregnancy by enabling pharmacists to prescribe emergency contraceptive pills (ECPs) directly to women through collaborative drug agreements with physicians. During the project, more than 1000 pharmacists who received training in all aspects of providing ECPs and 140 pharmacies participated in the project. In the sixteen months of pharmacy service provision, 11,969 ECP prescriptions were provided potentially preventing 700 or more unintended pregnancies, assuming a 10% pregnancy risk and 75% method effectiveness. While the grant project has ended, the State Board of Pharmacy has taken on the activities. Pharmacists are still being trained and ECPs provided<sup>50</sup>

### **First Steps**

The 1989 Maternity Care Access Act, implemented as the First Steps Program, expanded Medicaid coverage for pregnant and postpartum women from 90% FPL to 185% FPL. All medical and dental care services are covered through 2 months post partum; family planning services are available through 1 year post partum. Most women receive services through a Healthy Options plan. Since 1993, the state has made similar coverage available to undocumented pregnant/postpartum women through fee for service reimbursement. Services are also provided to most teens regardless of parents' income.

In addition to medical and dental services, two programs exist to provide comprehensive “wraparound” care. MSS are available to all pregnant/postpartum women on Medicaid and encompass community health nursing, nutrition, psychosocial assessment and counseling, assistance in following through on care plans, and childbirth education. MCM services are available to teens, women with substance use issues and others at high risk of adverse pregnancy outcomes. MCM involves nurses, social workers, chemical dependency counselors and others to develop service plans, assist in accessing social and medical services and providing support and advocacy for these women through the infant's first birthday. Currently MSS and MCM services are provided at county health departments, community clinics, hospital-based clinics, medical clinics, health or social service agencies, by home health agencies and by some Tribes. First

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<sup>50</sup> Program for Appropriate Technology in Health. *Quarterly Update for Collaborating Prescribers*.

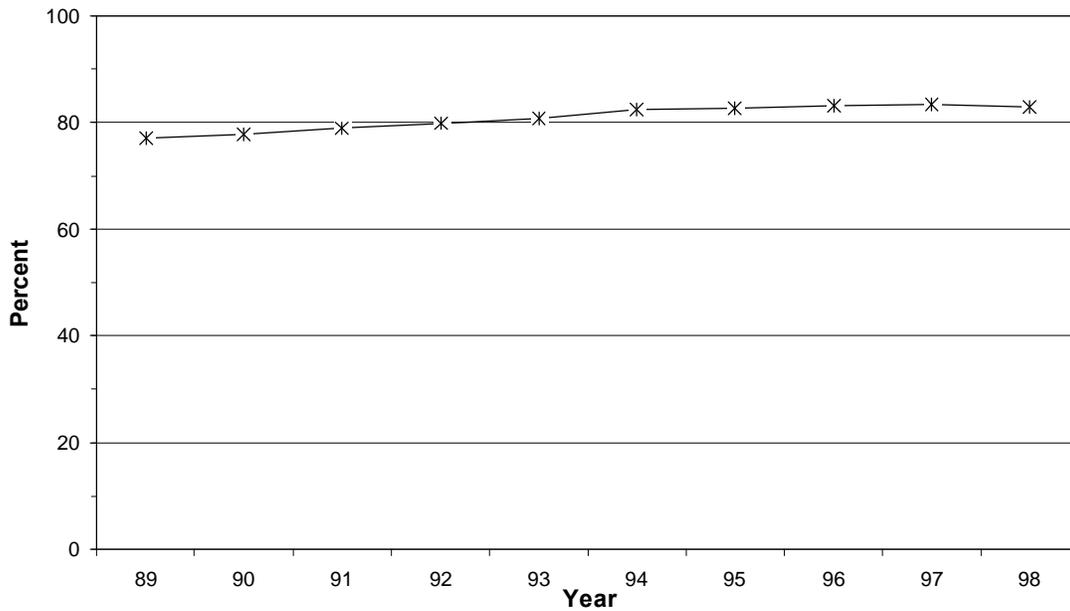
Steps also covers child care services for health care visits including bed rest and labor and delivery, transportation to Medicaid covered services, chemical dependency treatment services, outreach and accelerated application processing, and a toll free information line.

In 1998, 32,301 women representing 41% of all live birth deliveries received Medicaid. Sixty-seven percent of these women received MSS and 34% received MCM services. Greater proportions of adolescent mothers, and mothers of non-White race/ethnicity received Medicaid coverage.

**Prenatal Care Services**

Comprehensive, quality prenatal care helps to improve birth outcomes by identifying medically and socially high risk women early in their pregnancies in order to monitor their health status, provide timely interventions and refer them to support services. In 1998, 83.0% of women delivering live births received prenatal care during the first trimester.<sup>51</sup> This rate increased

**Washington State First Trimester Prenatal Care  
1989-1998**



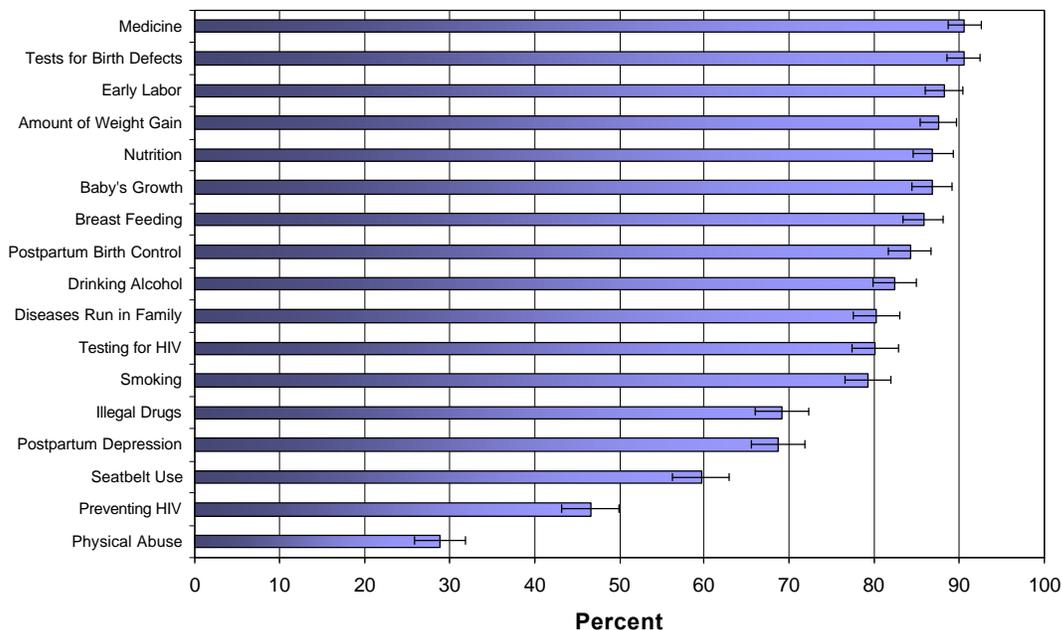
Source: Center for Health Statistics, Birth Certificates, 1989-1998

Seattle: 1999.

<sup>51</sup> It should be noted that information on prenatal care was missing for 9.7% of the 79,640 births in 1998. As those births missing data were removed prior to calculating a first trimester prenatal care rate, this proportion may be an overestimate of the true rate. Much of the missing data was due to a limited number of facilities. The Washington State Center for Health Statistics has been working with facilities to improve birth certificate reporting.

gradually in the early 1990s and has remained stable since 1994. Many rural counties in Washington, especially those in the central part of the state have low rates of early entry into prenatal care. Many of these counties also have higher birth rates among women under 20 years old and a greater proportion of all births to women in this age range. Only 68.9% of women under 20 received prenatal care in the first trimester. American Indians and Hispanic women are also much less likely to receive early prenatal care although the rates of early care have increased substantially for both groups over the past ten years. Still, only 71% of women in both these groups received care in the first trimester. Similarly, women on Medicaid, despite substantial improvement since First Steps began in 1989 also continue to lag behind with only 72.9% of women receiving early prenatal care in 1998. PRAMS data provide some information on the quality of prenatal care through reports of issues discussed during prenatal care visits. Over 80% of respondents reported discussing medication safety, nutrition, breastfeeding, family history of disease, HIV testing, prenatal testing, early labor, alcohol/drug use in pregnancy and postpartum contraception. Fewer respondents reported discussing physical abuse, HIV prevention, seat belt use or postpartum depression with their providers.

**1997 Washington State Prenatal Care Topics Discussed**



Source: Washington State Dept. of Health, Center for Health Statistics, PRAMS Survey, 1997.

Regional Perinatal Programs located in four regions of the state provide training and technical assistance on specialized care for high risk pregnant women and neonates to obstetrical and

neonatal care providers affiliated with facilities in their region. A network has been established linking hospitals providing primary and secondary levels of obstetric and neonatal care with the regional perinatal centers ensuring referral and/or transfer of high risk obstetric and neonatal patients as needed. Training and clinics are provided by the regional care programs throughout their catchment areas.

### **Women Infants and Children (WIC) Nutrition Services**

WIC provides nutrition and health assessment, education and breastfeeding counseling to pregnant and postpartum women and children under 5 with household incomes below 185% FPL in Washington. Currently, almost 188,000 residents are estimated to be eligible and 147,000 (78%) are being served. Services are provided at \$103/participant/ year by staff of 70 contract agencies at over 300 clinic sites throughout the state. Sites include: Indian health agencies, local health departments, community and migrant health clinics, non-profit organizations, and hospitals. Federal funding has been decreasing and in 1999 only 54% of costs were covered by federal dollars compared to 60% in 1998. A major source of supplemental funding is the Infant Formula rebate. Washington is the lead state for a 15 state coalition which competitively contracts for infant formula procurement. Rebates from infant formula sales are used to fund the purchase of supplemental food for WIC clients. Rebates from the current infant formula contract generate approximately \$2 million per month. In addition to funding, challenges facing WIC include the new welfare reform regulations, lack of transportation, limited clinic hours, the requirement to produce income documentation, and integrating with other services.

### **Healthy Mothers, Healthy Babies**

HMHB is contracted to operate the Title V toll-free information and referral line for consumer information and referral for maternity care and other maternal and child health concerns. This toll-free line plays an important role in improving access to maternal and child health care services and to WIC. A database of social and health service providers across the state is maintained by HMHB and callers are referred to resources in their local community. HMHB referral specialists also assist callers in determining how best to access resources. During the 1999 calendar year, 27,481 callers phoned the information and referral line. This represents a 43% increase over the calls received in 1998. This is likely related to an increase in outreach for WIC and Medicaid. In 1999, HMHB specifically targeted potential Medicaid clients by distributing information at a number of sites including child care facilities, WIC clinics,

pharmacies and provider offices. During the year, 2,664 callers were assisted in completing a Medicaid application and health plan enrollment form.

Callers to HMHB are classified according to the information they request as prenatal, child health, family planning, Answers for Special Kids (ASK), and Child Profile client callers. In 1999, 8,212 were prenatal clients, 11,404 were child health clients, 2,831 were family planning clients, 237 were ASK clients, 1,092 were Child Profile clients and 3,705 wanted information only. Among prenatal clients who were not already enrolled, 93% were eligible for Medicaid and 94% were eligible for WIC. Among child health clients, 95% and 87%, respectively, of those not enrolled were eligible for Medicaid and WIC. In addition to making referrals, the line serves as a source of consumer feedback. When asked why they contacted HMHB, 78% of prenatal clients and 86% of child health callers report medical financing or WIC as the main reasons.

In addition to the information they received on the phone, 6,752 callers received printed prenatal, child health or family planning health educational materials. HMHB also distributed 9,781 baby books in seven languages (English, Spanish, Vietnamese, Russian, Chinese, Somali, and Korean). The books include information on prenatal care and maintaining a healthy pregnancy, delivery information, breastfeeding, infant care, and immunizations.<sup>52</sup>

### ***Direct and Enabling Services Specific to the Child and Adolescent Population***

As previously stated, most direct health care services for low and moderate income people in Washington are covered by Medicaid, which covers children up to age 19 with family incomes at or below 200 percent of the federal poverty level. Services are provided to Medicaid clients primarily through managed health care plans. The Medicaid benefits package includes preventive and primary care including immunizations and periodic well-child visits, acute and tertiary care along with dental coverage.

While Medicaid covers well child care for enrolled clients, recent evaluations of managed care services have identified several gaps in the provision of well child care in Washington. Federal Medicaid statutes require states to provide periodic physical, mental and dental health screens for children known as Early Periodic Screening, Diagnosis and Treatment (EPSDT). A minimum of five screens are required in the child's first year of life, 3 between 1 and 2 years, annually

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<sup>52</sup> Healthy Mothers, Healthy Babies Coalition of Washington State. *Information and Referral Line 1999 Annual Report*. Seattle: 2000.

between 2 and 6 years, and every 2 years between 7 and 20 years. The screens should include a comprehensive health and developmental history, physical exam, appropriate immunizations, appropriate laboratory tests, health education and counseling, vision, hearing and dental screens, nutritional assessment, developmental assessment, mental health and substance abuse screen, and screen for Fetal Alcohol Syndrome. When a problem is identified, referral and treatment are also covered. In the managed care environment, Medicaid assures compliance by requiring plans to follow this screening schedule. Plan's that report clients received less than 60 percent of the required screens are required to submit a corrective action plan to the state.

The MAA contracted with the Oregon Medical Professional Review Organization (OMPRO) for record review to monitor managed care plan compliance with EPSDT requirements in 1998. The review found that 48% of infants received no well-child visits and only 18% had 4 or more exams. Among 3 to 6 year olds, only 15% of the expected number of visits were performed and among adolescents only 9% were performed. Follow up for identified problems, however, was greater than 95% for all age groups. The review found compliance with the physical exam and health history components was greater than the rate of compliance with the developmental, mental health and health education components. They also found that use of a structured assessment tool was associated with higher compliance<sup>53</sup>

In addition to Medicaid outreach to clients, the Federal Head Start and statewide Early Childhood Education Assistance Program (ECEAP) help ensure early access to health care services for low income children. To emphasize the importance of early identification of health problems, every child enrolled in either program is screened to identify medical, dental, mental health and nutritional needs, including up to date immunizations. Children and families are referred to any necessary community services. For the 1998/1999 school year, Head Start served 10,652 children in Washington who were primarily 3-4 years old. As a result of the screening and referral, 16.9% received medical treatment, 22.6% received dental treatment, 55.8% received preventive dental care, and 6.5% received mental health services.<sup>54</sup> During the same period, ECEAP served 8,141 children. ECEAP provides health screenings during the first 90 days of program enrollment with

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<sup>53</sup> Washington State Department of Social and Health Services. *1998 Healthy Options Focused Review: Early Periodic Screening, Diagnosis and Treatment*. Olympia: 1998.

Varon J. and Sauer C. *How Children Fare in Medicaid Managed Care. A Report on Washington State's Healthy Options and BHP+ Programs*. Seattle: The Children's Alliance, 1998.

<sup>54</sup> US Department of Health and Human Services, Administration for Children and Families. *Head Start Program Information Report for 1998-1999 Program Year State Level Summary Report for Washington*. Washington, DC: 2000.

children and families referred for services thereafter. A breakdown on the number of children who received services was not available<sup>55</sup>

### **Oral Health Services**

The availability of oral health services in Washington continues to be problematic for many children. In 1998, there were 3,652 licensed dentists and 3,072 licensed dental hygienists in the state. The supply of dentists is expected to peak in 2000, then decline sharply as 32% of dentists in the state are 55 years or older, and are approaching retirement. Furthermore, while Washington has added 350 dentists since 1995, 83% have chosen to practice in urban areas (Clark, Spokane and the central Puget Sound counties). Thirteen primarily rural counties have shown no increase in providers over the same period. The uneven distribution of dental needs compounds this issue, making rural access to dental providers particularly difficult. Access to providers is also limited by the lack of dental health insurance. While it is not known what proportion of children under 19 are covered by dental health insurance, it is clear that the most common source of payment is out-of-pocket.

As noted above, Washington's Medicaid EPSDT program does cover dental health screens. The OMPRO managed care review showed that 88.3% of records reviewed for 3-6 year olds recorded a dental health screen as did 77.7% of records reviewed for 12-20 year olds.<sup>56</sup> While oral health screening is occurring during medical encounters, Medicaid clients are not receiving dental services. In 1999, of the 592,839 clients 20 years and younger enrolled in all MAA programs, only 33.4% received a dental service paid by Medicaid.<sup>57</sup> One reason for the low rate of clients receiving dental services is the small number of dentists providing services to Medicaid clients. Only 36% of licensed dentists provided care to children on Medicaid in 1999, and of these only 30% saw more than 50 children on Medicaid per year.<sup>58</sup> This problem is heightened in rural areas. For example, in the Benton-Franklin area, there are approximately 1500 Medicaid enrollees for each practicing dentist. In addition to private provider offices, dental services are also provided at 17 Community and Migrant Health Centers, and through 4 mobile clinics. Waiting lists at these clinics, though, often delay care.

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<sup>55</sup> Washington State Department of Community Trade and Economic Development. Early Childhood Education Assistance Program Data. 2000.

<sup>56</sup> Washington State Department of Social and Health Services. *1998 Healthy Options Focused Review: Early Periodic Screening, Diagnosis and Treatment*. Olympia: 1998.

<sup>57</sup> Washington State Department of Social and Health Services. Medical Assistance Administration data., December 1999.

<sup>58</sup> Washington State Department of Social and Health Services. Medical Assistance Administration data. December 1999.

The low Medicaid participation rate is likely due in part to low reimbursement rates. Despite increased reimbursements for childhood dental services in 1995, Medicaid continues to pay less than the usual and customary costs of dental care in Washington State. Currently, only 57.7% of the cost of a periodic oral exam, 31.0% of bitewing film costs, 74% of dental sealant costs, and 40.4% of the cost of a permanent tooth surface filling are paid by Medicaid.<sup>59</sup>

### **Teen Pregnancy Prevention**

Washington State supports 10 comprehensive teen pregnancy prevention projects in 14 counties. These teen pregnancy projects provide information on youth development, sexuality education, skill building, parent-child communication support, mentoring, client advocacy/support and clinical family planning services. In FY 1999, approximately 9,500 teens 11-19 years received services at these sites, including 6,500 teens who received clinical family planning services. Teens also use Title X family planning services described previously. In 1998, 29,173 teens ages 10-19 received services at these clinics.

### ***Direct and Enabling Services Specific to Children with Special Health Care Needs***

Private insurance and Medicaid are the primary sources of funding for direct and enabling services in Washington state. Thus, only 2% of children with special health care needs in Washington receive direct or enabling services from the CSHCN program. In 1999, 97.5% of these children had a public or private source of insurance for primary and specialty care. Health care for children receiving Social Security Income (SSI) and other low income (<200% FPL) children with special health care needs is covered by Medicaid in Washington. Medicaid pays for medically necessary medical, specialty, and subspecialty care including home health care and rehabilitation services for its clients. SSI clients are covered by Medicaid under fee for service plans. Most other children with special health care needs on Medicaid are covered by Healthy Options managed care plans. Because of the breadth of services covered by Medicaid, relatively few SSI clients (9.0% in 1999) receive services from the OMCH CSHCN Program. While a broad array of services are available to these clients, access to services, quality of care, and care coordination continue to be concerns given the intensive use of services by this population.

The CSHCN Program is the payer of last resort for services not covered by Medicaid or any other funding source. The CSHCN program maintains a diagnostic and treatment fund, administered

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<sup>59</sup> Washington State Department of Health. *Schedules of Dental Coverage and Maximum Allowances*,

by LHJs, to pay for equipment, supplies, or other services not covered by Medicaid. Examples include hearing aid batteries, small adaptive equipment, and nutrition supplements beyond Medicaid levels. The diagnostic and treatment fund has been gradually reduced over the years, as Medicaid eligibility has increased. This fund is closely monitored for ongoing need. Currently, \$60,000/year is budgeted and that amount is adequate to meet current needs.

### **Early Identification and Intervention**

Early identification and intervention for infants and children at risk for health and developmental problems is a focus for a variety of OMCH activities, including identification and referral, care coordination, and provision of information to families and providers. These efforts assure that health and developmental concerns of infants and children are identified and families and providers can access information and services to address concerns.

Early intervention services for infants and children with special needs are available through a variety of providers across the state. Neurodevelopmental Centers (NDC) provide evaluation, diagnosis, coordinated treatment planning, and specialized therapy to children birth to 36 months of age with developmental or neurodevelopmental conditions at 14 sites statewide. These centers provided services to 1700 children in the CSHCN Program in 1999 compared to 1200 in 1998.<sup>60</sup> The centers also provided services to a much larger number of children who exceed the income eligibility for the CSHCN Section.

DOH provides a small portion of the neurodevelopmental centers' operating budgets through contracts with OMCH. The majority of NDC funding comes from a variety of sources that include contracts with other state agencies, local fund raising, United Way, reimbursement from Medicaid and private insurance, and other fees. Early intervention services are also provided by Developmental Centers funded by DSHS, Division of Developmental Disabilities, private providers, and some local school districts.

The Infant Toddler Early Intervention Program (ITEIP) of the Department of Social and Health Services (DSHS) has responsibility for implementing the Individuals with Disabilities Education Act (IDEA) Part C. ITEIP receives federal funds to implement a statewide, comprehensive, coordinated interagency program of early intervention services for infants and toddlers, birth to three years old, with disabilities and their families. DSHS has an interagency agreement with

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December 1999.

DOH, DCTED, OSPI, and Department of Services for the Blind. Programs within those agencies include: Early Childhood Education and Assistance Program (ECEAP), CSHCN, DASA, CA, DDD, Indian Policy and Services, First Steps, Mental Health Division, Office of Child Care Policy, Office of Deaf and Hard of Hearing, and Department of Services for the Blind. Tribal Governments and the Bureau of Indian Affairs also provide services. Each of these programs may provide services, pay for services, coordinate services or a combination thereof. A very broad array of services is available for infants and their families, including: assistive technology devices and services, audiology, vision, assistive devices, home visits, medical services, nutrition, occupational, physical and speech therapy, psychological services, social work services, special education, transportation, and service coordination. Service and care coordination is provided by ITEIP Family Resource Coordinators, CSHCN Coordinators and others. Providers of local services are a well-networked group, and parent support systems exist in every county.

### **Care Coordination**

In addition to the services listed above, OMCH contracts with LHJs to provide a CSHCN Coordinator in each LHJs to help children with special needs and their families access needed information and services. CSHCN Coordinators work in partnership with families, early intervention providers, hospitals, schools and community agencies to promote access to and coordination of services. Examples, of services include providing information to families and providers about health conditions, facilitating access to care (including financial access), helping with transitions from early intervention services to schools, and from child to adult health providers and services. In 1999, approximately 7500 children were served in this way.

As part of the HMHB project, a toll free "ASK"( Answers for Special Kids) Line is available for statewide resource information for families with children with special health care needs. An average of 50 calls per quarter was received in 1999.

OMCH has also been instrumental in promoting medical homes for all CSHCN. It is estimated that currently 48% of CSHCN have a medical home. OMCH supports 15 statewide medical home leadership teams, supports an annual statewide conference and has developed a care coordination notebook for providers.

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<sup>60</sup> The reason for this increase is not entirely clear, and is likely due both to administrative changes resulting in better documentation as well as increased numbers of children served.

Coordinating services and care for infants, toddlers, and children with special health care needs has improved over the past 10 years, but continues to be identified as an issue for families and providers. A recent qualitative study undertaken by OMCH noted that parents and providers continue to voice the need for advocates to help them navigate the system, access services (especially outside metropolitan areas), and ensure funding for services for their older children.<sup>61</sup>

### **Specialty Services**

As noted earlier, pediatric specialty care is covered by Medicaid for medically needy children and children on SSI. This care is provided at a number of outpatient facilities in the largest urban areas of the state (Seattle, Tacoma, Spokane, Yakima) and in Portland, Oregon. Facilities include CHRMC, UW's Center for Human Development and Disability, MBCH, Deaconess, Sacred Heart, and Shriners Hospitals. Satellite clinics and telemedicine are being used in some of the rural areas when grant funding is available.

Maxillofacial Teams provide treatment planning and care coordination in four regions of the state for children with craniofacial anomalies. Three of these regional teams are supported with funding from the CSHCN Program. The fourth team is part CHRMC. It serves the more populated northwest region of the state. A caseload of 525 children was reported by the three state funded teams in 1999, compared with 503 children in 1998 and 515 in 1997. The total caseload is impacted by new births in the state and movement of families into and out of the state and region.

Specialty CSHCN nutrition services for children with feeding and nutrition problems are supported with funding to two LHJs. In 1999, 470 intervention services were provided compared with 390 in 1998. The increase is due to an increase in referrals. It is not clear why there has been such an increase.

A specialty clinic for children with metabolic disorders is located at the University of Washington. The Washington State Public Health Laboratory coordinates the distribution of special formula for those children who are diagnosed and treated at the clinic.

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<sup>61</sup> Washington State Department of Health. *Early Identification and Intervention Assessment Report*, draft, March 2000.

### **Family Support Services**

Throughout Washington State, support and mentoring is available through parent organizations, such as: The Arc of Washington, Family Voices, Washington State Parent to Parent, The Washington State Father's Network and others. The Alliance of Genetic Services Support Group is also available for families with genetic concerns. Use of the internet and e-mail is helping connect families and provide links to education and services. Nevertheless, families of children with special health care needs, and public health professionals in Washington continue to specifically identify the need for support with transition issues and respite services.

### **3.1.2.4 Population Based Services**

As noted in the previous section, Medicaid funds most of the direct and enabling services for the low income MCH population. For this reason, the Title V agency focuses most of its efforts on population based and infrastructure building activities to ensure quality comprehensive care for all pregnant women, infants, children and adolescents in Washington. Population based services include several health promotion and disease prevention activities established for the entire Washington MCH population.

### ***Population Based Services Specific to the Maternal and Infant Population***

#### **Healthy Mothers/Healthy Babies**

In addition to providing consumer information and referral for services, HMHB also distributes health education materials to callers on prenatal care, child health and family planning, as mentioned previously.

#### **Pregnancy Exposures (Care NW)**

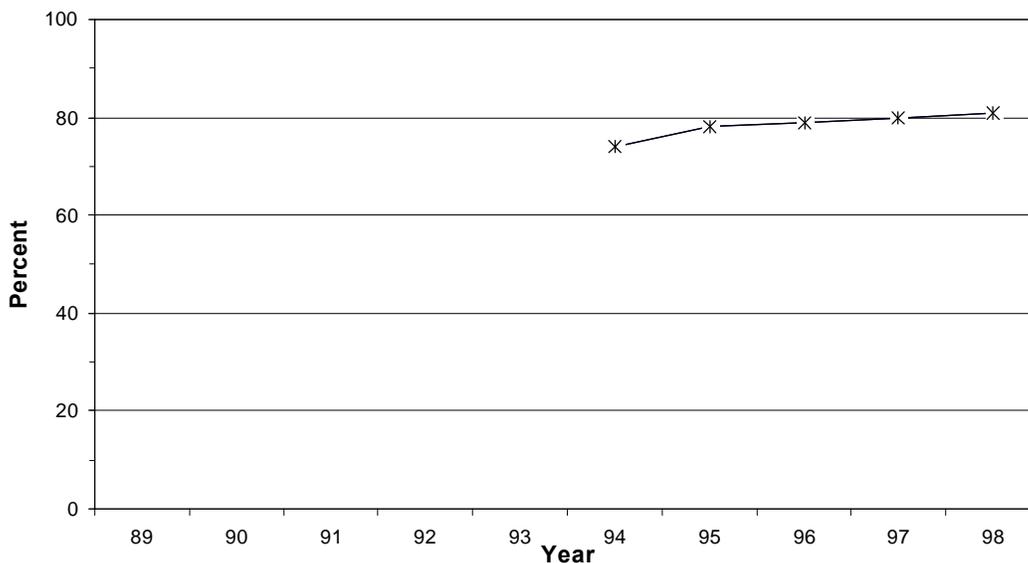
CARE NW is a regional hotline set up to provide information about potential risks from exposures to drugs and other chemicals during pregnancy. In 1999, 79% of the 825 calls received were from Washington. Among all calls, 52% came from physicians, nurses, dentists, genetic counselors and midwives; 38% came from consumers; and the remaining came from and pharmacists, lactation consultants, social workers or others.

## **Population Based Services Specific to the Child and Adolescent Population**

### **Immunizations**

Population based services for the Child and Adolescent Population include a variety of statewide preventive health services and health promotion activities. Major initiatives undertaken by the OMCH include Child Profile immunization tracking and health promotion activities, efforts to promote Bright Futures partnerships between providers and families, teen pregnancy prevention and abstinence education activities, preventive oral health services, and injury prevention activities. These activities are discussed in detail in the Block Grant Narrative, Section 2.4.1, starting on page 57. In addition, statewide access to vaccines and immunization activities are funded by the CDC and are described below.

**Washington State Immunization of Children  
19 - 35 months old  
1994 - 1998**



Sources: U.S. National Immunization Survey, April - Dec. 1994 to 1998

Washington State has a policy assuring that all children have universal access to the same vaccines regardless of income, insurance status, or eligibility for federal programs like Vaccines for Children. Vaccines are purchased through CDC contracts by the state and are distributed to LHJs who supply both public and private providers. Over 95% of children entering school have been vaccinated to schedule, and more recent immunization efforts have focused on younger children. The National Immunization Survey conducted by CDC reports that 81.1% ( $\pm 3.8\%$ ) of Washington children 19 to 35 months were immunized to schedule (4 DPT, 3 Polio, 1 MMR) in

1998. This rate has been increasing gradually since data collection began in 1994. The immunization rate for three Hepatitis B vaccinations for 19-35 month olds was 81.3% ( $\pm$  3.7%) in 1998. The Healthy People 2010 objective is for at least 90% of 19-35 month olds to be immunized. CHILD Profile immunization tracking aims to provide current data on immunization status of children to decrease the numbers of missed opportunities for immunization.

### ***Population Based Services Specific to Children with Special Health Care Needs***

Population based services specific to children with special health care needs include two efforts at early identification and intervention: Newborn Screening and Early Hearing Loss Detection described below.

#### **Newborn Screening**

Newborn screening in Washington State is coordinated by the Public Health Laboratories (PHL) in DOH. The PHL targets all newborn infants to screen for phenylketonuria, congenital adrenal hyperplasia, congenital hypothyroidism, and several hemoglobinopathies at birth. A routine second newborn screen, obtained at 7 to 14 days, is the standard of care in Washington. Over 99% of newborns are screened every year, and approximately 50 children are identified with one of these conditions. Diagnostic confirmation for those infants who screen positive for hemoglobinopathies is conducted through the PHLs by DNA mutation analyses. For infants with a screen positive result for congenital adrenal hyperplasia, congenital hypothyroidism, and phenylketonuria, a blood sample is collected and sent to the Regional Laboratory for Metabolic Disorders at CHRMC. Upon diagnosis, all affected infants are referred for appropriate follow-up care. Population based galactosemia screening is not currently done. In 1998, the issue of adding galactosemia screening to the Washington newborn screening panel was revisited. The decision was made to request that the State Board of Health add galactosemia, however newborn screening program staff learned simultaneously of a potential disruption of services from the comprehensive sickle cell clinics due to a funding shortfall. The decision was therefore made to ensure stability of the existing screening before adding new tests.

#### **Early Hearing Loss Detection**

Approximately, 7.3% of newborns were screened for early hearing loss in 1999. At that time, two of the 93 birth facilities were screening all infants (approximately 1700 births per year) and another 11 facilities were screening high risk infants and infants in neonatal intensive care units.

In 2000, three facilities with total births per year around 4500 began screening all infants. At the request of the state legislature, OMCH is facilitating communication among stakeholders and soliciting resources for statewide implementation of early hearing loss detection, diagnosis and intervention targeted at children 0-3 years of age.

### **3.1.2.5 Infrastructure Building Services**

As noted previously, much of the Title V program's activities in Washington State center on infrastructure building activities. These activities include informing policy initiatives, collaborating in quality assurance activities, and taking the lead in assessment of the MCH population. In fulfilling this role, the Title V program collaborates extensively with other agencies and offices who provide direct and enabling services to ensure that linkages between programs are made and that services/activities are not being duplicated.

In addition to the Title V program activities, several state and local agencies, advisory boards and non-profit agencies work to ensure a quality health service delivery system for the MCH population. As described in Section 1.5.2 of the Block Grant Narrative, OMCH maintains significant collaborations and communication with all of these entities. These entities include: Washington State Board of Health, DSHS, Washington State Office of the Insurance Commissioner, OSPI, FPC, UW's Medical School, Dental School and School of Public Health, UW Center for Human Development and Disability, WSALPO Children's Alliance, March of Dimes Washington Chapter, and the Health Care for Children and Youth.

Details of the OMCH Infrastructure Building activities are described in detail in the Block Grant Narrative, by population group served, Section 2.4.1, starting on page 61 and LHJ activities on page 81. Below is an overview of the OMCH system for addressing infrastructure service needs, as well as infrastructure services provided by entities other than OMCH.

#### ***Policy Development***

To facilitate communication and coordination in addressing policy initiatives, OMCH has a Senior Health Planner dedicated to policy and planning. OMCH staff with program expertise on specific issues coordinate closely with the Health Planner as well as with the CFH Division Legislative Coordinator and the DOH Office of Legislative, Policy and Constituent Relations (OLPC). During the legislative session, the OLPC coordinates an efficient team including several OMCH staff who assist with the analysis of bills introduced, and the development of DOH

positions and testimony. When the legislature is not in session, OMCH staff work in concert with DOH and CFH policy staff in developing position papers and reports requested by the legislature and convening stakeholders for policy conferences. Examples of these activities include recent work on substance use during pregnancy, revisions of the notifiable conditions Washington State Administrative Code (WAC), and early hearing loss detection and diagnosis.

Staff also work on strategic planning, including recent efforts on oral health and CHILD Profile planning.

### ***Quality Assurance***

To coordinate quality assurance efforts within OMCH and across DOH for the MCH population in managed care, an OMCH Quality Assurance Team was developed. These efforts were first begun through the MCHB funded 1997-1999 SSDI Grant. The grant facilitated strategic planning around managed care QA activities. Currently, the QA team is focussed on three strategies: 1) Coordinating activities within DOH for the MCH population; 2) strengthening partnerships with state purchasers of health care, initially focussing on MAA; and 3) informing, educating and partnering with managed care organizations to promote the health and well-being of the MCH population they are serving.

Additional quality assurance activities focussed on the entire MCH population include education and training primarily of providers. Recent trainings have focused on weight gain in pregnancy, substance use in pregnancy, screening for domestic violence, breastfeeding assessment, development of child death review teams, health and safety in child care, early identification of children with special health care needs, and nutrition for this population. MCHBG funded trainings were also held by the four regional perinatal programs on a variety of maternal and infant health issues. In addition, OMCH contracts with CHRMC on a variety of quality assurance activities related to children with special health care needs. These activities include providing information and resources to families and health care providers, promoting health consultation throughout Washington, developing materials on health and safety needs of this population in child care, promoting family centered care among providers, collaborating with health plans regarding care management, developing strategies to assess quality of care, and collaborating with OSPI and DSHS on the quality of care for these children in schools and child cares facilities.

## **Assessment**

A number of assessment activities enable the OMCH to continually evaluate OMCH program effectiveness and the health status and service needs of the MCH population. These efforts which are largely carried out by the OMCH Assessment Section are coordinated by the OMCH Data Committee in conjunction with the DOH Assessment Operations Group. Both groups meet monthly to coordinate communication and prioritization of assessment activities within OMCH and across DOH. The assessment capacity of OMCH has increased considerably in the past five years, and currently 8.1 FTEs are dedicated to assessment activities. Ongoing activities include compiling data for the MCH Block Grant, generating data reports using vital statistics and a variety of other databases, and managing the PRAMS system, Child Death Review database, and Birth Defects databases. Assessment activities conducted in collaboration with other DOH offices and through subcontracts include: the Smile Survey addressing the oral health status of children, the Health Assessment for Youth, injury prevention reports, CSHCN surveillance activities, and program evaluations of teen pregnancy prevention and abstinence education programs. In addition, the MCHB funded 1999-2001 SSDI grant is focused on assessment. Primary objectives include developing a systematic OMCH data report, using data to develop fact sheets on priority issues and disseminating fact sheets.

### **3.2 Health Status Indicators**

See Care Health Status Indicator Forms 1, 2, and 3 and Developmental Health Status Indicator Forms 1 and 2.

A discussion of the data from these health indicators is integrated into Section 3.1.2.1, where the health status indicators are referenced (starting on page 90).

OMCH was able to secure data for the majority of Developmental Health Status Indicators. In the few cases where the data are not available (portions of D6A, D9, D10, and D11), OMCH Assessment staff will be meeting with other state agencies to strategize regarding how the data can be obtained in the future. In some cases, data is collected on a monthly basis, so developing an annual unduplicated count is not yet feasible. See the notes for these forms for more information.

### 3.2.1 Priority Needs

The preceding sections of this Needs Assessment have described the health status and service delivery system needs for the MCH population. The information presented in the Needs Assessment narrative was based on the following population-specific priorities identified at retreats focusing on the MIH, CAH and CSHCN populations:

<b>Maternal and Infant Health</b>	<b>Child and Adolescent Health</b>	<b>Children with Special Health Care Needs</b>
<ul style="list-style-type: none"> <li>• Access to Prenatal Care</li> <li>• Unintended Pregnancy</li> <li>• Domestic Violence in Pregnancy and Post partum</li> <li>• Perinatal Transmission of Infections</li> <li>• Smoking in Pregnancy</li> <li>• Infant Mortality</li> <li>• Substance Use - Alcohol and Illicit Drugs</li> </ul>	<ul style="list-style-type: none"> <li>• Immunizations</li> <li>• Mental Health Conditions</li> <li>• Tobacco Use</li> <li>• Oral Health</li> <li>• Inadequate Nutritional Status</li> <li>• Child Abuse and Neglect</li> <li>• Teen Pregnancy</li> <li>• Asthma</li> <li>• Unintentional Injuries</li> <li>• Sexually Transmitted Diseases</li> </ul>	<ul style="list-style-type: none"> <li>• Valuing Families as Partners</li> <li>• Lack of Routine Sources of Data</li> <li>• Early Identification &amp; Diagnosis and Timely Intervention</li> <li>• Information resources for families, providers, plans, etc.</li> <li>• Lack of Coordination of Services</li> <li>• Availability of Support Services for Families</li> <li>• Adequacy of Benefit Packages</li> <li>• Inadequacy of Quality Assurance</li> </ul>

Despite the fact that the health of the MCH population in Washington is generally improving, and insurance coverage is widespread with both primary and specialty providers available, a number of challenging issues impede the attainment of optimum health for this population. Smoking and drinking during pregnancy have declined, but low birth weight rates are increasing, and infant mortality and unintended pregnancy rates have remained constant. Tobacco use among youth has been increasing and the need for oral health treatment and prevention services remains acute. And while the ability to identify the CSHCN population has improved dramatically over the past several years, ongoing surveillance of this population to evaluate quality of care and need for services has not become fully operational.

In selecting the final MCH Block Grant priorities listed below, the broad based stakeholder and DOH staff groups first considered the magnitude of each health issue in terms of the rate of disease, the prevalence of the health behavior or percent of population needing the services, as well as the absolute number of people affected. They further considered the seriousness of the issues in terms of the case-fatality, long term morbidity, and long term adverse impacts.

Additional criteria included assessing how well the issue fit within the purview of DOH, the economic impact of the issue, and whether resources were available or could be leveraged to address the issue. Less data were available to consider the effectiveness of interventions, and therefore less emphasis was placed on this criterion. Future prioritization and planning efforts will focus on enhancing the review of interventions and evaluating program effectiveness.

After preliminarily ranking these issues, group discussion generated one final criterion in developing the final list of priorities: to prioritize issues that were precursors to other outcomes. In other words, to focus on the most “upstream” approaches for prevention. So, for example, the group advocated for improving nutritional status, decreasing tobacco use, and improving mental health status as early interventions to prevent a number of adverse health outcomes. Similarly, improving access to comprehensive prenatal care was viewed as a way to address 1) the timeliness of prenatal care; 2) the need for genetic and infectious disease screening; 3) support for healthy pregnancy behaviors; and 4) long term family planning in order to ensure healthier families.

The final priorities are listed below and on Form 14. They reflect consideration of and coordination with other local, state and federal priorities, such as reducing youth tobacco use, preventing unintended pregnancies, improving surveillance of CSHCN, and further developing data for policy and health planning.

1. Improving access to comprehensive prenatal care.
2. Improving oral health status and access to oral health care services.
3. Improving the coordination of services for children with special health care needs.
4. Improving early identification, diagnosis and intervention services and coordination of services.
5. Decreasing family violence.
6. Decreasing unintended pregnancy and teenage pregnancy.
7. Improving mental health status.
8. Ensuring surveillance capacity for children with special health care needs.

9. Decreasing tobacco use.

10. Improving nutritional status.

Finally, there was significant discussion throughout the needs assessment process recommending increased efforts to diminish racial and ethnic disparities among all of the priority issues. This recommendation has been adopted by the OMCH, and OMCH has committed to both systematically evaluating and addressing racial and ethnic disparities in all OMCH efforts.

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

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

See Forms, 3, 4, and 5.

#### **3.3.2 Other Requirements**

The Agency Financial Reporting System contains budgeted data for past, present and future time periods. However, budgeted data information (allotments) for future time periods may not be reflected in the Agency Financial Reporting System for the agency. Two factors that exclude future allotments on current financial records are (1) the state biennium and (2) the type of funding.

1. The state biennium runs from July 1 of an odd numbered year to June 30, two years hence. No accounting data can be input into an ensuing biennium by an agency, until the biennium begins on July 1 or after.
2. The type of funding determines whether allotments for future time periods will be input. It is the policy of DOH to input federal grant allotments on the first day of the grant award budget period, or when the federal notice of grant award is received, whichever is later.

As the Agency Financial Reporting System records do not contain the budgeted data for the application, financial records for the most complete federal fiscal year are used. Adjustments are made to these allotments based on known or anticipated revisions in funding or category allocation.

The maintenance of effort from 1989 for the State of Washington Maternal Child Health Block Grant is \$7,573,626. This match is achieved using general fund – state funding provided to DOH through the state biennial operating budget. In addition to the general fund – state and MCH block grant funds, several other funding sources, including SPRANS, CDC, SSDI, Title XIX and Abstinence Education grant funds are used by the agency to provide the Title V program.

### **Form 3**

Category	FY01 Budgeted Minus FY 00 Budgeted Variance	Explanation
1. Federal Allocation	94,226	FY01 budgeted is higher than FY00 budgeted due to increase in MCHBG award.
2. Unobligated Balance	0	
3. Total State Funds	0	
4. Local MCH funds	0	
5. Other Funds	0	
6. Program Income	0	
7. Subtotal	94,226	
8. Other Federal Funds	(1,466,750)	FY01 budgeted is less than FY00 budgeted due to: (1) significant reduction in immunization grant award; (2) loss of three SPRANS grants (Genetics Education, Genetics in Managed Care, Oral Health).
9. Total	(1,372,524)	

### **Form 4**

Due to further discussion and analysis of the proper placement of budgeted funds by the categories on this form, significant variation between fiscal years materialized.

Category	FY01 Budgeted Minus FY00 Budgeted Variance	Explanation
I.		
a. Pregnant Women	100,000	FY01 budgeted figures have been adjusted based on historical expenditures to more accurately reflect anticipated spending.
b. Infants <1 year old	1,200,000	FY01 budgeted figures have been adjusted based on historical expenditures to more accurately reflect anticipated spending.
c. Children 1 to 22 years old	(1,500,000)	FY01 budgeted figures have been adjusted based on historical expenditures to more accurately reflect anticipated spending.
d. CSHCN	0	

Category	FY01 Budgeted Minus FY00 Budgeted Variance	Explanation
e. All Others	(155,774)	FY01 budgeted figures have been adjusted based on historical expenditures to more accurately reflect anticipated spending.
f. Administration	450,000	FY01 budgeted figures have been adjusted based on historical expenditures to more accurately reflect anticipated spending.
<b>g. Subtotal</b>	<b>94,226</b>	<b>N.A.</b>
<b>II.</b>		
a. SPRANS	(155,000)	Variance due to loss of three SPRANS grants (Genetics Education, Genetics in Managed Care, and Oral Health)
b. SSDI	0	
c. CISS	0	
d. Abstinence Education	0	
e. Healthy Start	0	
f. EMSC	0	
g. AIDS	0	
h. WIC	0	
i. CDC	(1,311,750)	Variance due to significant reduction in anticipated Immunization grant award.
j. Education	0	
k. Other-Title XIX	0	
<b>III. Subtotal</b>	<b>(1,466,750)</b>	<b>N.A.</b>

### **Form 5**

Due to further discussion and analysis of the proper placement of budgeted funds by the categories on this form, significant variation between fiscal years materialized.

Category	FY01 Budgeted Minus FY00 Budgeted Variance	Explanation
I. Direct Health Care Services	(200,000)	FY01 budgeted figures have been adjusted based on historical expenditures to more accurately reflect anticipated spending.
II. Enabling Services	1,500,000	FY01 budgeted figures have been adjusted based on historical expenditures to more accurately reflect anticipated spending.
III. Population-Based Services	(2,000,000)	FY01 budgeted figures have been adjusted based on historical expenditures to more accurately reflect anticipated spending.
IV. Infrastructure Building Services	794,226	FY01 budgeted figures have been adjusted based on historical expenditures to more accurately reflect anticipated spending.

Category	FY01 Budgeted Minus FY00 Budgeted Variance	Explanation
V. Federal-State Total	94,226	FY01 budgeted total has increased by \$94,226 due to the increase in the MCH Block Grant over FY00. Additionally, FY01 budgeted amounts have been revised from FY00 based on current placement of expenditure data by category.

### 3.3 Performance Measures

**Figure 4: Performance Measures Summary Sheet**

National Core Performance Measures	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		

National Core Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
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

Negotiated Performance Measures State (SP)	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
SP 1. The proportion of mothers who achieve minimum recommended weight gain in pregnancy. (Deleted for 2000) <sup>62</sup>			X				X
SP 2 Agreement will be reached between DOH and OSPI on a tool and process(es) to collect data for the surveillance of adolescent health behavior. A survey instrument will be in place for use in 1999. (Deleted for 2000) <sup>69</sup>				X		X	
SP 3 Increase to 100% the proportion of Washington's Local Health Jurisdictions connected to the CHLD Profile central immunization registry. (Deleted for 2000) <sup>69</sup>				X		X	
SP 4 The percent of pregnancies (live births, fetal deaths, abortions) that are unintended.			X				X
SP 5 Percent of pregnant women abstaining from smoking.			X				X
SP 6 Development/implementation of activities which will promote universal counseling and voluntary testing for all pregnant women and increase availability of therapeutic interventions to HIV positive women who choose to undergo treatment. (Deleted for 2000) <sup>69</sup>				X		X	
SP 7 Percent of pregnant women abstaining from alcohol. (Deleted for 2001, merged with SP 17) <sup>69</sup>			X				X
SP 8 Percent of women who receive counseling from the prenatal health care provider on tests for identifying birth defects or genetic disease.			X				X

<sup>62</sup> Rationale for deleting measures is described in Section 3.3

Negotiated Performance Measures State (SP)	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
SP 9 Community measures for identifying and monitoring infants and young children at risk for health and development problems will be assessed, and recommendations for increasing communities' ability to promote the health of this population will be develop. (Deleted for 2000) <sup>69</sup>				X		X	
SP10 The establishment of an assessment plan for Children with Special Health Care Needs. (Deleted for 2000) <sup>69</sup>				X		X	
SP11 Increase the number of perinatal providers who have attended training in identifying and referring victims of domestic violence during pregnancy and post partum. (Deleted for 2001, revised as SP 18) <sup>69</sup>				X	X		
SP12 Produce and distribute at least 2 reports annually using OMCH surveillance data (e.g., TRBS, PRAMS, Birth Defects, Disability Prevention data) to monitor trends, promote strategies and influence policy. (Deleted for 2001) <sup>69</sup>				X	X		
SP13 Increase the number of Local Health Jurisdictions with dedicated staff providing public health consultation on health and safety to child care programs.				X		X	
SP14 Develop and implement a standardized charting tool for well-child screenings in collaboration with Medical Assistance Administration, health plans, and others. (Deleted for 2001) <sup>69</sup>				X		X	
SP 15 <sup>70</sup> Increase to 90% the proportion of parents with young children (ages birth to 3, born in Washington State) sent CHLD Profile health promotion materials. (Deleted for 2001) <sup>69</sup>			X		X		
SP 16 Establish a sustainable strategy for assessing the prevalence of children with special health care needs.			X		X		
SP 17 <sup>63</sup> The percent of women who are screened during prenatal care visits for smoking, alcohol use, illegal drug use, HIV status, and postpartum birth control plans.				X			X
SP 18 <sup>70</sup> (SP 11 Revised) The percent of women who are screened for domestic violence during their prenatal care visits.				X		X	
SP 19 <sup>70</sup> Increase the capacity of OMCH to assess mental health needs of the child and adolescent population and to promote early identification, prevention and intervention services.				X	X		
SP 20 <sup>70</sup> Reduce the rate of youth using tobacco products.			X		X		

<sup>63</sup> New State Performance Measure

Negotiated Performance Measures State (SP)	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
SP 21 <sup>70</sup> Develop and implement a set of measurable indicators and a strategic plan to improve nutrition status among the MCH population, initially focusing on food security; that is, absence of skipped meals or hunger due to lack of food.				X		P	

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services

IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

## Introduction to Section 3.4, Performance Measure Status Report

The following discussion of performance measures is designed to respond to Annual Report and Application Requirements for describing progress made on each measure, whether or not the target was reached with accompanying explanations, why the measure was changed for FY 2001 if it was changed, information about other agencies involved and related circumstances, and a brief reference to what OMCH intends to do to achieve targets in the future. More detailed descriptions of activities related to all the performance measures are described in the Annual Report (2.4) and in the Annual Plan (4.1).

### 3.4.1 National “Core” Five Year Performance Measures

See Figure 4 and page 160.

#### 3.4.1.1 Five year Performance Objectives

See Form 11 and page 160.

### 3.4.2 State “Negotiated” Five Year Performance Measures (SP)

See page 154.

#### 3.4.2.1 Development of State Performance Measures

See pages 154 and 89.

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

See page 154

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

See Form 11

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

Scheduled for August 10, 2000

#### ***State Performance Measure Status Report***<sup>64</sup>

##### **SP1. The proportion of mothers who achieve minimum recommended weight gain in pregnancy. (Deleted for 2000)**

This measure was deleted for 2000 because of poor data. Furthermore, in Washington, women tend to gain more than the recommended amount of weight during pregnancy. (ES, Pri 1, OM 5)

##### **SP2. Agreement will be reached between DOH and OSPI on a tool and process(es) to collect data for the surveillance of adolescent health behavior. A survey instrument will be in place for use in 1999. (Deleted for 2000)**

This measure was deleted for 2000 due to successful completion of the project. The 1999 Washington State Youth Risk Behavior Survey was administered and the report is being developed. DOH expects to release the findings in late spring, 2000. In 2002, DOH, DSHS and OSPI will collaborate on a joint adolescent health survey entitled 'Healthy Kids 2002'. (IB, Pri 9)

##### **SP3. Increase to 100 percent the number of Washington's Local Health Jurisdictions connected to the CHILD Profile central immunization registry. (Deleted for 2000)**

The proportion of Washington's LHJs connected to the CHILD Profile central immunization registry increased from 20 to 24 for this year. This measure was deleted for 2000 because of limited capacity to control the outcome, and the dependence of this activity on outside funding

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<sup>64</sup> The references following each measure relate to the priorities set for 2001, not for 1999. Please see page 167 for a list of these priorities.

sources. Immunization coverage that is associated with this measure is reported under National Performance Measure 5. (IB, NPM 5, OM 6)

**SP4. The percent of pregnancies (live births, fetal deaths, abortions) that are unintended.**

The percentage of unintended pregnancies in 1998 was 53.1% ( $\pm 3.3\%$ ) which lies within the range of sampling error for the target goal of 52.2%. The result for this measure may have been marginally influenced by a change in the way unintended pregnancy is calculated (See Notes Section, Form 11). Teen pregnancy, which accounts for a large proportion of unintended pregnancies, has been declining steadily since 1995 and in 1998 reached an all time low of 71.2 per 1000 (ages 15-19). OMCH will continue to collaborate with IDRH, MAA, and local providers to develop and implement a strategic plan to continue to reduce unintended pregnancy. OMCH will also make an effort to expand the First Steps program to increase utilization of family planning services by 6 weeks post-partum. OMCH will continue to monitor this measure through Washington State PRAMS and the First Steps Database. (DHC, ES, Pri 6)

**SP5. The percent of pregnant women abstaining from smoking.**

The percentage of women abstaining from smoking during pregnancy remained steady in 1998, at 85.4% (with 5% of the data missing). This fell short ( $p < .05$ ) of the 86% target set for 1998. OMCH will continue to develop strategies to address the adverse effects of tobacco use during pregnancy and will collaborate with the DOH's Tobacco Prevention Control Program to increase the focus on smoking cessation by pregnant women and women of reproductive age. (ES, Pri 9)

**SP6. The development/implementation of activities which will promote universal counseling and voluntary testing for all pregnant women and increase availability of therapeutic interventions to HIV positive women who choose to undergo treatment. (Deleted for 2000)**

This measure was deleted for 2000 due to successful completion of activities for promoting universal voluntary testing and counseling for HIV among pregnant women (See Form 16 notes for details). OMCH will continue to collaborate with HIV/AIDS, FPRH, Regional Perinatal Programs, Medicaid Healthy Options and other contractors to implement effective policies and programs for HIV prevention and care in the MCH population. Activities around universal counseling and voluntary testing for HIV have been incorporated into SP17, which addresses access to comprehensive prenatal care. (IB, Pri 4, OM 6)

**SP7. The percent of women abstaining from alcohol. (Deleted for 2001)**

Third trimester alcohol use data, obtained from PRAMS, has been used as a measure of alcohol use in pregnancy. While the percentage from PRAMS represents an estimate only, it is rather than birth certificate data since 15% of the data for this measure are missing from the birth certificate file. The estimated percentage of women abstaining from alcohol in 1998 was 96.1( $\pm$ 1.4). This result was significantly higher ( $p < .05$ ) than the target of 92.3% set for this year. OMCH will continue to monitor rates of alcohol use through PRAMS and the First Steps Database. OMCH will also continue to develop strategies to improve screening for substance abuse by collaboration with the Regional Perinatal Program. (IB, SP 17, Pri 1)

**SP8. Percent of women who receive counseling from their prenatal health care provider on tests for identifying birth defects or genetic disease.**

The estimated percentage of women who received counseling from their prenatal care provider on tests for identifying birth defects or genetic disease for 1998 was 88.6( $\pm$ 2.0). The 95% confidence interval for this estimate includes the 1999 target so we conclude the state has met its target for this measure. OMCH will continue to monitor this measure through PRAMS. (DHC, Pri 4)

**SP9. Community systems for identifying and monitoring young children at risk for health and development problems will be assessed and recommendations for increasing communities' ability to promote the health of this population will be developed. (Deleted for 2000)**

This measure was deleted for 2000 as it has been completed. The aim of the assessment was to determine what DOH could do to support communities and increase the effectiveness of state efforts toward systems of identification and monitoring of children at risk for future health and/or developmental problems. OMCH met with key providers in six communities to understand how local systems work and to identify community needs and recommendations. OMCH also met with parents of children with special needs to obtain a greater understanding of how the health care system works for them. Recommendations from this effort included additional parent and provider education for identifying and monitoring at risk children, additional funding for services and an improved tracking system that could ensure children receive screening, referral and services that are monitored over time. A final report was completed in March 2000. (IB, Pri 4)

**SP10. The establishment of an assessment plan for children with special health care needs. (Deleted for 2000).**

SP10 was deleted for 2000 because of successful completion of the assessment plan. This measure was revised to SP16 which will form the next step in establishing a strategy for ongoing

data collection on the prevalence of children with special health care needs in Washington. (IB, SP 16, Pri 8)

**SP11. Increase the number of perinatal providers who have attended training in identifying and referring victims of domestic violence during pregnancy and post-partum. (Deleted for 2001)**

This measure has been deleted for 2001 and replaced with State Performance Measure 18 because, while training is an essential first step, OMCH wants to measure its success in actual screenings done by providers. OMCH continues to work with the Perinatal Partnership against Domestic Violence to train perinatal providers (950 as of December 1999) in identifying and referring victims of domestic violence. (IB, SP 18, Pri 5)

**SP12. Produce and distribute at least two reports annually using MCH surveillance data (e.g. YRBS, PRAMS, Birth Defects or Disability Prevention data) to monitor trends, promote prevention, and influence policy. (Deleted for 2001)**

This measure was added in the year 2000 application due to the need for OMCH Assessment Section to demonstrate enhanced capacity over time. OMCH is in the process of developing an annual data report using SSDI funding as well as several PRAMS reports for distribution this calendar year. This measure was deleted for 2001 because these reports will be produced on a routine basis and other priorities surfaced during the needs assessment process. (IB)

**SP13. Increase the number of Local Health Jurisdictions with dedicated staff providing public health consultation on health and safety to child care programs.**

Currently, 24 of 34 LHJs (70.6%) have dedicated staff consulting on health and safety with childcare programs. This exceeds the 1999 target goal of 65%. This measure was added last year because both Federal and State initiatives have led to increased funding for MCH childcare work. Because of the increased availability of funds, the number of LHJs is expected to reach 100% by July 2000. (IB)

**SP14. Develop and implement a standardized charting tool for well-child screenings in collaboration with the Medical Assistance Administration, health plans, and others. (Deleted for 2001)**

This measure was deleted for 2001 because it was completed. OMCH will continue to work with MAA to provide quality assurance for the Bright Futures initiative. OMCH has provided input to MAA regarding the content and format for the chart inserts. MAA is continuing to revise the

chart insert for well-child screening and plans to complete the revisions by the end of 2000. OMCH will continue to partner with Medicaid and other stakeholders to ensure that primary care providers administer complete EPSDT screens as part of efforts to improve early identification, diagnosis and intervention services. (IB, Pri 4)

**SP15. Increase to 90 percent the proportion of parents with young children (aged birth to 3 years, born in Washington State) sent CHILD Profile health promotion materials.(Deleted for 2001)**

OMCH will continue to work towards the goal of sending health promotion materials to 90% of children from birth to 3 years who live in Washington. These materials address several of the child and adolescent health priorities. The apparent decrease in the percentage of children sent materials for this year was due to incorrect reporting of the numbers for last year. This error has been corrected. (PB, Pri 4)

**SP16. Establish a sustainable strategy for assessing the prevalence of children with special health care needs.**

This measure was added in 2000 to replace SP10. OMCH completed all five activities (see notes section for complete description of activities) to stay on target with the overall goal of achieving a sustainable system to assess the prevalence of children with special health care needs in the State by the year 2005. Efforts are continuing in line with priority 5. (IB, Pri 8)

**SP17. The percent of women who are screened during prenatal care visits for smoking, alcohol use, illegal drug use, HIV status and post-partum birth control plans.**

This measure was added because access to comprehensive prenatal care has been identified as an OMCH priority for 2001. The goal of this measure is to improve access to comprehensive prenatal care that includes universal screening for smoking, alcohol use, illegal drug use, HIV status and postpartum birth control plans. For FY2001-2002, the benchmark will be the percentage of women who report that during their routine prenatal care visits, their health care provider asked about the following topics: smoking, alcohol use, illegal drug use, HIV testing, and postpartum birth control choices from PRAMS. (See Form 16 Detail Sheet for specific questions). (IB, Pri 1)

**SP18. The percent of women who are screened for domestic violence during their prenatal care visits.**

This measure was revised from SP11 to provide information more closely related outcomes (the number of clients screened is a desired outcome of MCH provider training). The PRAMS survey has been revised to facilitate reporting. The new survey asks if women were screened for domestic violence. Family violence continues to be an OMCH priority. In addition to monitoring the extent of domestic violence through PRAMS, OMCH will continue to provide resources for provider training in identification and program referral for victims of domestic abuse. (IB, Pri 5)

**SP19. Increase the capacity of OMCH to assess mental health needs of the child and adolescent population and to promote early identification, prevention and intervention services.**

This measure has been added because it has been estimated that as many as 20% of children and adolescents have a diagnosable behavioral, emotional or mental disorder. Because state specific data is limited, work on this performance measure will require increasing OMCH assessment capacity to identify the level of need. OMCH will also collect and analyze data from other State agencies regarding the availability and usage of publicly funded mental health services. (IB, Pri 7)

**SP20. Reduce the rate of youth using tobacco products.**

This measure has been added because reducing tobacco use among youth is both an OMCH and a DOH priority. Washington State has pledged that the Tobacco Settlement monies will be used to support tobacco education and prevention programs, and also to assess the success of those efforts. The baseline for this measure will be the number of youth who report using tobacco products on the 2000 Washington State Survey of Adolescent Health Behaviors. (PB, Pri 9)

**SP21. Develop and implement a set of measurable indicators and a strategic plan to improve food security, that is, absence of skipped meals or hunger, due to lack of food.**

This measure has been added to address the OMCH priority of improving nutritional status of the population served. Ensuring an adequate and nutritious food supply is the first step in improving nutritional status. The 1995-1999 Census Bureau Current Population Survey reports ranked Washington households as above the national average in Food Insecurity. The Urban Institute reported in 1996-97 Washington ranked 6<sup>th</sup> out of 13 states having families with children reporting one or more food related problems. Childbearing aged women, infants, and children are especially vulnerable to the adverse effects of hunger and nutrient inadequacies, and those with low income are at greatest risk. The purpose of this measure will be to develop and implement a

strategic plan to improve nutrition status among the MCH population through completion of 18 benchmark steps that will make up this process (see Form 16 detail sheet for benchmarks). (IB, Pri 10)

## ***NATIONAL PERFORMANCE MEASURES***

### **NPM1. 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.**

OMCH has set the objective for this performance measure at no more than 10% through the year 2000. In Washington, Medicaid eligibility and SSI eligibility have the same income threshold of 200% FPL. Direct and enabling services are paid for by Medicaid. The CSHCN program serves as ‘payor of last resort’ providing care coordination and outreach as needed. A substantial increase in our ‘safety net’ activities would indicate that the Medical service system for CSHCN is failing. A decline could indicate either that more SSI beneficiaries are receiving necessary services without the need for outreach and care coordination, or that the number of these children receiving outreach and care coordination services has declined irrespective of their needs. (IB, Pri 4)

### **NPM2. 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.**

The 1999 target for this measure remained unchanged and was met for this year. In 1999, CSHCN programs provided or paid for eight of the nine specialty and subspecialty services listed in Section 5.3. The one exception is home health care, which is provided by DSHS for Medicaid eligible clients. (IB, Pri 4)

### **NPM3. The percent of children with special health care needs in the state who have a ‘medical/health home’.**

The percent of children with special health care needs in the state with a “medical home” was estimated to be 47%. The data source for this measure changed this year, and the result is not comparable to last year. This year’s data come from the Washington State FAACT Survey, and are derived from a composite of questions asked of families who have children ages 0-13 with special health care needs enrolled in 3 commercial health plans. Ninety-one percent of respondents reported that their children had a primary care provider and 53% of those children met the threshold for having a ‘medical home’. These data represent the four counties in Northwest Washington served by the Northwest Medical Bureau. It is not possible to ascertain if

the survey results are representative of the Washington State population, but the survey may be expanded statewide in the future. (IB, Pri 4)

**NPM4. Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, and hemoglobinopathies (combined).**

The proportion of newborns screened in 1999 was 99.2%. This exceeds the 1999 target of 98.5% and the Healthy People 2000 goal of at least 95% of all newborns screened. This program is very well developed with a computerized tracking system that ensures the continued success of this effort. (IB, Pri 4)

**NPM5. Percent of children through age two who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, HiB, and Hepatitis B.**

The 1998 (January-December) National Immunization Survey reported that the estimated vaccination coverage (4:3:1:3) for children aged 19-35 months in the State of Washington was 80.8 ( $\pm 3.8$ ). The 95% confidence interval of this rate includes the target goal of 82%, so we conclude the state is meeting its goal. The Immunization Section will continue its education and consultation with private and public providers in the use of Clinic Assessment Software Application (CASA) and other quality assurance measures in FY2001 to assure continued success. (PB)

**NPM6. The birth rate (per 1000) for teenagers aged 15 through 17 years.**

The 1998 teen birth rate was 24 per 1000 teens aged 15-17, which not only surpassed the target of 25.2/1000, but also was within the range of sampling error for the year 2000 objective of 23.8 per 1000. OMCH will continue to provide pregnancy prevention services through the seven community-based abstinence programs and 11 comprehensive teen pregnancy prevention projects. In addition, OMCH will develop a plan for parenting education for parents of teens and pre-teens to further reduce the incidence of teen births. (ES, Pri 6)

**NPM7. Percent of third grade children who have received protective sealants on at least one permanent tooth.**

There have been no new data on sealants for third graders since 1994. The Smile Survey was conducted in 1999, and the results will be available by January of 2001, at which point we can provide more accurate information. OMCH will continue to provide sealants and work with CHILD Profile, Bright Futures, LHJs and the Oral Health Coalition to improve access to oral health care in Washington. (PB, Pri 2)

**NPM8. The rate of death to children aged 1 through 14 years caused by motor vehicle crashes per 100,000 children.**

The rate of motor vehicle crash deaths to children aged 1-14 years for 1998 was 2.8 per 100,000 and was not significantly different from the target rate of 3.3 per 100,000. More years of data will be necessary to assess any trends for this variable. OMCH will continue its work with the State Injury Prevention Program to monitor data in this area.

**NPM9. Percentage of mothers who breastfeed their infants at hospital discharge.**

We do not have data on breastfeeding at hospital discharge. The surrogate indicator for this measure is whether a woman reports breastfeeding at any time following delivery. The estimated proportion of women who breastfed in 1998 was 87.8% ( $\pm 2.0$ ). The estimate lies within the range of sampling error for the target of 88.0%. OMCH will continue to work with First Steps providers through MSS and will collaborate with WIC (Women, Infants and Children) to include a chapter on breastfeeding in their Nutrition Guidelines and develop local Breast Feeding Coalitions to address this goal. (IB, Pri 10)

**NPM10. Percentage of newborns that have been screened for hearing impairment before hospital discharge.**

The number of hospitals providing newborn hearing screening increased in 2000 from 11 to 17, with 6 hospitals screening all newborns before hospital discharge. This measure has been expanded to include one hospital which is not a birthing facility but screens both inpatient and outpatient infants under 3 months of age. The proportion of infants screened in 2000 was 7.3%. Because OMCH will expand its efforts to get statewide participation in newborn hearing screening, the indicator is expected to increase over time. (PB, Pri 4)

**NPM11. Percent of children with special health care needs in the State CSHCN Program with a source of insurance for primary and specialty care.**

In 1999, 97.5% of children served through the Title V program had a source of insurance for primary and specialty care in 1999. Children receiving direct services through the Title V program represent a small portion (2-3%) of the estimated CSHCN in the state, but as reflected in our reporting, they typically are insured. CSHCN Coordinators throughout the state work with un-insured children and their families to promote entry into the state Medicaid, SCHIP, and Basic Health Plan insurance programs when they are not otherwise insured. We estimate a large proportion of the population of children with special needs not served by the Title V agency is covered by Medicaid and SCHIP. Additional outreach efforts of these programs target children

with special health care needs. Thus, given an estimated 7% rate of uninsured in Washington State, we feel 98% is a reasonable goal for children served through Title V. This target will remain in place through 2005. (IB, Pri 3)

**NPM12. Percent of children without health insurance.**

The 1998 state population survey reported that 7.8% of children under the age of 19 were without health insurance. This estimate lies within the range of sampling error for the goal of 7.0%, and the objective has been met. Overall, children under 19 had the lowest rates of uninsured status in the state compared with other age groups. Implementation of SCHIP should further lower this percentage. This survey is scheduled to be updated every two years. (ES, Pri 4)

**NPM13. Percent of potentially Medicaid-eligible children who have received a service paid for by the Medicaid Program.**

In 1998, 88% of Medicaid-eligible children under the age of 19 were estimated to have received a service paid for by the Medicaid Program. Due to reporting errors in previous years, the target for this year was invalid, and target setting for the future has been reviewed. This percentage represents the total number of children under age 19 who were covered under a managed care or fee for service Medicaid Program and received a service out of the estimated number of children under age 19 living at or below 200% FPL. OMCH works to increase this percentage through joint administration of the First Steps Program with DSHS and other education and outreach provided by OMCH contractors such as the LHJs and the HMHB outreach project. (ES, Pri 4)

**NPM14. The degree to which the State assures family participation in program and policy activities in the State CSHCN Program**

The CSHCN program continued to expand family participation in program and policy areas during 1999, increasing its score from 15 to 16 of 18 possible points. This exceeded the 1999 performance target of 15. Improvement occurred by increased involvement of families in the Block Grant application process (#3). The CSHCN Family Consultant held focus groups and other forums to promote participation in both the Block Grant application process and the Five-Year Needs Assessment process. (IB)

**NPM15. Percent of very low birth weight live births.**

The rate of very low birth weight live births for 1998 was 1.1%. This was more than the target rate of .97% ( $p < .05$ ). We are working with our Perinatal Advisory Committee to explore very low

birth weight rates further. It is possible that this increase is a result of technological advances that allow extremely premature infants to be born alive. (IB, Pri 1, OM 1, 3)

**NPM16. The rate (per 100,000) of suicide deaths among youths 15-19.**

The number of suicide deaths among youths aged 15-19 for 1998 was 40, which brought the rate of suicide deaths for 15-19 year olds down to 9.9 per 100,000. This fell within the range of sampling error for the target goal of 11.8 per 100,000. There are limited resources dedicated to youth suicide prevention, and it is difficult to match the outcomes of the activities of these prevention efforts directly to the rate of suicide. OMCH will continue its assessment role in this area. The implementation of the Child Death Review Database will allow an enhanced capacity to monitor this measure and may impact on results in the future. (IB, Pri 7, OM 6)

**NPM17. Percent of very low birth weight infants delivered at facilities for high-risk deliveries**

The percentage of very low birth weight infants born at facilities for high-risk deliveries and neonates for 1998 was 79.0%. This exceeded the goal of 70% set for this year, following the 1998 revision of the target measure for this indicator. Due to the change in the way the proportion for this measure is derived, the numbers reported last year have been changed. OMCH will continue its efforts on this measure through its contracts with four statewide perinatal regional programs. (DHC, Pri 4, OM 1, 3, 4)

**NPM18. Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.**

The percentage of women entering prenatal care in the first trimester in 1998 was 83% and has remained constant since 1996. This percentage fell short of the target of 85.3% ( $p < .05$ ). OMCH will continue to explore the data to understand why progress on this indicator has slowed. OMCH will continue to provide outreach to pregnant women through the statewide toll-free line for consumer information and referral operated by HMHB and through participation in the multi-agency First Steps initiative. (ES, Pri 1)

### **3.4.3 Outcome Measures (OM)**

***The Infant Mortality Rate per 1000 live births***

The infant mortality rate met the target goal of 5.7 infant deaths per 1000 live births for 1998, but increased (although not significantly) over last year. This increase was due to a non significant

increase in neonatal deaths. At the same time, an increase in the low birth weight and very low birth weight births has been observed. Regionalization of perinatal care increases the likelihood that high-risk neonates will be delivered in the appropriate facilities. MSS and MCM provide additional health and social support services to high risk mothers, helping them to have healthier pregnancies. A new state performance measure, which addresses the need for comprehensive prenatal care, has been developed to help improve all birth outcomes. We will continue to explore in greater detail infant mortality, low birthweight, prenatal care, and regionalization of perinatal services with the Perinatal Advisory Committee to optimally address perinatal care needs. (ES, SP 4, 7, 8, 11, 17, Pri 1)

### ***The Ratio of Black Infant Mortality to White Infant Mortality***

The ratio of Black infant mortality to White infant mortality was 2.0 for 1998. This is below the target goal of 2.2 and reflects a continued decline in African American infant mortality. Of note, the American Indian infant mortality rate does appear to be increasing, and in 1998 was 11.3/1000 live births. OMCH will be exploring these data in greater detail with the Perinatal Advisory Committee and will be expanding efforts to address racial disparities in health care for this population. (IB, SP 17, Pri 1)

### ***The Neonatal Mortality Rate Per 1000 Live Births***

The neonatal mortality rate for 1998 was 3.6 per 1000. The value lies within the range of sampling error for the target, and the goal for this indicator has been met. As noted above, OMCH will continue to work with the Perinatal Advisory Committee on addressing this and related indicators. (IB, SP 17, Pri 1)

### ***The Postneonatal Mortality Rate Per 1000 Live Births***

The postneonatal mortality rate of 2.1 per 1000 live births for 1998, surpassed the target goal of 2.3 per 1000 live births. The goal of OMCH programs such as “Back to Sleep” which teaches mothers to place infants on their backs for sleeping is to reduce the incidence of Sudden Infant Death syndrome (SIDS) which can help to lower the postneonatal mortality rate. OMCH signed a contract in spring 2000 with a statewide SIDS agency to provide training & training materials to LHJ’s. OMCH will continue to provide education, one-to-one support to parents, and other forms of injury prevention through the MSS program. (ES, IB)

### ***The Perinatal Mortality Rate Per 1,000 Live Births***

The perinatal mortality rate for 1998 was 8.6 per 1000 live births and fetal deaths. The rate falls within the range of sampling error for the target, and the goal was met. Programs that may help reduce perinatal mortality begin preconception with genetic counseling and testing, and provide early and comprehensive prenatal care, identification of high-risk pregnancies, perinatal regionalization, and social support for high-risk mothers. OMCH will continue to provide genetic services and MSS in FY2000. (DHC, ES, SP 8, 17, Pri 1)

### ***The Death Rate for Children Aged 1-14 Years***

The 1998 death rate to children aged 1-14 dropped to 19.1/100,000. While not a statistically significant decrease, the indicator has shown a steady rate of decline over the last three years, and has already surpassed the 2000 target set for this measure. OMCH will continue to collaborate with the Injury Prevention Program to increase the use of car seats, bicycle helmets, smoke detectors and other safety devices to reduce deaths in this age group. OMCH will also increase its work on childcare safety through consultation and training with LHJs. OMCH will continue to promote HIV/AIDS counseling & testing of all pregnant women to prevent transmission. (PB, IB, SP 6)

## IV. Requirements for the Annual Plan

The activities discussed in the following chapter are organized by level of the pyramid, by population group, by performance measure (state and national), by outcome measure, and by priority. In some cases an activity may relate to more than one level of the pyramid, in such cases it is listed on the primary level under which it falls. When the activity specifically targets more than one population, it may be discussed under more than one level of the pyramid. Each grouping of activities provides a reference to the priority and measures to which it relates. (See the Key below to interpret these references.)

Following is a listing of the new priorities and performance measures developed for the 2001 block grant application. Note that several of these state performance measures have been developed since last year (marked \* below). Changes were made based on priorities identified from the five-year needs assessment process.

### Key To References

#### OMCH Priority Needs – 2001 ABG

1. Improving access to comprehensive prenatal care.
2. Improving oral health status and access to oral health care services.
3. Improving the coordination of services for children with special health care needs.
4. Improving early identification, diagnosis and intervention services and coordination of services.
5. Decreasing family violence.
6. Decreasing unintended pregnancy and teenage pregnancy.
7. Improving mental health status.
8. Ensuring surveillance capacity for children with special health care needs.
9. Decreasing tobacco use.
10. Improving nutritional status.

State Performance Measures – Need to revise list

(Note, the items below marked \* are new performance measures this year, so were added as the numbers SP 17, 18, 19, 20, and 21)

SP 4. Decrease the percent of pregnancies (live births, fetal deaths, abortions) that are unintended. (Pop. Based, Maternal/Infant, Risk Factor)

SP 5. Increase the percent of pregnant women abstaining from smoking (Pop. Based, Maternal/Infant, Risk Factor)

SP 8. Increase the percent of women who receive counseling from their prenatal health care provider on tests for identifying birth defects or genetic disease. (Direct Health Care, Maternal/Infant, Risk Factor)

SP 13. Increase to 100% the number of Local Health Jurisdictions with dedicated staff time providing public health consultation regarding health and safety in child care programs. (Infrastructure, Children, Process)

SP 16. Establish a sustainable strategy for assessing the prevalence of children with special health care needs. (Infrastructure Building, CSHCN, Capacity)

\*SP 17. The percent of women who are screened during prenatal care visits for smoking, alcohol use, illegal drug use, HIV status, and postpartum birth control plans. (Infrastructure Building, Maternal/Infant, Process)

\*SP18. (SP11 revised) The percent of women who are screened for domestic violence during their prenatal care visits. (Infrastructure Building, Maternal/Infant, Process)

\*SP19. Increase the capacity of OMCH to assess mental health needs of the child and adolescent population and to promote early identification, prevention and intervention services. (Infrastructure Building, All populations, Capacity)

\*SP20. Reduce the rate of youth using tobacco products (Population-based, Child and Adolescent Health, Risk Factor)

\*SP21. Develop and implement a set of measurable indicators and a strategic plan to improve nutrition status among the MCH population, initially focusing on food security; that is, absence of skipped meals or hunger due to lack of food. (Infrastructure Building, All Populations, Process)

\*New for 2001 MCH Block Grant Application.

National Performance Measures (NPM)

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.

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.
3. The percent of Children with Special Health Care needs (CSHCN) in the State who have a “medical/health home.”
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).
5. Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertusis, Haemophilus Influenza, Hepatitis B.
6. The birth rate (per 1,000) for teenagers ages 15 through 17 years.
7. Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
8. The rate of deaths to children ages 1-14 caused by motor vehicle crashes per 100,000 children.
9. Percentage of mothers who breastfeed their infants at hospital discharge.
10. Percentage of newborns who have been screened for hearing impairment before hospital discharge.
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.
12. Percent of children without health insurance.
13. Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.
14. The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.
15. Percent of very low birth weight live births.
16. The rate (per 100,000) of suicide deaths among youths 15-19.
17. Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
18. Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

#### Federal Outcome Measures (OM)

1. The infant mortality rate per 1,000 live births.
2. The ratio of the black infant mortality rate to the white infant mortality rate.
3. The neonatal mortality rate per 1,000 live births.
4. The postneonatal mortality rate per 1,000 live births
5. The perinatal mortality rate per 1,000 live births
6. The child death rate per 100,000 children aged 1-14.

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

Following is a detailed description of activities planned for FY 2001 by levels of the pyramid, and related to the performance measures and priorities for 2001. (See notation following each description.) For a discussion of each performance measure and a brief description of plans for FY 2001, see Section 3.3 on pages 154-164.

#### ***Direct Health Care Services***

##### **Pregnant Women and Infants**

**Genetics.** Due to the increasing demand for genetic specialty services and poor reimbursement for these services from other funding sources, the Genetic Services Section of OMCH will continue to promote the availability of genetic risk screening, counseling, and follow-up services by contracting with seven genetics clinics throughout the state. The purpose of this activity is to identify individuals and families at risk for genetic disorders and birth defects and provide them with information about possible interventions. (All populations, DHC, SP8, Pri. 4)

**Family Planning.** MCH funding will continue to be used by 6 LHJs to provide pregnancy detection and family planning services. This activity has a two fold purpose: first, to detect pregnancy early and second, to refer to family planning services those who test negative to prevent unintended pregnancies in the future.

LHJs providing these services will include: Adams, Asotin, Skagit, Walla Walla, Whitman, and Columbia. The population targeted for this activity is women of child bearing age in these communities. OMCH is the lead in terms of providing funding. (MIH, DHC, SP4, Pri. 6)

## **Children and Adolescents**

**Pregnancy Prevention.** Access to family planning services is one component of the teen pregnancy prevention program. This component will continue to help fund comprehensive family planning clinical services to sexually active teens. Clinics have been very successful in attracting and serving teens and are working over capacity. The literature supports the need for clinical family planning services to augment education and skill building being implemented by the teen pregnancy prevention (TPP) projects. The teen clinic model of family planning clinics has been extremely successful in this state. OMCH was the lead on this activity with partners including: Family Planning agencies, Planned Parenthood, and LHJs. (CA, DHC, NPM6, Pri. 6)

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

**Diagnostic and Treatment Fund.** OMCH will continue to make diagnostic and treatment funding available for children who have no other means of funding or payment for medically necessary services. This limited funding will allow children to receive services that would not be funded by any other source. This activity will be provided through the CSHCN coordinators in the LHJs and monitored by OMCH. This activity will continue because feedback from families and local CSHCN Coordinators still indicates that not all medically necessary services are available or financially covered by other programs or funding sources. For example, nutrition supplements, hearing aid batteries and daily living tools may be provided through this fund. (CSHCN, DHC, NPM2, Pri. 4)

**Neurodevelopmental Centers (NDCs)** OMCH will continue to provide funding for Neurodevelopmental Centers to maintain their capacity to provide specialty services for CSHCN, including occupational, physical, and speech therapies. This activity will be continued because OMCH has an ongoing role in assuring access to statewide early intervention services. These 14 non-profit centers depend on state funding to provide a structure for specialty services with support from other payers for services, other state agencies, and community resources. OMCH is the lead on this activity with support from MAA, ITEIP, DDD, and LHJs. (CSHCN, DHC, NPM2, Pri. 4)

## ***Enabling Services***

### **Pregnant Women and Infants**

**Genetics.** The Genetics Education Plan was developed in 1997 in response to the lack of coordination among groups providing genetic education. OMCH played the lead in coordinating

several partners for this activity. Provider education will continue. One new component to be implemented in 2001 is the addition of links to Washington State Genetic Resources on the DOH Website. (All populations, ES, SP8, Pri.1)

**Maternity Support Services (MSS).** MSS will continue as a major system for providing services to low-income pregnant women. Another enabling service involving Medicaid outreach will continue based on data that indicate a significant number of uninsured families/children might be eligible for Medicaid but unaware of the program. In these projects, families will be linked to Medicaid eligible services through the HMHB toll-free line and through MSS. In addition to routine linkage activities performed by HMHB, they will assist clients applying for Medicaid. The purpose of these activities is to increase the number of families eligible for Medicaid enrolling in Medicaid, and assist Medicaid clients in getting the health services they need. OMCH will be the lead on this activity, with partners including MAA, HMHB, and MSS Providers. (MIH, ES, NPM13, Pri. 1, 4)

### **Children and Adolescents**

**Pregnancy Prevention.** Unintended pregnancy, including teen pregnancy, has been identified as a priority through the OMCH five year needs assessment process. In addition, the Legislature as well as DOH, continue to support the teen pregnancy prevention program. For these reasons, OMCH will continue to provide numerous enabling services to reduce teen pregnancy. OMCH will fund 10 comprehensive teen pregnancy prevention projects in 14 counties in Washington State. These projects are designed to reduce teen pregnancy through a variety of interventions and activities including youth development, comprehensive sexuality education, skill building, client advocacy/support, mentoring, and parent-child communication, as well as clinical family planning services. OMCH will continue to be the lead on this project with partners including: Planned Parenthood, DSHS, OSPI, the LHJs, and youth serving agencies and advocacy groups. (CA, ES, NPM6, Pri. 6)

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

**Care Coordination.** Care coordination services will continue to be provided for children with special health care needs. Feedback from families indicates that this is an on-going need. Care coordination was also identified as a priority during the five year needs assessment process. This activity is designed to facilitate access to services and support to families so that children with special needs are connected to providers in their local community for the total array of services and supports. As a result of these activities, families will be given needed information and

assistance to access appropriate and needed services in their community. (CSHCN, ES, NPM2, Pri. 3)

**Medical Home.** Another enabling service which will continue in 2001 is promoting the concept of securing a medical home for all children with special health care needs. In addition to the activities described in the 1999 report, OMCH will promote the medical home concept by: exploring the addition of new medical home leadership teams in new communities; exploring partnerships with child care providers, and creating simpler versions of the Care Notebook. It will engage in these activities in order to promote the concept of medical home, train providers and promote coordinated care, early intervention, and quality health care for children with special health care needs, ages 0-18. This activity will continue in order to support the concept of medical home and respond to the data requirement of NPM 3. These activities will target children with special health care needs ages 0-18 and their families throughout the state. OMCH will be the lead; partners include UW's CHDD, MAA, the Medical Home Leadership Network, the AAP, families and providers. (CSHCN, ES, NPM3, Pri. 3)

## ***Population Based Services***

### **Pregnant Women and Infants**

**CHILD Profile.** OMCH will continue to include a message about birth spacing and family planning in the CHILD Profile health promotion letter sent to all parents through CHILD Profile. The goal is to provide a population based health education message about birth control and spacing so that women achieve planned pregnancies that are spaced for optimal outcomes. This activity targeted women of child bearing age who have delivered a baby in the State of Washington. OMCH is the lead on CHILD Profile health promotion materials. (CA, PB, SP4, Pri. 6)

### **Children and Adolescents**

**CHILD Profile.** The CHILD Profile Program, a major population based service led by OMCH, will continue to have two major components: health promotion and immunization tracking. The CHILD Profile Health Promotion project will continue statewide expansion in 2001, sending the materials to all parents of children born in Washington since July 1998. The expansion of the health promotion component should be complete in 2004. Immunization tracking expansion will also continue with health plans, private providers, and LHJs contracting to participate.

One goal of these activities is to send health promotion materials (reminders for well-child exams and immunizations) to the parents of all children born so that children will be more likely to get exams and immunizations. A second goal is to increase provider participation in the immunization registry in order to establish a statewide database of shared information so that children will be more likely to be appropriately immunized.

These activities were undertaken due to a 1992 task force which identified the need for a system to improve utilization of preventive health care. Low immunization rates are a proxy for low utilization of preventive care. Finally, MAA data showed the need for improvement in immunization and EPSDT rates. OMCH, DOH, King and Snohomish LHJs, MAA, Washington Health Foundation, WSALPHO are all partners in these activities. The system is infrastructure building, the outputs (health promotion materials) are population based. The targets for these activities include all Washington Children, 0-6 years of age. (CA, PB, SP15, Pri. 4)

**Bright Futures.** In 2001, OMCH will collaborate with MAA and the UW to implement the EPSDT/Early Developmental Screening Grant. The goal of this activity is to increase the use of Bright Futures and increase completion of developmental screens for Medicaid clients aged 0-3. This activity will target primarily Medicaid clients. Partners in this project include MAA, UW, NW Medical Bureau, Whatcom Health District, St. Joseph's Hospital, Snohomish Health District, Yakima Health Department, and Southwest Washington Health Department. (CA, PB, Pri. 4)

**EPSDT.** In 2001, OMCH will monitor implementation of the MAA chart insert tool. The goal of this activity is to increase the quality and quantity of EPSDT exams being done. The expected outcome of these activities is increased utilization of chart insert tools, especially for early developmental screenings. The target for this activity is children ages 0-3 covered by Medicaid. OMCH will be the lead on these activities, with partners including: MAA, Health Plans, Snohomish, Whatcom, Southwest Washington, and Yakima Health Districts and the UW. (CA, PB, SP14, Pri. 4)

**Abstinence Education.** Another major population based service to be continued by OMCH will be the abstinence education program, designed to reduce teen pregnancy. This project will continue due to feedback from community meetings, written input from residents, and a review of literature, all of which indicated an on-going need for this type of project in order to reduce teen pregnancy.

In order to implement the Title V Abstinence Education Program in Washington State, ten contracts will be developed and monitored by DOH for conducting abstinence education activities. These contracted agencies will provide programs, quarterly deliverables and documentation of program results including, number of youth served and in-kind match received. The programs will target youth ages 10-19 years of age in the seven communities. Partners included: OSPI, the UW's Experimental Education Unit; the UW's Washington Institute; and the Legislative Oversight Committee. The contracting portion of this project is an infrastructure building activity, with the programs being population based activities.

OMCH will also continue to collaborate with OSPI in order to provide grants to middle and high schools to conduct media campaigns promoting abstinence from sexual activity and media literacy campaigns. The goal of funding these projects is to empower youth to design and produce media campaigns promoting sexual abstinence and the importance of delaying sexual activity.

Another component of the Abstinence Education Program will include collaborating with the University of Washington's Experimental Education Unit in conducting a Youth Empowered by Abstinence (YEA!) media contest which provided technical assistance and support to 12 groups around the state. The purpose of these projects is to increase awareness about the benefits of abstinence through promoting teen media messages, media literacy and social marketing and how those skills can be applied to abstinence education.

In 2001, OMCH will collaborate with the UW's Experimental Education Unit to conduct social marketing and product distribution activities for teen generated materials promoting abstinence from sexual activity. Targets will include middle and high school age youth. (CA, PB and IB, NPM6, Pri. 6)

**Teen Pregnancy Prevention.** OMCH will continue to provide other population based services through its Teen Pregnancy Prevention program (TPP). OMCH will lead and/or arrange several trainings for TPP providers in order to increase awareness, skills, and expertise in teen pregnancy prevention and adolescent health. Contractor meetings will be held. These sessions are essential for ongoing coordination and communication.

The lack of parenting education for parents of teens and preteens has been identified by providers, stakeholders and parents. In 2001, OMCH will implement components of the parent education plan which includes establishing and conducting parenting groups in various communities

throughout the state. The purpose of this activity is to increase parenting skills for parents of preteens and teens. The expected outcomes of this activity will include the production of parent education materials (brochures, websites, curriculum) and increased parenting skills. OMCH will be the lead on this activity, with partners including: UW School of Education, OSPI, and the Cooperative Extension. (CA, PB, SP19, Pri. 6,7)

**Tobacco Use by Youth.** Tobacco use by youth was identified as a major priority during the Five Year Needs Assessment process. In addition, funding has become available through the Tobacco Settlement. OMCH is the lead on this activity, with partners including: DOH's Non-Infectious Conditions Epidemiology Section, and OSPI, DASA, CTED, and local schools.

In 2001, OMCH will include questions on tobacco use on the Healthy Kids 2002 Survey targeting all youth in the 6,8,10, and 12 grades attending public schools in Washington State. This activity is being done to monitor the use of tobacco products by youth. It will result in a data base/surveillance system on tobacco use among youth which will also be a tool in measuring the impact of DOH's Tobacco Prevention Program on usage by youth.

OMCH will also coordinate with DOH Tobacco Prevention Program in order to increase collaboration with state and local youth tobacco prevention programs. The outcomes expected from this collaboration include a decreased use of tobacco products by youth and increased awareness of youth tobacco prevention activities among OMCH adolescent programs. The collaborative effort will target youth ages 11-21 throughout the state.

This activity is being undertaken because it was identified as a priority during the Five Year Needs Assessment process. DOH's Tobacco Prevention Program is the lead on this project, with support from OMCH, OSPI, DASA, MAA, local teen pregnancy prevention and abstinence education programs. (CA, PB, SP20, Pri. 9)

**Oral Health.** In 2001, OMCH will use data from the Smile Survey 2000 to evaluate current activities and to plan programs that prevent dental disease in infants, children and adolescents. OMCH will continue to support community-based services that include early screenings and referrals for treatment, provision of dental sealants, and early disease interventions through education and the promotion of fluoride use. Recommendations from the Interagency Oral Health Planning Group will be used to create new work plans and for policy development. Integration and coordination of resources will be implemented between oral health and other health and OMCH services including WIC, Well-Child Care, Headstart, and First Steps.

Federal CISS grant funding support for 15 oral health coalitions expired in 2000. For this reason, the Washington State Oral Health Coalition and other partners will be searching for support to continue community-based activities. In the mean time, the Washington State Oral Health Coalition and Partners will continue to support coalition activity.

In 2001, OMCH will monitor and evaluate the use of the Washington State Sealant Guidelines developed in 1999-2000. These guidelines were designed to assist local communities in planning, implementing, and evaluating community-based sealant programs. The evaluation will aide in developing future revisions. OMCH will be the lead on this activity, partnering with the Washington State Oral Health Coalition. (CA, PB, NPM7, Pri. 2)

**Injury Prevention.** OMCH will continue to provide funding to DOH's Injury Prevention Program which provides technical assistance to locally based Safe Kids Coalitions and injury prevention groups , most of which include motor vehicle injury prevention. This activity is designed to increase the quality and amount of effective injury prevention activities across the state. In 2001, additional coalitions will be formed and a statewide planning group, comprised of local coalitions, will continue to operate, resulting in increased local and statewide injury prevention activities. This activity was identified as a result of the Five-Year Needs Assessment, and targets children 0-18 years of age statewide. (CA, PB, NPM8.)

OMCH, in collaboration with the Injury Prevention Program will continue the implementation and evaluation of the three components of the population based suicide prevention project: gatekeeper training, crisis system enhancement, and public education. This activities are designed to increase student awareness and participation in youth suicide prevention. In addition, OMCH and Injury Prevention will continue to collaborate with Juvenile Rehabilitation Administration to implement suicide prevention training. This training is for individuals working in the Juvenile Justice System.

**Youth Suicide.** In 2001, OMCH will also increase its partnership with other state and local organizations to address youth suicide prevention, with the addition of the Community Mental Health Council, an agency representing all the publicly funded mental health treatment centers. This activity was undertaken in response to a legislative appropriation to implement the youth suicide prevention plan. This plan targets youth ages 11-24 throughout the state. The Injury Prevention Program in DOH is the lead on this activity, with support from OMCH, the UW, local school districts, and local crisis response agencies. (CA, PB, NPM16, Pri. 7)

**Immunizations.** OMCH will continue to work with LHJs and other public clinics, WIC, Coalitions, and private clinics to improve immunization rates for preschoolers and adolescents via funding from Title 317FA. The alternate goal of this activity is to raise overall immunization rates. These activities are federal and state requirements. OMCH took the lead, with partners including LHJs, WIC, coalitions, and private clinics.

In addition, OMCH will implement new immunization requirements and continue to inform the public and providers about these changes. (CA, PB, NPM 5, Pri. 4)

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

**Early Identification and Intervention.** In 2001, OMCH will continue to support and promote efforts statewide to assure early identification and intervention. Birth defects surveillance will be enhanced through newly adopted legislation for reporting of notifiable conditions. OMCH will continue to support the implementation of early hearing loss detection diagnosis and intervention (EHDDI) through voluntary hospital based newborn hearing screening. The Adolescent Health Transition Project (AHTP) will continue to provide information statewide to all those concerned about or involved in transition issues for adolescents with special health care needs. A pilot of the "Health History Summary" will be tested during 2001 with statewide dissemination to follow. The AHTP is supported through a contract administered by the CSHCN Program.

**Hearing Loss.** OMCH will continue to facilitate communication among stakeholders and solicit resources for the statewide implementation of EHDDI. These activities have been undertaken at the request of the state legislature which recognized the importance of early hearing screening for all infants in 1998 and issued a budget proviso to develop a financing plan for EHDDI implementation. These activities will target all children 0-3 born in the State of Washington. (CSHCN, PB, NPM 10, Pri 4)

### **Infrastructure Building Services**

OMCH sees the role of its state office as being primary focused on infrastructure building, to enable the LHJs or other contractors to provide the direct, enabling, and population based services. Therefore, numerous infrastructure building activities will take place in 2001 for each of the three target population.

## **Pregnant Women and Infants**

**Unintended Pregnancy.** An unintended pregnancy performance measure in the MSS program will be implemented July 1, 2000. Prior to implementation, a state wide pilot project including private and public stakeholders developed an interview guide to discuss planning pregnancy and tested the tool with feedback from providers and clients. Other recommendations from the pilot project are annual family planning education trainings and community partnership building meetings to promote a continuum of family planning outreach after two months postpartum.

Unintended pregnancy performance measure activities planned during October 2000 through September 2001 include:

- Developing a data retrieval and analysis method for the unintended pregnancy performance measure.
- Use data to monitor provider activities in discussing pregnancy planning and the outcomes at six weeks post partum.
- Use data to monitor trends of birth control choices at six weeks post partum.

The anticipated outcomes from this project include increasing the percent of MSS clients who receive pregnancy planning information, increase the use of birth control at six weeks postpartum, and, ultimately contribute towards reducing the rate of unintended pregnancies in Medicaid clients served by First Steps Maternity Support Program. Another objective planned in 2001 is to meet with community groups to identify ongoing family planning outreach systems to assist women beyond two months postpartum. This activity will be jointly led by OMCH and MAA, with DOH's Family Planning and Reproductive Health staff and providers working as partners. (MIH, IB, SP4, Pri. 6)

**Pregnant Women and Tobacco.** OMCH will continue to collaborate with the Tobacco Prevention and Control Program (TPCP) and MAA on tobacco issues related to prenatal/postpartum smoking and pediatric exposure to smoke. In 2001, OMCH will pilot a smoking cessation project with First Steps Providers. (MIH, IB, SP5, Pri. 9)

**Pregnancy and HIV.** In 2001, OMCH will continue to collaborate with partners (see 18) to promote universal HIV testing in pregnancy. The purpose of this activity is to increase the number of providers who encourage and offer testing for HIV for pregnant women. This activity

will include: disseminating a revised booklet to providers entitled, “Update on Screening and Management of Maternal HIV Infection;” monitoring provider practices via PRAMS and HIV/AIDS KABB surveys; and exploring the option of revising current WAC from advising medical providers to encourage testing based on risk to requiring that providers offer testing to all pregnant women, and base counseling on risk.

The reason this activity will be undertaken is that some providers are not encouraging women to be tested. They appear to base recommendations on risk and most pregnant women do not believe themselves to be at risk. The target for this activity will be prenatal providers throughout the state. OMCH and the Infectious Disease and Reproductive Health Office of DOH will both take the lead on this activity, with Regional Perinatal Programs as partners. (MIH, IB, SP17, Pri.1)

**Domestic Violence in Pregnancy.** In 2001, OMCH will continue to monitor domestic violence rates via PRAMS, BRFSS and First Steps data bases in order to assess the impact of provider trainings on the prevalence of domestic violence screening. This activity will continue because having adequate data is crucial to monitoring progress, and assessing prevalence. Family violence including child abuse and domestic violence were identified as priorities through the Five-Year Needs Assessment process. This activity targets pregnant women throughout the state. OMCH is the lead, with DSHS’s First Steps Program and DOH Assessment Unit as partners. (MIH, IB, SP11 and 18, Pri. 5)

OMCH will continue to collaborate with DSHS, the Perinatal Advisory Committee, the Washington State Coalition Against Domestic Violence (WSCADV), professional groups, WIC, and other stakeholders to reduce battering to pregnant women. These activities include an expanded training targeting 1,200 maternity related providers in 2001. The number of trainers will also be expanded by 20%. The purpose of this training is to increase the screening of pregnant women for domestic violence so that more women will be identified and provided assistance. The desired end goal is to reduce domestic violence and create more safety for women. The purpose of these activities is to assure that targets and plans for addressing domestic violence during pregnancy and effecting systems change will be well coordinated and integrated among those agencies involved.

This activity will be conducted because training in domestic violence had been identified as a need by First Steps workers, in OMCH community meetings, and in national priorities. PRAMS

data reveals that only 28% of women recall being asked about domestic violence issues during prenatal care. Nationally, other medical providers were developing models to help them identify victims of domestic violence and address their needs. OMCH will be the lead on this activity with support from DSHS's Procedures and Policy: WCADV, DOH's Office of Community and Rural Health, First Steps, WIC, and other members of the Perinatal Advisory Committee. (MIH, IB, SP11, SP18, Pri. 5)

**Breastfeeding.** In order to increase the percent of MSS clients that initiate breastfeeding and increase the duration of breastfeeding, OMCH will sponsor training in breastfeeding assessment and counseling for MSS staff through the ABC's of First Steps Training. This project will be continued as WIC data on duration of breast feeding indicates a need to promote longer breastfeeding. Site visits and chart reviews with MSS providers indicate good initiation rates but early discontinuation of breast feeding. WIC data will be more accurate and complete in 2000 as a new data system was implemented in 1999. This project targets Medicaid eligible pregnant and postpartum women throughout the entire state. OMCH will work closely with WIC and DSHS's MAA on this project. (MIH, IB, NPM9, Pri.10)

In 2001, an assessment of education and training needs of health care providers will be completed by all four regional perinatal programs. All four programs will review hospital-specific birth outcome data to monitor perinatal regionalization and identify areas for follow-up. Regional maternal and neonatal transport systems will be maintained to promote appropriate levels of care.

OMCH will continue to support regional perinatal systems of care through funding of regional perinatal centers to provide consultation and education to obstetrical and pediatric providers. The purpose of these activities is to improve maternal and birth outcomes by assuring opportunities for education and consultation for obstetrical and pediatric providers. Key perinatal initiatives in 2001 are completion of a revised perinatal hospital levels of care guidelines document, development of a maternal mortality review system, and promotion of prenatal screening for Group B Strep. OMCH will increase the focus in meetings and trainings on screening and interventions for tobacco, drugs, alcohol use, and domestic violence because of their correlation with LBW rates. (MIH, IB, NPM 15, SP 17, 18, Pri 1,9,5)

**Substance Use During Pregnancy.** In 2001, OMCH will collaborate with DASA, Regional Perinatal Programs and key professional organizations to promote universal perinatal substance abuse screening as the standard of practice. The goal of this activity will be to increase the

number of providers who screen for substance abuse during pregnancy and refer women needing treatment. The expected outcomes for this activity include: 1) Disseminate "Guidelines for Screening for Substance Abuse During Pregnancy" provider booklets to medical providers statewide; 2) Provide training, site visits and workshops to providers aimed at improving screening and identification skills; 3) Presentations at continuing medical education events to increase awareness and gain support for universal screening as standard practice.

These activities will be undertaken due to the fact that drug affected infants are a legislative priority. The legislature provided additional funding to increase efforts to reduce substance abuse during pregnancy. The targets of these activities are prenatal care providers throughout the state. OMCH and DSHS's DASA will be working together on this project. Other partners include the Regional Perinatal Programs, Washington State Obstetrical Association (WSOA), and ACOG. (MIH, IB, SP17, Pri.1)

**Maternity Support Services (MSS).** OMCH will continue to manage MSS and monitor the utilization and the quality of prenatal care services. The goal of these activities is to monitor access to first trimester prenatal care and pregnancy outcomes. These activities were undertaken due to the decreased access to prenatal care for low income women during the early 1980s and continued disparity in first trimester utilization rates for low income women. These activities target Medicaid eligible pregnant and post-partum women throughout the state. This project is co-sponsored through a partnership between OMCH and DSHS's MAA Program. (MIH, IB, NPM18, Pri. 1)

**Assessment.** OMCH will continue to conduct the PRAMS survey, maintain the analytic files and conduct analyses of PRAMS data. The PRAMS survey will continue to oversample by race/ethnicity as well as a combined sampling strata for King and Snohomish counties to allow for county specific analysis by those counties. A routine reporting template was developed in FFY00 with broad distribution planned for key program areas and stakeholders. Analysis plans in FFY01 include initial review of new phase IV questions on provider screening services needed and received, as well as continued monitoring of OMCH priorities.

### **Children and Adolescents**

**Youth Health Assessment.** The Joint Survey Committee, comprised of OSPI, DASA, DSHS, CTED, FPC, and DOH's Offices of MCH and Non-Infectious Epidemiology, will implement a joint survey targeting public school students. This plan was initiated because 1) all of these state

programs need data on a variety of topics and 2) schools have been approached by several state agencies, resulting in confusion and the appearance of duplicated effort. Even though this performance measure was deleted for 2000, the project will continue to be developed as data from this survey is crucial for assessment purposes. (CA, IB, SP2, Pri. 9)

**CHILD Profile.** In 2001, OMCH will administer a new parent satisfaction survey to a random sample of parents receiving CHILD Profile Health Promotion materials to evaluate the materials and determine what changes are needed. The survey will continue to occur every two years as a quality assurance measure. OMCH is the lead for this activity, with partners including Public Health-Seattle and King County, Snohomish Health District, and MAA. (CA, IB, SP15, Pri. 4)

**Teen Pregnancy Prevention.** In order to evaluate the effectiveness of the intervention being used in the Teen Pregnancy Prevention Community Projects (TPP), outcome and process evaluations were conducted on the TPP Projects. This evaluation used random assignment methodology in several of the projects. A report is available on the findings to date — evaluation is on-going. An article on the evaluation of Washington State's Teen Pregnancy Prevention Program will be published in Family Planning Perspectives in mid 2000. OMCH is the lead on this activity with the TPP community projects as partners. (CA, IB, NPM6, Pri. 6)

OMCH will continue to analyze data at the state level related to teen pregnancy and teen births in order to monitor trends, assess the impacts of prevention projects, determine needs in various locations, and to improve program planning. Data will be used to target activities for FFY 2001-2002. This assessment activity targets the entire state. (CA, IB, SP 4, NPM6, Pri. 2)

**Abstinence Education.** In order to ensure the continued development and implementation of a rigorous evaluation design for the Abstinence Programs funded through MCH, OMCH will continue to conduct site visits to projects to monitor program evaluation, trouble shoot, and collaborate with the evaluators. Quarterly meetings and teleconferences will be conducted with the Principal Evaluator, the Washington Institute.

These activities will be continued due to the fact that a literature review revealed a lack of research and evidence regarding the effectiveness of abstinence only education interventions. These abstinence-only education activities will target youth 10-19 years of age who will be served in Bellingham, Port Angeles, Seattle, Walla Walla, and Kennewick. OMCH is the lead in these activities, with other partners including: UW's Washington Institute; School administrators, seven community-based projects; parents of youth receiving services. The

evaluation component of these population based activities is infrastructure building. (CA, IB, NPM6, SP 4, Pri. 2)

**Oral Health.** In 1999, OMCH began the infrastructure building process of developing an inter-agency strategic oral health plan in collaboration with government partners that mirrors the national Oral Health Initiative. The purpose of this work is to decrease dental disease and increase access to preventive services for under served populations. This planning process will be completed by summer of 2000 with implementation to take place in 2001.

OMCH is the lead on this project, with public partners including, DOH, DSHS, HCA, UW School of Dentistry. Private sector partners include: Washington Oral Health Coalition, Washington Dental Association, WA Dental Service/Foundation and numerous other oral health advocates. Sealant Guidelines and Coalition Building Guidelines will be distributed and training will be provided to give communities a base for building prevention and access programs in oral health. This project was undertaken as a result of the large unmet need for prevention and intervention oral health services in the state of Washington, particularly among low income and high-risk populations (as determined by SES factors, exposure to fluoridated water systems, etc.). (CA, IB, NPM7, Pri. 2)

**Student Health Initiative.** As part of the student health initiative, a health services management software package for schools funded by OSPI is being piloted and looks promising. If the pilot is successful, the software will be installed in school districts statewide. Data from this could provide important information on all aspects of student health including tobacco usage. The expected outcome from this project would be that statewide data would be collected in a consistent format to look at services, gaps, needs and predict trends. This project addresses school age students (K-12) throughout the state in each school district. The lead on this project is OSPI, with partners including OMCH and school nurse supervisors at each Educational School District (ESD) compiling the data. (CA, IB, SP20, Pri. 9)

**Injury Prevention.** OMCH will continue to provide funding to support an FTE in the CFH's Injury Prevention Program within DOH. This funding will provide for maintaining the statewide data base (surveillance). This data base provides information for use in monitoring trends, identifying needs, evaluating the impact of interventions, and program planning. This activity is essential for assessment purposes and targets all children in Washington State.

Through OMCH's support of the Injury Prevention Program (IPP), IPP will also continue to work with the WTSC which provides state leadership in the prevention of motor vehicle collisions, injuries, and deaths. Due to the work of this commission, OMCH avoids duplicative efforts by working directly on motor vehicle collisions. However, information is shared through the IPP liaison with WTSC. (CA, IS, NPM8)

**SCHIP.** In order to assure that the needs of the MCH populations will be addressed in the new SCHIP program, OMCH will continue to monitor the development of Washington's program, which took effect in January of 2000. This monitoring will result in increased collaboration between OMCH and the MAA and SCHIP programs and increased awareness of the needs of uninsured children and families. The targets for this program include families between 200-250% of the Federal Poverty Level throughout the State. (CA, IB, NPM 11, Pri. 4)

**SSDI Grant.** In 2001, the OMCH Quality Assurance Team will meet on a regular basis to coordinate quality assurance activities throughout OMCH. This activity was initiated through the 97-99 SSDI grant. The initial focus of this work was on publicly funded managed care organizations (MAA and HCA) in their involvement with families throughout the state. OMCH will be the lead for this activity with MAA, HCA, and DOH's Office of Planning and Policy partnering in this work. (CA, IB, NPM12)

**Child Death Review.** In 1999, OMCH negotiated with DSHS to develop and maintain a common Child Death Review System (CDR), an important infrastructure building assessment tool. OMCH will continue to provide technical assistance to LHJs on how to maintain multi-disciplinary CDR Teams. In order to maintain a link to the death investigation network in Washington State, CDR staff will continue to attend all meetings of the State Forensic Investigations Council.

The goals of the CDR system continue to be: to maintain a shared system to prevent duplication of effort and to yield richer data and model collaborative work towards the common goal of decreasing child deaths; to maintain a statewide system of community review of unexpected child deaths; to maintain lines of community between CDR and the death investigation system; and to provide DOH with consistent data which will identify opportunities for preventing future deaths of children. Data collection began January 2000. Aggregate information will be available in Summer 2001. This project targets children 0-18 years of age throughout the state. OMCH is the lead with DSHS and the LHJs as partners. (CA, IB, NPM8, NPM16)

**Child Care.** By 2001, OMCH anticipates the inclusion of all 34 LHJs providing health consultation to child care providers. The purpose of this work is to build a statewide system to promote health and safety in child care. This includes building infrastructure at the state and local levels. Over 160,000 children per day are in licensed child care in Washington State. Many more children are being cared for through informal channels, such as friends, family, neighbors. These numbers have increased due to the pressures of TANF and WorkFirst families struggling to identify child care.

By 2000, OMCH anticipates completing the statewide system by building local capacity in all 34 LHJs in Washington state. The funder from the project, DSHS's Office of Child Care Policy (OCCP), has expressed strong interest in the results of our public health child care partnership and anticipates increase our dollars to complete the statewide system. This will result in over one million dollars going directly to LHJs to serve child-care providers and children in their communities. This system will include special training utilizing the University of North Carolina health consultation model. Additionally it will include special components on children with special health care needs, mental health and behavioral issues, focus on the National Standards 'Caring for Our Children and Stepping Stones' and efforts to expand Medicaid Outreach and SCHIP to children in child care. (CA, IB, SP13, Pri. 4)

**Immunizations.** In 2001, through Title 317FA funding, the Immunization Program will continue implementation of immunization assessment plans using CASA software and related quality improvement methods. The number of private provider sites using CASA/AFIX will be increased. The purpose of this activity is to improve clinic immunization practices and thereby improve immunization coverage rates.

OMCH's Immunization Section will be the lead on this activity, with partners including medical providers, LHJs, and Community Migrant Health Clinics. Children through age 2 are the ultimate targets of this activity, which was mandated by CDC. (CA, IB, NPM 5, Pri. 4)

**Mental Health.** In 2001, OMCH and Injury Prevention will facilitate meetings with state and local mental health agencies in order to develop partnerships with key policy makers and providers. The purpose of this activity will be to increase the awareness of mental health needs of the MCH population and to begin to assess the current services and gaps in mental health services faced by MCH populations. Based on this assessment data, OMCH will develop an inventory of

mental health services, needs, and resources. These data will be used to develop strategies for increasing access to mental health services for children and adolescents.

OMCH will be the lead on this activity and plans to partner with the Division of Mental Health and the Community Mental Health Council, an agency representing mental health agencies throughout the state. This activity will be undertaken because mental health was identified as a priority during the Five-Year Needs Assessment process.

OMCH will also assess program areas already in place within OMCH to identify where mental health issues can be included (i.e., teen pregnancy prevention, teen media literacy and child care consultation.) In this way, programs will increase their knowledge of mental health issues and strengthen the capacity of programs to address mental health needs of the MCH populations being served. Ultimately, this will result in increasing mental health in this population.

This activity is being undertaken in response to the identification of mental health as a priority in the five year needs assessment process. (CA, IB, SP19, Pri. 7)

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

**Fetal Alcohol Syndrome.** In 2001, OMCH will continue to work with the Washington State FAS Interagency Group to develop statewide and interagency prevention, assessment, intervention, and educational activities to prevent FAS. In cooperation with OMCH's partners, and due to feedback from the FAS Conference in 1999, an annual FAS Conference will be planned and hosted. A FAS prevention plan will also be written to fund state agency coordinated prevention efforts. (CSHCN, IB, SP8, Pri. 4)

**Early Identification.** OMCH will continue to provide training and technical assistance to family practice physicians, pediatricians, nurses, family resource coordinators, and managed care representatives on topics of early identification and management of infants and children at risk for health and developmental problems. The purpose of these activities is to (a) increase physician and provider awareness of identifying children at risk and access to available early intervention services and (b) to provide training on early identification and management of infants and young children at risk for health and developmental problems. These activities will continue as training and technical assistance were identified as necessary by stakeholder input and through the 0-3 Interagency Coordinating Council. A need for training was also identified by participants (physicians, public health nurses, and family resource coordinators) in the Medical Home Training Project. OMCH will be the lead on these activities, with the University of Washington,

LHJs, medical home trainers, families, and Part C – Infant Toddler Early Intervention Program. Even though this performance measure was deleted in 2000, these activities will continue on a statewide basis in 2001. (CSHCN, IB, SP9, NPM3, Pri.4)

**CSHCN Assessment** In 2001, CSHCN will analyze and disseminate the data gathered through implementation of the assessment strategy and determine on-going strategies for the CSHCN Assessment. It is expected that these activities will result in the following outcomes:

- Meaningful responses to the national performance measures.
- Documentation of the usefulness and need for on-going primary data collection.
- Model for using SLAITS data.
- Documents/fact sheets for sharing findings.
- Proposal for continued data collection/assessment for CSHCN.

OMCH will be the lead on this project, with partners including Center for Children with Special Needs and Chronic Health Conditions (CCCHC), MAA, OSPI, LHJs, Foundation for Accountability (FACCT), MCHB, and the UW. (CSHCN, IB, SP10, SP16, Pri. 8)

**CSHCN Quality Assurance.** In 2001, OMCH will evaluate potential methods for promoting and measuring quality assurance for CSHCN in the health care system in order to develop an on-going quality assurance strategy. It is expected that this activity will result in the following outcomes:

- Documentation of usefulness/need for quality assurance measurement tools and strategies
- Documents and fact sheets for sharing findings
- Proposal for continued data collection activities for quality assurance for CSHCN.

OMCH will be the lead on this activity, with the following partners: CCCHC, MAA, LHJs, Foundation for Accountability, MCHB, the UW, parents and others. (CSHCN, IB, SP10, SP16, Pri. 8)

**Data Sharing.** A data sharing agreement will continue to operate in 2001 between Disability Determination Services (DDS) of DSHS and OMCH in order to inform families of children with special health care needs of a local public health contact for care coordination and other services.

During the Five Year Needs Assessment Process, care coordination for children with special health care needs was identified as a priority. This activity is one way to proactively keep children from falling through the cracks of service systems. The lead on this activity is OMCH, with partners including: DDS and LHJs.

**Adolescent Transition.** In 2001, OMCH staff and AHTP staff will continue to work with the Division of Vocational Rehabilitation (DVR). The goal of this activity will be to maintain links and information sharing with state level program and individual DVR Transition Coordinators. The expected outcome is that DVR Transition Coordinators will have the knowledge of the resources of the AHTP (i.e., the website, printed materials, etc.) to utilize in work with teens with special health care needs. CSHCN will continue to engage in these activities because of the success of reaching adolescents through this approach. This activity targets adolescents with special needs throughout the state. OMCH will continue as the lead, and partnering with DVR.

**Neurodevelopmental Centers.** Through contracts with NDC's, OMCH will continue to receive reports indicating the number of SSI child recipients under age 16 who receive rehabilitative services at the centers. This data is used to enhance OMCH's knowledge of the number being served at centers in our state. OMCH does not pay for direct services for children at NDCs, but rather supports capacity for NDC's to provide services. (CSHCN, IB, NPM1, Pri.8)

**CSHCN Nutrition.** In 2001, two semi-annual workshops will be offered to members of the CSHCN Nutrition Network and one annual workshop for feeding teams. In addition, ten more practicing nutritionists will be identified and provided with three days of intensive training in CSHCN nutrition. The goal of these activities is to provide opportunities for education, networking and technical assistance for community-based nutritionists and feeding teams to enhance their capacity to provide specialty services statewide to children with special health care needs. These activities will result in support of the ongoing network of nutritionists and feeding teams as they provide services to children with special health care needs, and the capacity of the nutrition network will increase with the addition of new members from underserved areas of the state. These activities will continue to be undertaken as part of OMCH's strategy to address nutrition which was identified as a priority in the five year needs assessment process. OMCH will continue to be the lead on this activity, with CHDD at the UW as a partner. (CSHCN, IB, SP21, NPM2, Pri. 10)

**Contracting with LHJs.** OMCH will continue to contract with LHJs for activities related to children with special health care needs. The contract activities vary across the state but will include assessment, collaborative efforts, information sharing, provider awareness, family support, system improvement for access to services and care coordination. Access issues typically address financial supports as well as appropriate types of services. LHJ staff participate on many local community based health care coalitions, i.e., Healthy Options Oversight Committees with MAA. These activities are necessary based on the feedback provided by families and public health staff. The state CSHCN program will continue to support regional and statewide networking, information sharing and problem solving among local CSHCN Coordinators, families, and other agencies. OMCH is the lead for contracts and DSHS/MAA is the lead for coverage issues. Other partners included the LHJs. (CSHCN, IB, NPM11, Pri. 3)

**Family Leadership.** In 2001, OMCH will continue to promote the involvement of families in leadership roles through numerous opportunities. OMCH, together with CHRMC, will sponsor a meeting with representative families from around the state to continue to develop leadership opportunities and collaboration with families in the health policy arena. OMCH will involve families in leadership by: providing training to parents on cultural competency and workshop methods; assisting parents in attending AMCHP; provide funding and support for the Statewide Parent to Parent organization and the Washington Fathers Network; providing assistance in identifying parent speakers to present at policy making forums on various topics. OMCH is the lead on these activities, with partners including: Families, CHRMC, Parent to Parent, Fathers Network, Family Voices, Medical Home, DSHS/ITEIP, OSPI, MAA. (CSHCN, IB, NPM14, Pri.)

## **4.2 Other Program Activities**

### ***Health Disparities***

Data on health indicators continues to show significant disparities based on race, with people of color having consistently higher risks for health problems. As part of efforts in this area, OMCH continues to be active in the Multi Cultural Work Group sponsored by the Community and Family Health Division which has focused on promoting cultural competency and providing training for over six years. Also, during the prioritization retreats held as a part of the Five Year Needs Assessment process this past year, stakeholders emphasized the need for OMCH to focus on reducing health disparities related to race and ethnicity. In addition, in last year's MCH

Block Grant Review, OMCH was challenged to go beyond internal training of OMCH staff and include more targeted outreach or intervention strategies directly or through contracts.

Furthermore, during the Spring of 2000, the issue of health disparities was identified as a major focus for the Board of Health and in the DOH through the strategic planning process. Thus, a Health Disparities Work Group was established in Spring of 2000 to assist OMCH to reducing health disparities in MCH populations. This group will coordinate with other DOH efforts and with other OMCH activities already underway. Examples of these activities are listed below.

PRAMS surveillance system oversamples by race/ethnicity in order to learn more about maternity related health issues among people of color, (the PRAMS staff reflects diverse backgrounds including Hispanic, African American and hearing impaired and has been effective in improving PRAMS response rates). PRAMS staff are also developing an annual set of newsletters targeted to pregnant women and new parents. The newsletters, which will be available in English and Spanish, will cover topics such as unintended pregnancy, smoking and sleeping position. They will be distributed to tribal clinics, community and migrant health centers, WIC clinics, LHJs, and other community settings.

Another project designed to increase outreach is through the HMHB toll-free line, which continues to provide services to callers from diverse racial and ethnic backgrounds through the use of Spanish and Vietnamese bilingual information and referral specialists and the use of AT & T Multilingual Services. In 1999, HMHB provided outreach to 1338 callers who identified that their primary language was not English. HMHB continues to provide baby books in multiple language to women enrolled in prenatal care. Baby books distributed in 1999 included 5765 English, 2607 Spanish, 409 Vietnamese, 388 Russian, 280 Chinese, 219 Somali, and 102 Korean. The books include English translations so that they can be used as teaching tools with providers and clients. Client outreach materials are also available in English and Spanish.

Through the HMHB work with the Immunization Action Coalition, posters have been developed in six languages about Hepatitis B. Each poster has different photos and cultural designs for English, Vietnamese, Korean, Chinese, Tagalog, Samoan, and Cambodian. A Laotian poster is being developed this year. The posters were shared at the National Hepatitis B Task Force who provided funding so that all of the state chairs for Hepatitis B could receive a set.

MSS providers have been effective in serving a high percentage of African Americans, Hispanic, and Asian clients. The unintended pregnancy provider updates on family planning have had

participation by MSS Hispanic providers who have shared strategies for discussing family planning with Hispanic clients and their partners.

The domestic violence MCHB grant awarded to DOH effective May 1, 2000, is a collaborative project with the International Community Health Center which provides health services to Asian/Pacific Islander families in Seattle. The project will focus on: 1) Training medical providers who serve pregnant post partum women (first trimester goals); 2) Developing a community response to domestic violence in the Asian Pacific Island Community; 3) Developing a model for replication by community health care clinics in Washington State.

MCH is also participating on a WIC committee to explore strategies to reduce disparities in breast feeding rates.

In addition, OMCH has translated all CHILD Profile materials into Spanish and some materials into 12 languages. Contracts with family organizations, such as Washington State Parent to Parent and the Washington State Fathers' Network fund translation and ethnic outreach. Through a contract with CHRMC, training materials and care coordination tools have been translated. In addition, the ASK Line (Answers for Special Kids) has been promoted to Spanish speaking communities with support from a multi-lingual information and referral specialist who answers the phones. The Sealant program consent forms and information have be translated into five languages.

In May of 2000, OMCH signed a contract with the SIDS Foundation to provide training and educational materials to LHJ's on the prevention of SIDS.

### **4.3 Public Input**

A plan for a more in-depth public input process for the upcoming Five Year Needs Assessment was designed and completed in March of 1998. This plan included four major retreats in which OMCH staff and stakeholders, including families of children with special health care needs, were invited to participate in a prioritizing process. One of these retreats was held on November 2, 1998 and focused on selecting priorities for the maternal and infant health population. A second retreat was held April 20, 1999 which focused on selecting priorities for the child and adolescent population. The third retreat was held in August of 1999 to select priorities for children with special health care needs population and genetics issues. Focus groups for genetics providers and families and families of children with special health care needs were held prior to the retreat. The

final retreat was held in November of 1999 including stakeholders and staff to synthesize the data and priorities from the three retreats and identify a final list of priorities.

The priorities generated through this public input process became the basis for the state negotiated performance measures for 2001.

In April of 2000, a letter was sent to over 150 stakeholders, including all those who attended the four needs assessment retreats, LHJs, family organizations, and other constituents, asking them to indicate their interest in receiving a copy of the draft application, the draft report, and/or the draft Five Year Needs Assessment for review and comment. Draft applications were sent to the 40 stakeholders who expressed interest. Following the return of this feedback, the comments were used in developing this year's application.

#### **4.4 Technical Assistance – See Form 15**

In addition to the current technical assistance (TA) request for consultation by Linda Chamberlain regarding the domestic violence grant evaluation, OMCH is seeking TA for three projects. First, OMCH is requesting TA on oral health policy development to follow up on oral health initiative work. OMCH is researching possible consultants for this project and would value suggestions from Region X. Second, OMCH would like TA on implementing Universal Hearing Screening, given that this is a new program area for OMCH. Again, we would appreciate suggestions on consultants for this project.

Finally, OMCH continues the challenge of developing a system of data collection across state agencies to identify children with special health care needs, to assist in program evaluation, etc. We are seeking an appropriate consultant for this project.

The projected dollars for these three projects are simply estimates and may not be adequate for the needs once proposals are fully developed.

## V. SUPPORTING DOCUMENTS

### 5.1 Glossary

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

**Assessment** - (see “Needs Assessment”)

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

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

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

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

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

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

**Children With Special Health Care Needs (CSHCN)** - *(For budgetary purposes)* Infants or children from birth through the 21<sup>st</sup> year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems

requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. *(For planning and systems development)* Those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

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

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

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

##### 2. State Support for Communities

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

##### 3. Coordination of Health Components of Community-Based Systems

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

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

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

**Classes of Individuals** - Authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

**Community** - A group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

**Community-based Care** - Services provided within the context of a defined community.

**Community-based Service System** - An organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

**Coordination** (see Care Coordination Services)

**Culturally Sensitive** - The recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

**Culturally Competent** - The ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

**Deliveries** - Women who received a medical care procedure associated with the delivery or expulsion of a live birth or fetal death (gestation of 20 weeks or greater).

**Direct Health Services** - Those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care: inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and

subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

**Enabling Services** - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, WIC and education. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

**Family-centered Care** - A system or philosophy of care that incorporates the family as an integral component of the health care system.

**Federal (Allocation)** (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

**Government Performance and Results Act (GPRA)** - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

**Health Care System** - The entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

**Infants** - Children under one year of age not included in any other class of individuals.

**Infrastructure Building Services** - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs

assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

**Local Funding** (as used in Forms 2 and 3)-Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

**Low Income** - An individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. [*Title V, Sec. 501 (b)(2)*]

MCH Pyramid of Health Services - (see “Types of Services”)

**Measures** - (see “Performance Measures”)

**Needs Assessment** - A study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining:

- 1) What is essential in terms of the provision of health services;
- 2) What is available, and
- 3) What is missing.

**Objectives** - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)

**Other Federal Funds** (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

**Others (as in Forms 4, 7, and 10)** - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

**Outcome Objectives** - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

**Outcome Measure** - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, “Why does the State do our program?”

**Performance Indicator** - The statistical or quantitative value that expresses the result of a performance objective.

**Performance Measure** - A narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: “The rate of women in [State] who receive early prenatal care in 19\_\_.” This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

**Performance Measurement** - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

**Performance Objectives** - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

**Population Based Services** - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

**Pregnant Woman** - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

**Preventive Services** - Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

**Primary Care** - The provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

**Process** - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

**Process Objectives** - The objectives for activities and interventions that drive the achievement of higher-level objectives.

**Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3)** - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

**Risk Factor Objectives** - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

**Risk Factors** - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

**State** - As used in this guidance, includes the 50 States and the 9 jurisdictions of the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Belau.

**State Funds (as used in Forms 2 and 3)** - The State's required matching funds (including overmatch) in any given year.

**Systems Development** - Activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

**Technical Assistance (TA)** - The process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration, and identification of core public health issues.

**Title XIX, number of infants entitled to** - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

**Title XIX, number of pregnant women entitled to** - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

**Title V, number of deliveries to pregnant women served under** - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

**Title V, number of infants enrolled under** - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

**Total MCH Funding** - All the MCH funds administered by a State OMCH 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."

## 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© 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. Sect. 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 with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

#### **CERTIFICATIONS**

##### ***1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION***

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion—Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

**2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS**

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about-
  - (1) The dangers of drug abuse in the workplace;
  - (2) The grantee's policy of maintaining a drug-free workplace,
  - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
  - (1) Abide by the terms of the statement; and
  - (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
  - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
  - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight  
Office of Management and Acquisition  
Department of Health and Human Services  
Room 517-D  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

**3. CERTIFICATION REGARDING LOBBYING**

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into.

Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code.

Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

**4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)**

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

**5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE**

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

## **5.3 OTHER SUPPORTING DOCUMENTS**

### **5.3.1 ACRONYMS USED IN THE MCH BLOCK GRANT**

AAP	American Academy of Pediatrics
AFDC	Aid for Families and Dependent Children
AHTP	Adolescent Health Transition Project
BHP	Basic Health Plan
BRFSS	Behavioral Risk Factor Surveillance System
CA	Children's Administration
CAG	Community Advisory Group
CAH/CP	Child and Adolescent Health/CHILD Profile
CAHMI	Child and Adolescent Health Measures
CDR	Child Death Review
CEC	Critical Elements of Care
CFH	Community and Family Health
CHC	Community Health Clinic
CHRMC	Children's Hospital and Regional Medical Center
CISS	Community Integrated Service Systems
CPS	Child Protective Services
CSHCN	Children with Special Health Care Needs
CSO	Community Service Office
CWP	Community Wellness and Prevention
DASA	Division of Alcohol and Substance Abuse
DCTED	Department of Community Trade and Economic Development
DDS	Disability Determination Service
DOH	Department of Health
DSHS	Department of Social and Health Services
DVR	Division of Vocational Rehabilitation
ECEAP	Early Child Education Assistance Program
EHDDI	Early Hearing Loss Detection, Diagnosis and Intervention
EPSDT	Early Periodic Screening Diagnosis and Treatment
EQRO	Medicaid External Quality Review Organization

ESD	Educational Service Districts/Employment Security Department
FACCT	Foundation for Accountability
FAE	Fetal Alcohol Exposure
FAS	Fetal Alcohol Syndrome
FAS-IAG	FAS Interagency Workgroup
FPC	Family Policy Council
FPL	Federal Poverty Level
FPRH	Family Planning and Reproductive Health Office
HCA	Health Care Authority
HCCW	Healthy Child Care Washington
HCFA	Health Care Financing Administration
HIV	Human Immunodeficiency Virus
HMHB	Healthy Mothers Healthy Babies
HRSA	Health Resources and Services Administration
HSQA	Health Systems Quality Assurance
IDEA	Individuals with Disabilities Education Act
IDRH	Infectious Disease and Reproductive Health Office
IPP	Injury Prevention Program
ITEIP	Infant Toddler Early Intervention Program
KABB	Knowledge Attitudes Beliefs and Behavior
LHJ	Local Health Jurisdiction
MAA	Medical Assistance Administration
MBCH	Mary Bridge Children's Hospital
MCM	Maternity Case Management
MCWG	Multi-Cultural Work Group
MIH	Maternal and Infant Health
MSS	Maternity Support Services
MVET	Motor Vehicle Excise Tax
OMCH	Office of Maternal and Child Health
OMPRO	External Quality Review Steering Committee
OSPI	Office of Superintendent of Public Instruction
PAC	Perinatal Advisory Committee
PHN	Public Health Nurses
PPADV	Perinatal Partnership Against Domestic Violence

PRAMS	Pregnancy Risk Assessment Monitoring System
QuiCC-R	Questionnaire for Identifying Childhood Chronic Conditions-Reduced
SCHIP	State Children's Health Insurance Plan
SLAITS	State and Local Area Integrated Telephone Survey
SPRANS	Special Projects of Regional and National Significance
SSA	Social Security Administration
SSDI	State Systems Development Initiative
SSI	Supplemental Security Income
TANF	Temporary Assistance to Needy Families
TPCP	Tobacco Prevention and Control Program
TPP	Teen Pregnancy Prevention
UW	University of Washington
VFC	Vaccines for Children
WSAC	Washington State Association of Counties
WSALPHO	Washington State Association of Local Public Health Officers
WSCADV	Washington State Coalition Against Domestic Violence
WSFN	Washington State Fathers Network
WTSC	Washington Traffic Safety Commission
YRBS	Youth Risk Behavior Survey

#### **5.4 FORMS**

#### **5.5 NATIONAL "CORE" PERFORMANCE MEASURE DETAIL SHEETS**

#### **5.6 STATE "NEGOTIATED" PERFORMANCE MEASURE DETAIL SHEETS**

#### **5.7 OUTCOME MEASURE DETAIL SHEETS**