

STATE TITLE V BLOCK GRANT NARRATIVE

STATE: **PR**

APPLICATION YEAR: **2005**

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I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

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

B. FACE SHEET

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

C. ASSURANCES AND CERTIFICATIONS

/2004/ By signing the SF424 Form and submitting the Title V Block Grant (BG) Application for 2003-2004, the Puerto Rico Department of Health (PRDoH) is committed to comply with all requirements established by OBRA'89 (PL 104-193, 1996). Funds allotted to PR will only be used for addressing the identified needs of women in their reproductive age, their infants, children and adolescents, including those with special needs and their families; and for the proper management and implementation of the action plan as described in the application. The allotted funds will be fairly distributed across all geographical areas for the different MCH population groups in accordance to the mandate (30-30-10).

Under any circumstance the Title V Block Grant funds will be used for construction or the purchase of land.

We will comply with all applicable requirements of other federal laws, executive orders, regulations and policies governing this program.

The undersigned agrees that the PRDoH will comply with the Public Health Service terms and conditions if the grant is awarded as a result of the submitted application.

Additionally, we certify that services will be rendered in a smoke-free environment, to provide a drug-free workplace in accordance with 45 CFR Part 76, and to comply with the prohibition of using federal funds to support any activity regarding lobbying or its appearance to. //2004//

/2005/ The PR Department of Health reiterates all its commitments stated above.//2005//

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

/2005/ Public input was requested through advertisements in two newspapers of wide circulation: "El Nuevo Dia" and "El Vocero". The draft of the 2004-2005 Application was available for review and input of the general public on June 8-9, 2004 in Aguadilla, Bayamon, Caguas, Ponce and San Juan. Given past experiences regarding the scarce response of interested individuals to come review the application and provide their input, other strategies were used toward compliance with this Title V requirement. These strategies were the following: 1) input was obtained from meetings with the MCH Advisory Committee (Healthy Start Consortium) and participation in many interagency committees and coalitions where MCH issues are raised; 2) meetings of the Regional Working Groups of the SSDI project; 3) input obtained from regional meetings of Healthy Start participants.

In addition to the above listed activities, a summary was developed of the vision, mission, goal, priorities, services according to the MCH pyramid, description of the MCH outcomes and a graph depicting its trends up to 2003. A table with Spanish translation of the 18 National and the 9 State negotiated performance measures accompanied this summary. The table had space to provide one concrete recommendation for an activity that could be implemented during the coming year to promote the achievement of the performance measures. This exercise was conducted at the May meeting with Regional MCH Staff (N=26) and the June Consortium Meeting (N=11). Recommendations collected through this exercise were reviewed and integrated into the action plan for FY 2004-2005. //2005//

II. NEEDS ASSESSMENT

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

III. STATE OVERVIEW

A. OVERVIEW

Geography and Population Characteristics

Geography: Puerto Rico is a Caribbean island, the smallest of the Greater Antilles. It is located between latitudes 17' 50' and 18'30'; and longitudes 65' 13' and 67' 50'. The climate of the Island is a tropical maritime one, with an average high temperature of 86F and a low average temperature of 66.9F. The Atlantic Ocean borders the north of Puerto Rico and the Caribbean Sea borders the South Coast. The island of Puerto Rico is 100 miles long and 35 miles wide for an approximate area of 3,500 square miles.

Towards the east of Puerto Rico, across the sea, there are two small islands that belong to Puerto Rico, Vieques and Culebra. The population of these two islands travels to and from the islands in boats or small planes in order to access secondary, and tertiary health care as well as other human services.

The Dominican Republic, another of the Greater Antilles islands, is located west of Puerto Rico. Our proximity allows for mutual tourism and the sharing of economic and cultural resources. However, it also allows the entry of a significant number of illegal immigrants affecting our health care systems as well as our health indicators.

Geographically, the Island is divided in 78 jurisdictions known as municipalities, each headed by a mayor who is elected every four years. The largest municipalities in Puerto Rico are San Juan, the capital; Bayamon, Carolina, Caguas, Arecibo, Mayaguez and Ponce.

Population: Puerto Rico is one of the most densely populated areas of the world. According to the 1990 Census Bureau, the total population of the Island was 3,522,037. This represents a population density of 1,025 inhabitants per square mile. Over 71% of the population resides in the urban areas, where an overwhelming concentration of people reaching figures as high as 9,314 persons per square mile are found.

More than 37% of the population was comprised of children and adolescents; over 44% were under 24 years of age; 23.5% represented women of childbearing age (WCBA, 14-44 years). The male to female ratio was 94:100; the average number of persons per family was 3.7. Twenty-three percent of all households were headed by single women; and 51% of all female householders with no husband present, lived with children under 18 years of age.

The estimated population trends indicate that the population will increase close to twenty percent (18.6%) from 1990-2025. It also shows a decrease in the proportion of age groups under 24 and an increase in the proportion of persons over 60 years of age.

/2002/ According to the Census Bureau the total population in Puerto Rico was 3,808,610 inhabitants in 2000. This figure represents an increase of 7.5% as compared to 1990. Nearly fifty-two percent (51.9%) of the population was comprised of females and 48.1% of males. The segment of children and adolescents between 0-19 years of age represented 32% of the total. The MCH population comprised by children and adolescents (0-19 years) and women 20-44 years of age surpassed fifty percent (50.5%) of the total population in the Island. On the other hand, the proportion of persons over 65 years of age reached 11.2% (425,137). The median age was 32.1 years, compared to 28.4 in 1990. The average family size was 3.1 persons. The population of female householders with no husband present was 21.3% compared to 23% in 1990. Among this group, 49% (131,854) of them had children less than 18 years of age under their custody.

/2003/Profile of Economic Characteristics for Puerto Rico: 2000 Census (El Nuevo Dia, June 5, 2002).

According to the 2000 Census, the economic profile of individuals and families significantly improved

during the last decade. The level of poverty declined from 58.9% to 48.2%, and the number of families under the poverty threshold leveled off from 55.3% to 44.6%.

The per capita income increased from \$4,177 to \$6,809 (63%). The mean income by household increased from \$8,695 to \$11,989 (34.9%) and the individual mean income grew from \$5,721 to \$10,403; an increase of 81.8%.

A variable not investigated in 1990 is one related with grandparents living with children under 18 years of age. A total of 133,881 grandparents lived in the same household with children under 18 years old. Among these, 52.5% were the main provider for their grandchildren. This situation should be studied in order to understand the reasons and the implications for children and grandparents.

Race and Ethnicity: It is important to highlight that Puerto Ricans are not classified by race. The most significant ethnic groups residing on the Island are Dominicans and Cubans. Most Dominicans are concentrated in the metropolitan areas close to San Juan. A significant number of Dominicans are undocumented. In 1998, the U.S. Immigration Agency reported 7,540 new lawful permanent residents' aliens and approximately 37,700 illegal residents in the Island. Puerto Ricans, Dominicans and Cubans have a Hispanic background. Spanish is the official language of the Government of Puerto Rico. In addition, a significant proportion of Puerto Ricans can also communicate in English quite well.

/2002/ The 2000 Census revealed the following ethnic composition in PR: 95.1% Puerto Ricans, 0.5% Cubans, 0.3% Mexican and 2.8% other Hispanic or Latino. Only 0.2% were Asian, Native Hawaiian and other Pacific Islander. Interestingly, according to the Census, 84 percent of the population residing in the Island was White, 10.9% Black and 9.6% some other race.

/2003/ No significant changes in the ethnic composition of the population were identified during the last year.

/2004/ No major changes regarding the information previously discussed.//2004//

Education: According to the Census Bureau the illiteracy rate was close to 10% in 1990. This is unexplainable when we consider the wealth of the public and private education systems available in Puerto Rico.

Currently, there are 1,547 public schools with 613,083 active students (1999-00). The higher education system consists of the University of Puerto Rico located in Rio Piedras, a San Juan area; and its regional colleges located in Arecibo, Bayamon, Carolina, Cayey, Humacao, Mayaguez and Ponce. Its Medical Sciences Campus includes the Puerto Rico School of Medicine and the School of Public Health located within the complex of the Puerto Rico Medical Center.

/2002/ In FY 2000-2001, the population of students in the public sector decreased to 612,024 (<0.2%), compared to 613,083 in the previous year.

/2003/ During FY 2001-2002, the number of students enrolled in the public system was 604,093. This figure is 1.5% lower compared to FY 1999-2000. Similarly, the number of schools decreased from 1,547 to 1,537 during the same time period.

/2004/ The number of students continues its downward trend. In 2002-2003, the number of students decreased to 596,502 (-1.3%).//2004//

/2005/ In 1999-2000, the number of students in the public system was 613,083 in comparison with 585,022 registered in 2003-2004 (<25,061). This represents a decrease of 4.6%. //2005//

Parallel to the public education system is the private education sector. It also provides elementary, high school and college education. More than 55 institutions of higher education had been established in Puerto Rico since 1980. These include three (3) private schools of medicine located in Bayamon,

Caguas and Ponce.

/2002/ The private education system serves around 184,000 students from K-12th grade.

/2003/ The number of students enrolled in the private system dropped from 184,000 to 140,443, or 24 percent.

However, data from 1998 reflects that the number of women who achieved less than high school education at the time of delivery amounted to 17,057 (28.2%), compared with 21,009 (31.3%) in 1995. In spite of the 18.8% decrease, it continues to be a significant number of women with poor educational attainment that places them at social and economic disadvantages. It has been found that women with less formal education have higher smoking and substance abuse rates, thus contributing to increased infant morbidity and mortality rates.

/2002/ Hopefully, the percentage of women with less than high school education in 1999 continued its decreasing trend. Only 27% of women who had a live birth had not graduated from high school.

/2003/ Overall, of women who had a live birth in 2000, 25.7% (15,298) had not attained a high school diploma. Among these, 24 had never gone to school.

Income and Poverty: According to the 1990 Census, 58.9% of the population, 66% of children under 5-17 years and 55.5% of all families lived below the poverty line. On the other hand, in 68 of the 78 municipalities, 50% of the population lived below the poverty level. The per capita income was \$4,177 in 1990. The per capita personal income increased to \$9,930 by 1999 but, it is still under the U.S. and the Mississippi averages. The unemployment rate in February 2000 was 10.5, in contrast to 3.9% in the U.S. (April 2000, El Nuevo Dia). Among adolescents and young adults unemployment is even higher, creating a fertile environment for criminal activities and other social problems.(Table 1)

In FY 1999, the number of beneficiaries of the Nutritional Assistance Program was 1,139,397 compared to 1,480,547 in 1992. This represents a decrease of 23%. The downward trend in the number of the beneficiaries of the Food Stamp Program would be the result of an increase in the per capita income and the effect of the implementation of the Puerto Rico Welfare Reform Act (PRWORA). However, in Puerto Rico, one out of three persons still continue enrolled in the Food Stamp program.

Another indicator that reflects the socioeconomic status is the number of individuals enrolled in the Temporary Assistance to Needy Families (TANF) program. During FY 1998-99, there were 76,146 families for a total of 150,427 individuals participating in the TANF program. Nearly 63 millions dollars (\$62,958,364) were invested in assistance for these families.

/2002/ Data provided by the Department of the Family (Puerto Rico Welfare Agency) revealed a small decline in Food Stamp participants. The proportion of families decreased 3.4% and the total participants 5%. On the other hand, the decrease in the proportion of TANF families and participants was significant; 64% and 48%, respectively.

/2003/ Puerto Rico's unemployment rate increased from 10.5% in February 2000 to 13.7% in February 2002. This represents an increase of 23.4%. However, in spite of this upward trend in the unemployment rate, there is a significant downward trend in the number of participant families and individuals of both Food Stamp and TANF programs. As of March 2002, the proportion of individuals enrolled in the Food Stamp program decreased 29.5% compared with 1992. Similarly, the number of families and individuals participant of the TANF program declined 14.4% and 24.8% respectively, during the same time period. It is unclear whether delinked individuals and families are self-sufficient or simply what we try is to be in compliance with administrative procedures required by federal mandates.

/2004/ Data provided by the Department of the Family continue to demonstrate the downward trends

in the number of families and individuals participants of both the Food Stamp and TANF programs.//2004//

/2005/ In 2003, the Food Stamp Program served 412,440 families and 1,003,151 individuals. On the other hand, the TANF program supported 60,587 families comprised of 95,609 individuals. This number includes 19,383 (20.3%) children. It is important to underscore that the number of families and participants of both programs continued its downward trend. //2005//

Private Sector Resources: Significant improvements have been made in the economic conditions since the late 1940's. In the early 1990's, manufacturing was the leading economic activity. Other important sources of income are government, commerce, and tourism. Among the major manufactures are pharmaceuticals, industrial machinery, printed materials, rubber and plastics, metal items, precision instruments, timepieces, footwear and alcoholic beverages. Agriculture is another source of income. The most valuable crop is coffee, followed by vegetables, bananas, plantains, pineapples and other tropical fruits. Dairy products, poultry, beef cattle and calves are also important sources of income. The warm year round climate in Puerto Rico and its abundant sunshine and beautiful beaches promote the tourism toward this precious Island.

Vital Events (1998)

Births: Figure 1 summarizes the vital events in Puerto Rico as reported in the latest vital statistics report of 1998. The estimated population was 3,833,482 inhabitants.

A total of 60,518 live births were registered; 99.8% occurred in hospitals. Very few live births (121) occurred at home or other places. The natality rate was 15.8/1000 inhabitants as compared to 18.0/1000 in 1998, a decrease in 12.2 percent. The cesarean sections rate climbed to 35.1 percent.

Marriages and Divorces: The rate of marriages was 9.3/1000 and divorces occurred at a rate of 5.2/1000 inhabitants. The divorce rate showed an increase of 5.8% as compared with 1995 data (4.9/1000).

General Mortality: Total deaths amounted to 29,990, a rate of 7.8/1000 persons. The leading causes of death occurred in the following order: (1) Heart Disease (20.1%); (2) Cancer (16.5%); (3) Diabetes (7.7%); (4) Cardiovascular (4.7%); (5) Hypertensive Disease (4.7%); (6) All Accidents (4.6%); (7) Obstructive Pulmonary Disease (4.6%); (8) Pneumonia and Influenza (4.4%); (9) Homicides (2.7%); and (10) Liver Diseases and Cirrhosis (2.2%). It is important to underscore that AIDS moved from rank number 6 in 1995 to the 12th position in 1998.

/2002/ Figure 1 was updated with data from 1999. In 1999, nine (9) of the 10 leading causes of death were similar to 1998. The most significant change occurred with nephritis/nephrosis and homicides. Nephritis/nephrosis changed from position number 14 in 1998 to position number 9 in 1999. On the other hand, homicide moved from position number 9 in 1998 to position number 12 in 1999.

/2003/ Figure 1 was updated with data from 2000. In 2000, a total of 59,460 live births were registered representing a decline of 1.7% compared with 1998. The crude natality rate was 15.6 per 1,000 inhabitants. Fortunately, after more than ten years of an increasing trend in the percentage of LBW, the proportion decreased from 11.4% to 10.8%. The first trimester admission rate remained almost unchanged and the infant mortality rate decreased from 10.6 (1999) to 9.9/1,000 live births in 2000. The percentage of teen births continued its downward trend initiated in 1998. The stillbirth rate decreased 4.5%, but the maternal mortality rate increased from 18.4 to 20.2/100,000 live births. This represents a 9% increase. The 10 leading causes of death remained the same and the first seven maintained the same order.

/2004/ In 2001, the first 10 leading causes of death remained the same and almost in the same order; except for Alzheimer's, which moved from position 11 to 9 and liver diseases from the 8th to the 10th position.

Infant Mortality: This topic will be discussed in the section of needs assessment.

B. AGENCY CAPACITY

The Health Care Delivery Environment: In just six years, the health care environment of the Government of Puerto Rico has been radically changed. The environment for delivery of maternal and child health services has been refocused as a response to the changes of the entire system of care. Therefore, an understanding of the changes that are occurring in the health system of Puerto Rico is important to providing the context of the MCH/CSHCN programs priorities and activities.

Traditionally, the health care system in Puerto Rico has been divided into two parallel systems: public and private sectors. The public sector served people of low economic resources through a regionalized health care system in which the portal of entry was the primary level. This system was responsible for addressing all health care needs for almost half of the population with scarce resources. On the other hand, the private health care system served 42% of the population who paid out of pocket or through third party payers.

After enactment of Law No. 72 on September 7, 1993, an aggressive Health Care Reform (HCR) was launched in Puerto Rico. The HCR attempts to bridge the gaps in services between the public and private sectors. At the same time, one of its goals was to privatize the public health care systems through renting or selling its facilities. In addition, the Department of Health established its core functions of public health following the recommendations of the Association of State and Territorial Health Officials (ASTHO). The Department of Health instituted as its top priority the promotion and protection of health.

As of July 1st, 2000, the HCR was implemented in all the Island. By December 31, 1999, close to 1.8 million residents were enjoying the benefits of the government insurance plan. The second phase of the HCR includes the offering of the GIP to public employees on a voluntary basis. By July 1st, 2000, public employees were given the option to be enrolled with their dependents in the GIP at no cost to them. However, those employees who don't want the GIP will continue with their preferred health care plan as usual. Figures 2 and 3 demonstrate a shift in the proportion of Medicaid to GIP while the percentage of the population with private health insurance remains more or less the same.

The Puerto Rico's Health Care Reform introduced a new model of health care delivery to uninsured patients, aimed at providing health care to all low income residents, offering quality services and eliminating existing or potential barriers to the access of primary, secondary, tertiary and supra-tertiary health services.

The success of the Health Reform has been possible due to the extensive collaborative effort at the municipal, regional and state levels. The personal interest that the Governor of Puerto Rico has in this project, as a pediatric surgeon and public health professional, is of great importance for this endeavor. Without his enthusiastic initiative, this project would not have been possible. This collaboration provides the necessary components to ensure satisfaction among the population and demonstrates a genuine effort on behalf of the current administration to improve the quality of life of our citizens.

An expanded coverage of health care services was one of the most significant accomplishments of our Health Care Reform. It includes the following services: Preventive Ambulatory Services, Surgical, Hospitalization, Maternity, Mental Health, Prescription Drug Services, Dental, Emergency Room, General and Drug Rehabilitation, Ambulance (Ground and Air), Laboratory testing, X-Rays and Catastrophic Coverage including AIDS, TB, Cardiovascular, Cancer, Neonatal and Intensive Care,

among others.

This new approach of expanded health services complies with the basic principles of the Health Care Reform, which are to:

1. Eliminate the public and private sector disparity and discrimination in health care;
2. Guarantee access to quality health care to all residents;
3. Have freedom for selection of a primary health care provider;
4. Increase the efficiency and productivity of the health care industry through a competitive mechanism;
5. Improve the quality of services;
6. Modify the role of the Government in the areas of health promotion and disease prevention; since participants have the option of selecting the health care site and provider, these principles enhance and guarantee universal access to adequate health care services.

Who benefits from the Government Insurance Plan (GIP)?

- * Medicaid Beneficiaries
- * Veterans (Non service connected)
- * Medicare Beneficiaries (Part A and B)
- * Police Officers and their families
- * Public Employees and their direct dependents

An important strategy of the Health Care Reform is the transfer to the private sector of the diagnostic and treatment centers (DTC's) and the public hospitals. The first step of the privatization process was the leasing of the public health facilities located in the areas where the Health Care Reform had been implemented. After a request for proposal and its comprehensive evaluation, a contract is signed between the renter and the Government.

As the health facilities are privatized, physical improvements are made. The scope of the quality of services is a top priority for privatizers. A visit to these facilities demonstrates that the privatization process has benefited all parties involved. Health services that were not provided prior to the implementation of the health care reform are now possible through the privatizers. Another aftermath of the privatization process is the decrease of the bureaucracy processes.

The second step of the privatization process is the sale of the public health facilities. The Government had to amend or legislate, as for example, State Law 31, which expedites and facilitates the sale of the government owned DTC's and hospitals. The facilities are now sold to private for profit and non-profit organizations. The first request for proposals was announced in May 1997. As of June 2000, the Department of Health had sold 50 health facilities, including 8 hospitals. There are still 10 other facilities rented or administered by the Department of Health.

In order to comply with the core functions of the Department of Health, the categorical programs coordinate efforts with the private sector. These providers are seen as partners in the Health Care Reform and we are very pleased with the ongoing progress of these coordinated efforts.

One of the indicators that can be used to demonstrate the success of the Health Care Reform is the annual cost per patient. Until 1992, this index had shown a dramatic increase. From 1985 to 1992, it increased over 250%. After 1993, it has been consistently decreasing year after year.

Another indicator of the Health Care Reform success has been a marked increase in the availability of health care providers. For example, before the Health Care Reform, 1,147 physicians served the medically indigent population residing in the Health Reform areas. This number increased to 4,644, which represents a growth over 400 percent. A similar trend is observed in other groups of health care providers and in primary care centers, pharmacies, laboratories, and hospitals, among others. (Table 2)

An additional important strategy is the transformation of the Department of Health from a disease-oriented agency to one that encourages health promotion and protection programs and primary, secondary and tertiary prevention programs within the context of a comprehensive continuum of public health services.

Studies and surveys conducted by our agency and the "Administracion de Seguros de Salud de Puerto Rico" (ASES) or the Puerto Rico Health Insurance Administration, show a high percentage of satisfaction among the clientele. Close to nine out of 10 (87.8%) of those interviewed reported being satisfied with the new service system. This finding has encouraged all of us, because it is the best index of the success of HCR as a social justice project. (See Figure 4)

Among the reasons given by beneficiaries to preferring the new system in contrast to the traditional system are:

1. The Government Insurance Plan (GIP) is better than the services we had before.
2. The availability of more and better services.
3. There is more accessibility to medications and better pharmacy services.
4. There is better attention at the health service centers.
5. Services are free or require low co-payment.

/2002/ During the last fiscal year, the HCR has not suffered major changes. However, the new administration is in the process of evaluating this initiative aimed at identifying its weaknesses and to take action accordingly. One of the new policies is to stop selling public health facilities.

/2003/ The new Administration has been evaluating the implementation of the HCR. Currently, some concrete changes in the implementation process have been established and others are being considered to be introduced in a near future.

Among the changes already established are:

- * Enactment of Law Num. 194, August 2000. This law requires the establishment of an agency to advocate for the rights of patients holding the GIP.
- * Enactment of Law 408 of 2000. The PRDH is retaking the primary responsibility for the provision and coordination of mental health services for the population enrolled in the GIP.
- * Pilot project for the implementation of the Intelligent Card. This is an electronic card which contains sociodemographic data, relevant information regarding the health history of the patient, medications and other information.
- * Establishment of 14 Clinical Guidelines including Perinatal Services, EPSDT, Guidelines for the management of pediatric patients with asthma and diabetes.
- * The Department of Health will be the primary provider for immunization services after June 2002.
- * Increase the length of the contract between ASES and the Health Insurance Company to at least 3 years. The three health insurance companies that will be providing the services for the population with the GIP are MCS, Triple S and Humana.

Other changes under consideration are to: 1) Readjust the HCR areas to traditional Health Insurance regions; and 2) Contract directly with HMO providers.

/2004/ No significant changes have occurred regarding the implementation of the HCR during the last fiscal year. //2004//

/2005/ In July 19, 2002, Law No. 105 empowered PRHIA to conduct demonstration projects of contracting directly with providers, without intermediaries such as managed care

organizations. The Demonstration Project began operations on July 1, 2003 with Alianza de Medicos del Sureste, Inc. (AMSE) as a sole provider assuming risks under the basic coverage. A second contract was negotiated with the Family Medicine Group on March 1, 2004. For this second group the Division of Education and Social Communication of the Secretariat for Health Promotion of the Department of Health provides prevention and education services under contract.

The PRHIA is also implementing what is called the "intelligent card", a pocket size card with a microchip that stores the subscriber's medical history including: personal data, diagnosis and medications, last five physician, hospital and emergency room visits, immunization history and more. As of April 2004 a total of sixteen thousand intelligent cards (16,000) have been distributed in the municipalities of Bayamon (4,000), Isabela (7,000) and Vieques (5,000). This is an initiative toward better access and quality of services since it offers electronic retrieval of all the necessary medical information to providers. The 1.6 million health care reform patients in Puerto Rico will eventually have an intelligent card. //2005//

State Health Agency's Current Priorities or Initiatives: In addition to the GIP, which is mainly implemented by ASES, and as a result of the HCR, the Department of Health has modified its role and approaches in pursuing the optimal health of the population. The Department of Health has been emphasizing in the core functions of public health that include needs assessment, policy development and assurance. It has also modified its role of a disease-oriented agency towards one of health promotion, disease prevention and health protection of the population at large.

A Strategic Action Plan has been developed which is divided into three major phases: planning, implementation and evaluation. A variety of initiatives or programs have already been implemented to address the health needs of the population at large or to segments of the population with special needs. These initiatives include, but are not limited to:

* The Healthy Community Program ("Programa de Municipios Saludables") - The mission of this program is to raise the health status of the diverse population groups residing in each of the municipalities. The strategy to develop this concept and reach its goal involves a comprehensive assessment of the needs and capacities of the community. Challenges and opportunities to improve the health of the community are identified. Beginning with the Mayor of the municipality, all community leaders are brought to the table to design a concerted action plan to address identified health needs. Currently, the Healthy Community program has been implemented in 10 municipalities. In each of these Healthy Communities several health promotion and disease prevention programs are implemented responding to its specific identified needs and the available resources. Among these programs we can mention the Chronic Disease Prevention Program, called Carmen Project (Conjunto de Acciones para Reducir la Mortalidad por Enfermedades No Transmisibles), the Wellness Center, the Diabetes Mellitus program, From Neighbor to Neighbor, Trip to the Supermarket, etc. /2002/ As a result of an evaluation performed by the present administration, the 10 municipalities were reduced to five, because these were the only ones that had really initiated the planning or development phase. Due to multiple psychosocial problems related to the health status of women in their reproductive age, children and adolescents, this program will develop and strengthen community-based strategies, integrating all programs of the Secretariat for Health Promotion and Protection. Community health workers will be trained for this ambitious initiative.

* Two new assessment studies used to determine prevention strategies are:

- The Behavioral Risk Factors Survey, which is a national CDC-sponsored cross-sectional yearly study designed to identify health trends, lifestyles and behaviors among Puerto Ricans. Four questions addressed to identifying asthma morbidity were added this year.
- The HIV Prevention Needs Assessment, an Islandwide study of a large sample of high-risk populations. The purpose of the study is to identify the health needs of these groups. The results are used to design custom-made HIV/AIDS/STD primary and secondary prevention programs.

* The Basic Sample Survey -This is an annual representative probabilistic survey of approximately

3,000 personal interviews that looks for sociodemographic characteristics, service utilization, prevalence of health conditions and the reasons for work absenteeism, including hospitalization and ambulatory conditions.

/2004/ This survey provides information by municipality. //2004//

* The Distance Learning (An Interactive Education program) - To educate and train private and public health professionals through nine transmission centers located at regional hospitals Islandwide by means of telecommunications.

* Rape Victim Centers - The opening of four centers to assist rape victims ("Centro de Ayuda a Victimas de Violacion") and the expansion of services to assist domestic violence victims across the Island.

* The Implementation in Hospitals of the Health Policy on Breastfeeding - This policy encourages private and public hospitals to promote breastfeeding practices among their patients. A Steering Committee has been established at the state level to promote the implementation of breastfeeding. The MCH Nutrition Coordinator leads this committee. The Committee has already developed a five-year plan aimed at increasing the breastfeeding rate in Puerto Rico.

/2005/ After the retirement of the MCH Nutritionist Consultant, the Ob/Gyn was designated to lead this committee. //2005//

* Puerto Rico's Safe Kids Coalition - A multi-sectorial organization. Its goal is to reduce unintentional injuries among children and adolescents.

/2002/ This is a non-profit organization.

* The Folic Acid Campaign - A long-range collaborative campaign, which includes a broad array of organizations, private and public agencies and is aimed at decreasing the number of infants with neural tube birth defects.

* The Birth Defect Registry - It has already included the registry of NTDs and cleft lip/palate. Down Syndrome, gastroschisis, clubfoot and limb reduction defects.

/2002/ Down Syndrome, gastroschisis, clubfoot and congenital amputations have already been included into the registry.

/2004/ During the past fiscal year, the Birth Defect Registry included seven more conditions: Omphalocele, Ambiguous Genitalia, Trisomy 13, Trisomy 18, Siameses, Albinism, and Congenital Heart Disease. //2004//

/2005/ Currently, a total of 13 birth defects are monitored. These include: neural tube defects, cleft lip and palate, Down syndrome- trisomy 21, club foot, gastroschisis, limb defects, trisomy 18, trisomy 13, omphalocele, congenital heart disease, conjoined twins, ambiguous genitalia, albinism. //2005//

* The State Systems Development Initiative (SSDI) - It was launched in 1993 to facilitate the development of State level infrastructure which would, in turn, support the development of systems of care at the community level. The SSDI program is designed to complement the Title V (Maternal and Child Health Block Grant Program) and to combine the efforts with the State Maternal and Child Health (MCH) and the Children with Special Health Care Needs (CSHCN) Programs. The SSDI Program focuses on the Title V Block Grant needs assessment; and monitoring of performance, outcome measures and MCH health status indicators.

* The Healthy Start Project with its Home Visiting Program- Its goal is to reduce the infant mortality rate through a home visiting program for at risk pregnant women and children under 3 years of age. The Puerto Rico Healthy Start Project replicates the care coordination/case management model by means of trained registered nurses. In the public health arena, one of the best indicators of the health status of a country is its infant mortality rate. Our efforts have improved this indicator. A net downward trend has been reported since 1993 (Figure 5). Our goal for the Year 2000 is an infant mortality rate of

8.5/1,000 live births. It is expected that the Home Visiting program will be an essential component to achieve the stated goal.

/2005/ As a results of new requirements of Healthy Start to continue following post partum women up to 24 months after their last delivery, we have to reduce home visiting services to children up to two years of age. The capacity to enroll new pregnant women would be affected too.//2005//

/2004/ The PRDH was awarded one of the four March of Dimes Mission Investment Opportunity grants. These funds will enable the PRDH to conduct activities geared toward reducing disparities in early prenatal care related to maternal age. The Project will begin as a pilot project in ten municipalities selected on the basis of a high natality and preterm births rates in adolescents. The project will facilitate early admission to prenatal care through outreach efforts in public schools; providing serological pregnancy test free of charge and subsequently linking those who test positive with the local Medicaid, WIC, Home Visiting programs and prenatal care providers. Teens who test negative will receive information regarding preconceptive health. In addition to the efforts related to improving their health and that of their unborn child, other efforts are being undertaken in conjunction with PRAEP to establish a support system that will increase the chances they will graduate from high school.//2004//

* The Title V Evaluation and Monitoring Section - This section of the MCH Division has re-established the Infant Mortality Epidemiological Surveillance System for Puerto Rico ("SIVEMI") and the "Estudio de Salud Materno Infantil" (ESMIPR). This is a customized PRAM survey carried out by means of the resources of Title V. The Title V Evaluation and Informatics Section, in conjunction with the SSDI Project, monitors all the performance and outcome measures. In December 1999, two scientific abstracts were presented at the "Annual Maternal, Infant and Child Health Epidemiology Workshop" to document part of our efforts analyzing Puerto Rico MCH data. We were honored with the 3rd prize in the poster section.

/2002/ In December 2000, a descriptive study of C/S was presented at the Annual MCHP meeting held in Atlanta.

/2003/ The Title V Evaluation and Monitoring Section (TVEMS) has been affected because the MCH Epidemiologist left the Agency. Again we are starting with new staff that is in great need of training and technical assistance in the area of linking data from different sources. The underlying cause of this problem is that the staff of this section has been recruited through contract instead of regular positions.

/2004/ We are very delighted with the achievement reached for this section. The capacity of this section has been strengthened with the recruitment of a very well trained team of professionals which include: a Senior Epidemiologist who is a pediatrician with an MPH and MS in Epidemiology, an MS in Epidemiologist, an MS in Demography, an MS in Biostatistician and a BA in Computer Sciences. However, a concern still exists, because all this staff was recruited through irregular positions. //2004//

* The Asthma Coalition -Is an initiative based on a collaborative, multidisciplinary model including agencies, private and public organizations, universities and parents to reduce the morbimortality due to Bronchial Asthma in PR. The Pediatric Pulmonary Program is located at the PR Cardiovascular Hospital and has served around 100 children since August 1999.

/2002/ During FY 1999-00, the Pediatric Pulmonary Program (PPP) served around 300 new patients. The Asthma Coalition was incorporated as an organization comprised by public and private sectors.

/2003/ The coalition held monthly meetings and has submitted the PR Asthma state plan in collaboration with the Department of Health for the reduction of morbimortality due to asthma in PR. The coalition is specifically in charge of the educational objectives of the plan. The educational plan is targeted to physicians, health professionals, asthma patients and their families.

/2004/ An update report will be found in the Annual Report, Section IV.//2004//

/2005/ The CDC awarded the grant "Addressing Asthma from a Public Health Perspective" to the Division of Habilitative Services of the PRDoH. This allows us to develop the infrastructure with the required staff to implement the State Asthma Plan and a Surveillance System. Activities are described in Section D, State Performance Measure No. 7. The PRDoH and members of the Puerto Rico Asthma Coalition (PRAC) continued efforts for asthma awareness

through activities during the 2003 and 2004 World Asthma Day.//2005//

* The AIDS Affairs Program - The AIDS Affairs Program provides prevention and treatment to the population at large. In 1993, 2,697 AIDS cases were reported, and by 1994 this number decreased to 2,358. In 1999, 855 new cases were reported, for a decrease of 2,000 cases as compared with 1993. There is a 68% downward trend for the seven-year period. A triple therapy protocol has been possible through federal funding. (Figure 6)

A decrease in pediatric AIDS cases has been observed during the past years (Figure 7). During 1999, only one HIV+ child was born among the 83 pregnant women treated according to the protocol.

/2002/ As of May 31, 2001, the AIDS Surveillance System had registered a total of 26,045 cumulative cases. Among this figure, 395 (1.5%) were children and adolescents between 0-19 years of age.

/2003/ By December 31, 2001, the AIDS Surveillance System had registered 26,371 cumulative cases and 16,675 deaths. This figure represents 63% of all registered cases.

* The Oral Health Prevention Program - Under the Health Care Reform, oral health services are included in the benefit package. Patients are not required to obtain a referral to get oral health services. They can access oral health whenever they want and with their preferred dentist. In addition, the Assistant Secretariat for Oral Health has a very active prevention program throughout the Island. Preventive encounters show an increasing tendency since 1994, except in 1999 as a result of Hurricane Georges.

/2002/ Currently, the Assistant Secretariat for Oral Health is no longer a Secretariat. It became an Office within the Secretariat for Health Promotion and Protection.

* The Immunization Program - The Puerto Rico Government established compliance with the Hepatitis B vaccination as a requirement for school admission, for those born from 1991 on, and those who are 13 years of age. By 2000, all adolescents from 13 to 18 must be immunized against Hepatitis B. Puerto Rico has achieved an immunization rate of 93.7% in children through 2 years (2000). Puerto Rico has been the jurisdiction with the highest percent of immunized children in the nation for three consecutive years. (Figure 8)

* /2002/ Universal Newborn Hearing Screening-The proposal for the implementation of the UNHS program was approved and funded. An Advisory Committee is in the process of implementing a strategic plan for a four year period.

/2005/ A legislative mandate (Law #311) for newborn hearing screening is in place since December 19, 2003. Coverage for screening and audiological diagnostic testing is required for all health insurance plans in Puerto Rico. //2005//

* /2002/ Medical Home -A CIS/COG Grant was approved; the AAP provided an initial technical assistance for the training of primary physicians in the medical home concept.

/2005/ The ECCS grant approved in 2003 includes among its activities a need assessment of the services available for the 0-5 years old population at each municipality. //2005//

* /2002/ PININES -An instrument was designed with the collaboration of the Medicaid program to identify CSHCN, at the time of certification for Medicaid. This is an alternative to the SLAITS, since Puerto Rico was left out of the survey. Since March 2000, a total of 8,783 children have been identified through PININES. Asthma is the most prevalent condition.

/2003/ Collaboration with Medicaid for the identification of CSHCN continues.

/2004/ Collaboration with Medicaid continues. Since March 2000, a total of 15,328 CSHCN have been identified through PININES. Asthma is the most prevalent condition. //2004//

/2005/ Since March 2000, a total of 449,012 children 0-21 years old have been certified as eligible for the Government Insurance Plan. Of the total certified, 14,186 children were identified as children with special health care needs. Asthma was the most prevalent condition (54.5%). //2005//

The evaluation process is a continuous cyclic activity that starts with the planning, development and implementation. This will allow us to assess the immediate impact and the long-term effects in

improving the health of the population at large through the different programs previously described.

The Welfare Reform: Concerning the impact of the welfare reform, it is expected that this will not negatively affect the unique initiative of HCR that is being implemented in Puerto Rico. Even with the cap imposed by the federal government to the allocation of the Medicaid program of Puerto Rico, it was planned that by Year 2000 all municipalities will be in the Reform. This goal was achieved by July 1st, 2000. Over 80% of the funds used to cover the government insurance plan for eligible clients come from the partnership among state and local municipalities.

Puerto Rico CHIP Program: The PR CHIP plan was finally approved in June 1998. Through this program, Puerto Rico receives \$9.8 million dollars during the first year and \$32 million in 1999. Based on the current premiums, this amount helps to cover about 150,000 uninsured and underinsured children, between 101-200% poverty level. Puerto Rico shall continue allocating its State funds to achieve the goal of the HCR aimed at assuring a health insurance plan to all residents in the Island irrespective of their age.

Current MCH Priorities and Initiatives: As already described, in 1994, the Government of Puerto Rico began implementing an aggressive HCR, under which the public service delivery system is being incrementally privatized in all the island's health regions. Under the reformed system, responsibility for providing personal health services to low income and underinsured populations is being transferred from the public to the private sector and all care is delivered through managed care service delivery models. The Reform was first implemented in the sub-region of Fajardo and moved very quickly to other areas. Currently, the HCR has been implemented Islandwide.

The reformed system replaced an extensive public health infrastructure that traditionally served low income and uninsured residents of Puerto Rico. The PRDH historically functioned as the predominant provider of personal health services for these populations, operating an extensive network of primary care diagnostic and treatment centers (86) and hospitals (9) reaching all corners of the Island.

The PRDH has delegated the provision of direct care services to the private sector, through contracts with health insurers, while maintaining the non-delegable core functions of public health. These functions include needs assessment, policy development, assurance and training of health professionals. The Department of Health has also retained the administration of certain federal programs and special services such as the WIC program, Medicaid, services for persons with AIDS and the MCH program, among others.

Considering the above context and the mandates of Title V, the MCH role was refocused to assure, at this time of transition, that the most vulnerable population does not fall through the cracks of the evolving system. The MCH struggles to enable women, infants, children, adolescents and CSHCN to receive high quality and comprehensive services across a system that is now more complicated. Responding to this need, a new program was designed and is being incrementally established in municipalities under the HCR. This is the Home Visiting Program that serves pregnant women and children less than 3 years of age with multiple social and health risk factors.

Early intervention services for children with developmental delays from zero to 3 years of age continue to be provided directly by the Department of Health. The child count on December 1999 accounts for a total of 2,978 infants and toddlers served, representing approximately 1.6% of the population 0 to 3 years of age. The Pediatric Centers located in each of the seven (7) health regions continue to provide direct specialized services to the special needs population. In December 1999 the Department of Health initiated a contract with Health Care Consulting Services, an external accounting firm, aimed to oversee the billing of the Pediatric Centers to the insurance companies, including those under the HCR. Reimbursement from the private sector for services rendered that are included in the benefits package of the government insurance plan (GIP) are used to support and complement services not provided by the GIP.

/2005/ The child count for the Early Intervention System (Avanzando Juntos) as of December 1, 2002 comes to a total of 2,778 infants and toddlers, representing approximately 1.66% of the 0

to 3 years population islandwide. An Annual Performance Report and Improvement Plan to increase this number to 2.0% by next year was submitted on April 2004. //2005//

The MCH program has an Advisory Board, which is a multi disciplinary and intersectorial group of professionals and representatives of the MCH population. They are very committed and knowledgeable of MCH issues. The Advisory Board has been a fundamental piece in providing input regarding new priorities and strategies to address the needs of the MCH population within the emerging new HCR environment. Most of their recommended strategies are considered in the action plan aimed at improving the health and well being of the MCH population, including CSHCN.

C. ORGANIZATIONAL STRUCTURE

The Department of Health of Puerto Rico (DHPR) is the umbrella agency assigned in Article IV, Section 6 of the Constitution of the Government of PR responsible for all matters pertaining to public health, with the exception of maritime quarantine. The Secretary of Health is appointed by the Governor of Puerto Rico and confirmed by the legislature. The Department of Health organizational chart is included in Appendix 1.

The Administrative Order No. 99, signed by the Secretary of Health on July 28, 1995, determines the current organizational structure of the agency (Appendix 1). It comprises 7 secretariats, 14 offices, 3 programs and administrations, the General Council of Health and the Corporation of the Cardiovascular Center of PR and the Caribbean, all responding directly to the Secretary of Health, as well as three offices which respond to the Sub-Secretary of Health.

A. Secretariats:

1. Secretariat for Auxiliary Services
2. Secretariat for Planning, Evaluation, Vital Statistics and Information Systems
3. Secretariat for Health Promotion and Protection
4. Secretariat for Regulation and Certification of Health Facilities
5. Secretariat of Nursing Affairs
6. Secretariat of Environmental Health
7. Secretariat of Oral Health

/2002/ The Secretariat of Oral Health is now an Office under the Secretariat for Health Promotion and Protection.

B. Offices and Programs

1. Office of the Secretary of Health
2. Office of Legal Affairs
3. Office of Federal Affairs
4. Communications Office
5. Office of Special Projects
6. Office of Human Resources
7. Office of Internal Audit
8. Fiscal Affairs Office
9. Medicaid Program
10. Correctional Health Program
11. Demographic Registry
12. Laboratory Institute
13. Congress of Quality of Life
14. WIC Program

/2002/ The Congress of Quality of Life was relocated into the infrastructure of the Secretariat for Health Promotion and Protection.

C. Independent Administrations Created by Law

1. Health Services Facilities Administration: Law No. 26, November 13, 1975
2. Health Services Administration of Puerto Rico: Law No. 66, June 22, 1978. This was abolished by Law No. 187, August 7, 1998.
3. Administration of Mental Health and Anti Addiction Services: Law No. 67, August 7, 1993

D. General Health Council: Law No. 23, June 23, 1976

E. Corporation of the Cardiovascular Center of PR and the Caribbean: Law No. 51, June 30, 1986.

In addition to the components listed above there are three other offices under the direction of the Sub-Secretary of Health. These are the following:

1. Office of the Sub Secretary of Health
2. Health Professional's Education Office
3. Office for Regulation and Certification of Health Professionals

The Department has two main functions: Normative and Administrative or Operational. The normative function is performed by Secretariats, Offices and Programs, which respond to the Secretary of Health. The Health Services Facilities Administration ("AFASS") established by Law in 1975 was abolished in August 1998. Presently, the Department of Health, through its Secretariats and categorical programs, assumes the operational function also.

The Puerto Rico Department of Health provides a three-level regionalized system of health services. The Department divides the 78 municipalities of the island of Puerto Rico into six Health Regions: Arecibo, Bayamon, Caguas, Mayaguez, Metropolitan and Ponce, and three Sub-Regions: Aguadilla, Fajardo and Humacao (Figure 9). The MCH program agreed to consider the municipality of San Juan as a health region for resources allocation purposes. Each health region has a Regional Director. This regionalized health system provides a common framework for the coordination of a full spectrum of comprehensive care for the Maternal and Child population including CSHCN.

Puerto Rico's Title V program is administered by the Assistant Secretariat for Health Promotion and Protection (ASHPP). The Secretariat is also responsible for conducting needs assessment, developing policy, ensuring quality, and coordinating health services for women of reproductive age and children, including children with special health care needs (CSHCN). Within each of Puerto Rico's health regions, a Regional Medical Director is responsible for the implementation and supervision of the different programs. At the regional level, the MCH program has MCH Regional Directors and Coordinators. This staff is under the supervision of the Regional Medical Director administratively and to the state level in the normative function. CSHCN services are provided through seven pediatric centers or satellite units, one rehabilitative hospital, the specialty clinics at the University Hospital, and 7 immunology centers for AIDS patients. The administration of Title V allotments as well as other federal programs is supported by several of the components of the Department of Health. Among these it is important to highlight the role of the Budget Office, Office of Federal Affairs and the Secretariat for Auxiliary Services.

//2004/ In 2003, the ASHPP was changed to Assistant Secretariat for the Prevention and Control of Diseases (ASPCD). The Appendix 2 depicts the new organizational structure of the ASPCD. //2004//

//2005/ The ASPCD did not suffer structural changes during the past year. //2005//

D. OTHER MCH CAPACITY

Historically, Puerto Rico's MCH program has played many different roles in serving mothers and children, including providing direct services, administering population-based programs, and assuming responsibility for core public health functions.

Before the Reform, the MCH program provided preventive primary care services for pregnant women, mothers and infants, and preventive and primary care services for children. These services were provided through a network of clinics located at DTCs/FHCs across the Island. However, as mentioned elsewhere, these services have been delegated to the network of primary providers of the health insurers.

The role of the MCH program has been refocused to the core functions of public health such as needs assessment, policy development and assurance. In addition, we also complement services not covered by the Government Insurance Plan and have developed new programs such as the Home Visiting for at risk pregnant women and children under three and an infant seat leasing program in four regional hospitals.

As described above, Puerto Rico's MCH program plays many different roles in serving mothers and children, including directly providing services, administering population-based programs, and assuming responsibility for core public health functions. Unlike many states' MCH programs, PR had assumed lead responsibility for providing primary care services to all its low-income citizens. A detailed discussion of the range of services provided by the MCH Division is presented below:

* Personal health services. Through PRDH's network of local public health clinics and hospitals and its contracts with other providers, an array of personal health services were provided to women, infants, children, and adolescents including CSHCN. Services that are provided to the MCH population include family planning, prenatal and postpartum care, high risk delivery, routine and intensive newborn care, child and adolescent health services (including the provision of Early Periodic Screening, Diagnostic, and Treatment {EPSDT} services), Comprehensive Adolescent Health program (CAHP), health education, nutrition counseling, and services provided under Puerto Rico's Special Supplemental Food Program for Women, Infants, and Children (WIC). Most of these services have been delegated to the health insurance companies and their provider network.

PRDH also provides the MCH population with access to school health, oral health, and mental health services. Under its school health program, the Department of Education contracts with other providers to complement ophthalmology, optometry, ENT, psychology, and audiology services to eligible Title I and special education children. The oral health services are very well covered through the GIP. Pregnant women with substance abuse problems receive care from primary providers in coordination with PRDH's Administration of Mental Health and Anti-Addiction Services and other private providers.

* Services to CSHCN. The CSHCN program provides services to eligible chronically ill and disabled children through its 7 pediatric centers, 1 rehabilitative hospital, specialty clinics at the University Hospital, and 7 immunology centers for AIDS patients. At these facilities, eligible children receive specialty care, rehabilitative and ancillary services, assistive technology services and devices, AIDS related services, services for hemophiliacs, children with other genetic and metabolic disorders, and mental retardation. The CSHCN program also provides care coordination services to special needs children; however, the service focuses primarily on children with developmental disabilities between the ages zero and three who are eligible for Puerto Rico's Early Intervention program. The CSHCN program has provided training to staff graduate nurses of the Pediatric Centers in a service coordination model. Other nursing personnel relocated at the Centers as a result of privatization of health facilities due to the health reform have also been trained in care coordination for CSHCN. These personnel will work in collaboration with the Home Visiting nurses and case management staff of the insurance companies under HCR to assure a comprehensive delivery of services. Through the GIP, CSHCN access primary, secondary and tertiary services. The Pediatric Centers are providers of specialized services. Title V funds complement services not covered by the HCR. Insurance companies are billed for services rendered at the Pediatric Centers and reimbursement monies revert to the Pediatric Centers. The Association of Parents of Children with Disabilities (APNI, Spanish acronym), in coordination with SSDI, assists the program to develop parents' committees in each health region in order to identify unmet needs of families and children and local resources in the communities to satisfy other needs.

/2005/ Some services such as specialized formulas for children with genetic/metabolic conditions are provided upon availability of funds./2005//

* Population-based services. The PRDoH administers a variety of population-based programs, including a newborn metabolic/genetic screening program, an immunization program, a prenatal care outreach program with access to a toll-free information line, a service directory co-sponsored by SSDI and MCH program, a folic acid campaign to reduce neural tube defects, HIV counseling and testing to prenatal patients and AZT administration to HIV positive patients on a voluntary basis. A task force has been appointed to initiate the needs assessment and the planning process for the implementation of the newborn hearing program.

/2005/ Although the incidence of neural tube defects is decreasing, the folic acid campaign activities continue and are now focused on increasing the number of women 10-50 years using the folic acid vitamin daily./2005//

* Public health functions. In addition to providing direct services to the MCH population, several divisions within PRDH are also responsible for conducting similar core public health functions for different segments of the population, including needs assessment, assurance, and policy development. For example, the MCH program within the PRDH conducts population-based needs assessment for MCH populations and develop standards of care for services provided under their programs. The DOH is responsible for developing guidelines for the providers of the HCR.

Another important achievement on this area was the development and approval by the Secretary of Health of a public policy aimed at improving the sexual and reproductive health of our population. This policy is a very comprehensive one that includes genders, family planning services, STD's including HIV/AIDS, and adolescents. During FY 2000-01, the MCH program will continue the dissemination and discussion of this public policy with concerned professionals, programs and organizations.

The CSHCN program, in collaboration with Medicaid, has established a process for the identification of the special population throughout the Island. Data include the population being served at the Pediatric Centers and the new patients identified by the primary providers of the GIP. Additionally, the Medicaid MA-2 form (the intake form) was revised by a team comprised by the CSHCN director and evaluator, the MCH Epidemiologist, Medicaid staff, ASES representatives and ODSI. This information is a useful tool in the development of an effective and efficient managed care model of service delivery. This activity will be described in more detail in the Annual Report.

/2005/ In December 2003, Law #318 was approved designating the PRDoH as responsible for developing and implementing public policy for the evaluation, management, and registry of children and adults with autism./2005//

The PR MCH program has 35 full time positions, nine more than last year (Table 3).

*/2002/*The number of full time positions was reduced to 31 during the last year. Three regional coordinators, the assistant of the epidemiologist and one secretary resigned. One pediatrician was relocated as the injury prevention coordinator.

The MCH director is a board-certified pediatrician who holds a master degree in public health. He has occupied different positions at the PRDoH for 27 years. He has been a primary health care provider, director of a pediatric residency program, director of the MCH program at regional level and holds the present position since December 1990. He was honored as the best student graduated from the MCH program at the 25th anniversary of the School of Public Health.

*/2004/*During FY 2002-2003 we were successful in filling several vacant positions at the central, regional and local levels. The Title V Evaluation and Monitoring Section was strengthened with a team of well trained professionals. The total number of positions at the central level is 33. (Table 3)

At regional levels, the position of MCH Director is vacant in Arecibo; positions of health educators are vacant in Arecibo, Caguas, Fajardo and Ponce; as well as position of adolescent health coordinators

in Bayamon and Fajardo.

In recent months we have had several resignations of Home Visiting Nurses. Currently, a total of 14 municipalities are lacking Home Visiting Nurses. Efforts are underway to recruit needed personnel at all levels. Appendix 3 depicts the current infrastructure of the MCH program.//2004//

/2005/ During FY 2003-2004, we had several resignations at the central level. These included the nutritionist and nurse coordinator (regular positions). In addition, the two epidemiologists resigned (contract positions).

At regional levels the positions of MCH Regional Directors were filled at Arecibo and Fajardo. The position of Health Educator for Fajardo was also occupied. Positions for Adolescents Health Coordinators continue vacant in Bayamon and Fajardo. A total of 10 municipalities do not have Visiting Nurses. //2005//

/2002/Financing of the support structure and services at the Pediatric Centers is given by state and other non-Title V funds. During 1999-2000, a total of 298 FTE's were available at the Pediatric Centers. Seventy of these FTE's were support staff and 228 direct service providers. Other direct services staff is also available to serve the Title V population at the 7 Pediatric Centers. One hundred and seventy-five direct service FTE's are paid by funds other than Title V.

/2003/State and other non-Title V funds are available for the Pediatric Centers to support services to CSHCN. For FY 2000-2001 a total of 337.5 FTE's were available at the centers. Of these, 95 are direct service staff and 37.5 FTE's for support staff funded exclusively by Title V. Two hundred and five additional FTE's are provided with state and Part C funds.

/2003/During the past fiscal year the original Medical Home Coordinator was appointed to another position within the DOH and was substituted in 2001 by a Health Educator with an MPH.

/2004/The CSHCN program has 20 positions at the central level (see Table 4). The CSHCN director is a pediatrician dedicated to private practice during 19 years; with an MPH degree with outstanding achievement. She is also responsible for the implementation of the Early Intervention Program in PR. The Deputy Director of the division of CSHCN holds an EMPH in Health Policy and Management.//2004//

/2005/ The Deputy Director resigned and an Executive Director assumed her responsibilities on June 2004.//2005//

/2004/ The operational level consists of 7 Pediatric Centers with a team of physicians, nurses, social workers, nutritionists, allied health professionals, secretaries, office clerks, medical records technicians, administrators, accountants, fiscal assistants, data entry and other support staff. The Division of Habilitative Services has integrated the services of an Administrator of Information System, an important component in order to obtain reliable data and establishing linkages with existing data banks related to the special population in PR. It is important to highlight that with the implementation of the HCR the administrative branch of the DOH (AFASS) was eliminated. As a consequence, the categorical programs have to provide for the program management at central and regional levels.

Financing of the support structure and services at the Pediatric Centers is given by state and other non-Title V funds. During 2001-02 we had a total of 118 FTE's available to the 7 Pediatric Centers to supplement and balance the centers needs and the Title V resources. Other direct services staff is also available to serve the Title V population at the 7 Pediatric Centers. Group contracts account for most of the specialty and subspecialty services. Seven of these contracts are paid with reimbursement funds.//2004//

/2005/ During 2002-2003 we had a total of 116 FTE's available to the 7 Pediatric Centers to supplement and balance the centers' needs and the Title V resources.//2005//

The combined efforts of the MCH staff and the Secretariat of Planning, Evaluation & Statistics and

ODSI have resulted in an increase in the number of computers at central & regional levels. (Table 5)

E. STATE AGENCY COORDINATION

The needs of the MCH population are multiple and complex. Because of this, there is no public or private agency, program, or community based organization that can satisfy all the needs of the most vulnerable population comprised of women in their reproductive age, children and adolescents. It is therefore imperative to establish appropriate coordination mechanisms among all concerned entities in order to reduce duplication and fragmentation of services and to be more efficient in the utilization of the scarce resources available.

In Puerto Rico, we have in place fairly satisfactory coordination mechanisms among several public agencies and other sectors of the community at the state, regional and local levels. These coordination mechanisms are at both formal and informal levels. The Department of Health has established formal relationships with other state public agencies, local public health agencies, academic institutions, federally qualified health centers and tertiary health care facilities. All of these formal arrangements enhance the capacity of the MCH/CSHCN programs.

This formal coordination is the outgrowth of established laws and executive orders of the Governor, which mandate specific agencies and programs to sit at the table to coordinate certain types of services for the MCH population. There are also memorandums of understanding (MOU) among agencies and programs, which enhance the coordination of services. Other formal mechanisms, which contribute to the achievement of this goal, are interagency committees, task forces and coalitions, among others. Several of the laws, executive and administrative orders and committees require the participation of consumers.

At this point, we want to highlight some of the laws, executive orders, MOU and committees that enhance coordination among all concerned entities, which serve the MCH population. The central staff of the MCH/CSHCN programs are regular members of most of these arrangements.

* Law No. 27 -Enacted on July 1992, allows health care professionals to provide prenatal care and postpartum services to minors without parental or guardian consents.

* Law No. 51- This law was enacted on June 7, 1996. It mandates the provision of comprehensive educational services to individuals up to 21 years of age who have special educational needs. The law requires the establishment of an Advisory Council. An outstanding responsibility of the Department of Health under this law is to screen all children born in PR in facilities of the DOH or privatized, for developmental delay during the first three months of age. Identified children will be referred to the Early Intervention Program (EIP) with parental consent for eligibility determination and for provision of services until age 3 years. This strategy will assist the program to increase the number of children identified and enrolled during the first year of age. From ages 3 to 21, the Department of Education is ultimately responsible for providing educational and related services and the required coordination with six other agencies.

* P.L.105-17 - Infants and Toddlers with disabilities (Part C of IDEA). On April 8, 1992, the Governor of PR signed Executive Order No. 1992-28 amending Executive Order No. 5427-A of August 14, 1989 to comply with PL. 102-119, Inter Agency Coordinating Council (ICC) requirements.

* The ICC has been organized into committees to deal with identified areas of concern in the system: Members are actively involved in transition from Part C to Part B services, developing a central directory and plans for training child care providers with concerned agencies.

* Law No. 70 - Enacted on August 1997. It mandates the Secretary of Health to establish a committee charged with the responsibility to develop studies and provide recommendations for the reduction of

infant mortality. The law requires an interagency committee including ASES, comprised of nine members under the leadership of the MCH Director.

- * Executive Order No. OE-1997-13 - Our Children First ("Nuestros Ninos Primero") under the leadership of the First Lady gathers 21 agencies and six representatives of the community. /2002/ This executive order was derogated.
- * Executive Order No. OE-1997-12 - Timely Rescue ("Rescate a Tiempo") comprised of 12 agencies. The goal is to prevent school desertion.
- * Healthy Start Consortium and Advisory Board to the MCH programs. Currently, it is comprised of about 40 members who represent public agencies including the Department of Health, academic, community based organizations, Medicaid, ASES, WIC, consumers, etc.
- * State SSDI Committee and eight Regional Working Groups - Integrated by several agencies and consumers.
- * Adolescent Task Force - Includes Mental Health, Department of Education, Community groups.
- * Interagency Network for the Prevention of Child Abuse and Neglect - Includes the Department of Justice, Police, Department of Education, Department of Health (mainly MCH staff) and others.
- * Advisory Board of the Department of Family - Includes several agencies and community organization.
- * Advisory Board of the Midwife Training Program of the School of Public Health - The MCH Director is an active member.
- * Committee of the University Affiliated Program (UAP) - Includes consumers.
- * Committee for the Promotion of Folic Acid Campaign - includes the Department of Education & Puerto Rico's chapter of March of Dimes.
- * PR Safe Kids Coalition - Includes private enterprises, the Police Department, Fire Department and many community agencies and individuals.
- * Administrative Order No. 95 - The Metropolitan Pediatric Center is integrated to the University Pediatric Hospital to maximize its administrative functions and to better serve the special needs population. Normatively, the Pediatric Center responds to the Division of Habilitative Services.
- * Advisory Council of Special Education to the Secretary of Education - The CSHCN director represents DOH.
- * State Council on Developmental Disabilities - The CSHCN director represents the Secretary of Health.
- * United Funds of PR - CSHCN director participates with other representatives of the community.
- * Administrative Order 129 - To establish regulations for training in breastfeeding through continuing education for all health professionals.
- * Law 32 -Enacted on January 10, 1999. To establish areas designed for breastfeeding and change diapers for young children in malls, government centers, ports and airports.
- * Administrative Memorandum No. 09-1993 - Which allows two hours to take children for vaccination.

- * /2002/ Law 259 -Enacted on August 31, 2000. To establish an Emergency Medical Service System for Children Program for the prevention and surveillance of pediatric emergencies. The law assigns \$100,000.00 per year for the implementation of the program. This legislation will allow the sustainability of the EMSC program granted by the federal government.
- * /2002/ Law 296 - Enacted on September 1, 2000. This law mandates a medical evaluation according to EPSDT standards for all children enrolled at day care centers, Head Start programs, and private and public schools on an annual basis.
- * /2002/ Law 427 - Enacted in December 2000. To require that working breastfeeding women be allowed 30 minutes per day to express their milk.
- * /2002/ Administrative Order 158 - To establish regulation for training in Comprehensive Adolescent Health.
- * /2003/ Administrative Order 166. In October 10, 2001, the Secretary of Health signed the new Administrative Order of the Department of Health. The Order states the vision, mission, goals and policies that will lead the Department's main functions: normative, regulator and evaluator of the health care system.
- * /2003/ The PR Asthma Coalition implemented in 2000 to reduce morbimortality due to asthma in Puerto Rico.

/2005/ On March 13, 2004, Puerto Rico enacted Law 79 aimed at prohibiting the administration of any breast milk substitute to newborns without the written consent of the mother. Any institution that violates this law will be fined. //2005//

/2005/ Law 95, enacted on April 23, 2004, prohibits discrimination against women who breastfeed in any public setting. //2005//

/2005/ Law 311 - A legislative mandate for newborn hearing screening is in place since December 19, 2003. Coverage for screening and audiological diagnostic testing is required for all health insurance plans in Puerto Rico. //2005//

/2005/ Law 318 -Approved on December 2003, designates the PRDoH as responsible for developing and implementing public policy for the evaluation, management, and registry of children and adults with autism. //2005//

/2005/ During 2004, interagency agreements with the Department of Family and the Early Head Start consortiums were revised and updated. Interagency steering committees were implemented for the UNHS and ECCS programs. //2005//

At the regional level the MCH staff participates in the following committees:

- * Regional Network for Child Abuse & Neglect, includes MCH Staff.
- * Regional SSDI working groups integrated by many programs, which serve the MCH population. These include consumers.

At local levels, the coordination is more informal, but supported by state laws and MOU's. Among the MOU we can mention the following:

- * Medicaid, WIC and MCH
- * SSDI Regional Working Groups (RWGs)
- * Regional Interagency Networks for the Prevention of Child Abuse and Neglect
- * Department of Education for Early Intervention system including transition procedures
- * The Early Intervention Program collaborating with Our Children's First Initiative for the identification

and referral of children with developmental delays.
/2002/ Our Children First Initiative was eliminated.

There are also systems in place for the coordination of perinatal services. The Healthy Start Project developed a tracking system towards this goal. Through the Visiting Nurses program the high-risk infants from birth to 3 years of age are identified and referred for evaluation to EIP.

F. HEALTH SYSTEMS CAPACITY INDICATORS

/2005/ The two main goals of the health services system are to: (1) optimize the health of all segments of the population by employing the most advanced knowledge about health and disease; and (2) minimize the disparities across population subgroups to ensure equal access to health services and the ability to achieve optimum health. (Starfield, 1992)

In 1992, Starfield developed a model for understanding systems functions and for devising approaches to measuring the performance of the health care system. The three components of the functioning of the health care system include structures (inputs), processes and outcomes (outputs). These three components are linked by a system of information necessary to provide a continuous feedback concerning the performance of the health care system. It is important to underscore that the HCS operates within the larger context which includes the social, political, economic and physical environment.

The evaluation of the health system capacity to improve the health of pregnant women, mothers and children, including CSHCN, is most appropriately measured through the analyses of health status indicators than through the use of health status goals.

Toward this aim, the Title V Guidance has identified 11 health systems indicators to be used by all States and Jurisdictions to assess the capacity of the health care system to address the needs of the MCH population. These HSCIs measure the percentage of children financed through Medicaid, CHIP or SSI who have access to specific preventive services. However, as mentioned elsewhere, the allocations of Medicaid and CHIP funds to Puerto Rico are capped. Even worse, Puerto Rico does not receive SSI monies. The amount of Medicaid funds used in Puerto Rico in 2003-2004 to purchase a health insurance plan for the low-income population represented only 13.25% of the total budget designated for this purpose. Similarly, the proportion of CHIP funds was only 2.4%.

Therefore, it will be quite difficult for us to measure the proportion of infants, children and women who receive any specific service paid by means of Medicaid or SCHIP funds. However, we are able to measure the number and proportion of infants, children and women who receive services paid by the GIP. This is understood to be a proxy of what these HSCIs intend to measure.

Adequate health care does not equate maintaining good health status; however, lack of quality health care is a significant contributing factor to poor health status of any of the segments of the population. In this regard, the PR Department of Health is the ultimate responsible for maintaining the health care system, both at the population based-infrastructure as well as individual health care services, such as preventive and primary care.

The infrastructure of the HCS of Puerto Rico includes a variety of components. These are the Department of Health, Health Insurance Administration, health carriers and their network of providers, federally funded primary care centers, community-based organizations and many others. Definitely, the components needed to serve the population are there. On the other hand, nearly 99% of children and adolescents hold a health insurance plan; either government paid or through third party payor. However, the infrastructure of the health care system alone does not have the capacity to appropriately serve the segment of the MCH population

comprised by infants, children and adolescents. This is so because in order for a system to achieve its goal, it is necessary to have clear processes (norms and regulations) and excellent data and information systems to connect and communicate each one of its components. This is the Achilles tendon of the PR Health Care System and social accountability needs to be improved in this respect.

Currently, it is possible to determine the number of children and adolescents who have a health insurance plan. But we cannot identify how many children have received appropriate preventive services through the primary preventive care system comprised by the public-private sectors resulting from the implementation of the HCR initiated in 1994.

The identification of persons disjointed from the HCS is not an easy task in the new evolving system.

Similarly, there are no mechanisms for the identification of persons who have been hospitalized during a specific time period for conditions like asthma, diabetes, suicide attempts, etc. PR does not participate in the National Hospital Discharge Surveillance.

Another problem encountered is the lack of mechanisms in place to assure that services are provided according to the current standards of care and the patient's age.

The cornerstone of the health care system is primary care. Health Systems Capacity Indicators are a useful tool to monitor the capacity of the primary care infrastructure to address the needs and maintain the health of the population.

Primary Care is described by several characteristics (Starfield). It is the point of entry into the health care system-first contact. First contact must lead to a continuous, comprehensive and well-coordinated care rendered to all individuals without discrimination of any kind.

Other important characteristics of primary care are that it should be community-based, family-centered, with the appropriate number of culturally competent providers.

Comprehensiveness requires that the facility has available a range of services needed to address the most common health problems affecting the population at the community level. It is in the area of comprehensiveness that issues related to the provision of all types of services are of concern for both physical and mental health problems, attention to acute conditions, ongoing care for individuals with special health care needs as well as the preventive services to maintain optimal health. Individuals with an identifiable source of primary care (Medical Home, PM #3) are more likely to have chronic conditions (e.g. asthma) that are well controlled than those without a regular source of care.

In PR, over 95% of the overall population holds either the GIP or private insurance paid by a third party. However, this is not translated to expedited accessibility to needed services. The HCS is quite fragmented and the capitated model of care for more than 60% of the population (low income) does not promote a primary health care system exhibiting the characteristics described earlier.

The capacity of the emerging health care system of PR to address the needs of the MCH population will be commented very briefly using the HSCIs.

#01 HSCI: The rate of children hospitalized for asthma (10,000 children less than 5 years of age).

Asthma is the most common condition among CSHCN in the Island. In 2003-2004, there were 37,571 children enrolled in the Head Start Program. Of these, 4,448 (14.9%) were asthmatic.

Children suffering from asthma show higher school absenteeism, are more prone to use the ER services, and more likely to require hospitalizations. Hospitalizations may be an indicator of the level of severity of an asthmatic child, lack of continuity of care or inadequate management of the condition by the primary providers.

Please refer to State PM No. 7 for the activities that have been planned by the Division of Habilitative Services to address this health problem.

#02 HSCI: The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.

It is important to highlight that PR is not treated fairly at the time of allocation of Medicaid monies. As a matter of fact, Puerto Rico uses close to \$1.208 million to purchase the GIP for low-income persons under 200% of the FPL. Medicaid dollars represent only 13.25% (\$160 million) and SCHIP funds 2.4% (\$29 million). Since the budget used to purchase the GIP for low-income individuals is a combination of state and local funds (municipal), Medicaid and CHIP, it is quite difficult to ascertain the number of Medicaid enrollees at any age who have received at least one initial periodic screening during any given period.

Another problem that complicates the monitoring of this HSCI is that the model of health care is based on capitation and providers do not bill the Medicaid program for services rendered, as is the case in the mainland.

#03 HSCI: The percent of SCHIP enrollees whose age is less than one year who received at least one periodic screen.

The explanation provided for #02 HSCI applies to this one also.

#04 HSCI: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck Index.

The MCH Division has a well-trained competent team with the skills for determining the Kotelchuck Index by age groups, municipality of residence, health regions, as well as by many other sociodemographic variables. Indeed, this is one of 15 health indicators that we analyze on a yearly basis to determine the Integrated Index of Maternal and Child Health by municipality (IIMCH). Data generated is widely disseminated to concerned entities and stakeholders responsible for promoting first trimester admission into PNC and the quality of prenatal care.

#05 HSCI: Comparison of health system capacity indicator for Medicaid, non-Medicaid, and all MCH population in the state.

In Puerto Rico, the MCH population under 200% of the poverty level is granted the government insurance card. This may be considered a proxy for Medicaid. Information regarding the health plan held by women at the time of delivery is collected in the birth certificate. This allows us to evaluate birth outcomes according to the type of health insurance. Over 60% of all live births occur to women beneficiaries of the GIP. (2003)

A similar analysis is more difficult for other groups of the MCH population such as children and adolescents.

#06 HSCI: The percent of poverty level for eligibility in the State Medicaid and SCHIP programs for infants (0-1), children and pregnant women.

The Medicaid program is responsible for developing the criteria for the level of income that a family should have in order to be awarded the GIP. The GIP is the proxy for Medicaid and the level of income is not necessary the same as the FPL.

#07 HSCI: The percent of EPSDT eligible children age 6 through 9 years who have received any dental service during the year.

All EPSDT eligible children (0-100% FPL) hold the GIP, as well as those in the FPL 101-200%. Both of these groups have direct access to dentists. However, it is quite difficult to estimate the proportion of children 6 through 9 years who have received a dental service during any year. The reason for this difficulty is that the collected information is related to the number of encounters. Since a child may have more than one visit per year, the number of encounters is not an appropriate measure to estimate the percent of children who use dental services in PR.

#08 HSCI: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the state CSHCN Program.

Puerto Rico does not receive SSI funds. For this reason, we cannot respond to this HSCI.

#09A HSCI: The ability of States to assure that the MCH program and Title V agency have access to policy and program information and data.

In Puerto Rico, the Office for Development of Information Systems (ODSI) has the responsibility to develop the data banks of births, deaths and stillbirths files. For a long time, the ODSI Director has been a great collaborator of the MCH Program. Close to June of every year he provides us the linked birth and infant death as well as stillbirth banks. Additionally, the ODSI Director supports us whenever a technology problem arises.

On the other hand, the MCH program is fortunate to have on staff a very well trained and enthusiastic team of public health professionals to analyze the data contained in the banks provided by ODSI. The team consists of a Demographer, who is the Coordinator of the Title V Monitoring and Evaluation Section; an Evaluator, a Biostatistician, a BA in Computer Sciences and a Data Entry Clerk. Currently, the two Epidemiologists positions are vacant because both resigned last year, and epidemiologists are difficult to recruit and retain in our system. A pediatrician with an MPH and an OB/GYN consultant with vast experience in public health support this team.

Over the years, the MCH Director has developed the relationships and mechanisms to get the needed information from other programs under the umbrella of the DoH such as WIC, Medicaid, Immunization, Pediatric AIDS, as well as from other programs outside the DoH. Among this last group are the Newborn Screening for Hereditary Diseases, the Department of Education, the Department of the Family and many others.

However, even though the MCH program has the ability to access information and data collected by other programs and agencies, these may be useless because it is not collected in the form needed by us.

#09B HSCI: The ability of States to determine the percent of adolescents in grades 9 through

12 who report using tobacco products in the past month.

This information is available from the Department of Education whenever they perform the YRBS.

#09C HSCI: The ability of States to determine the percent of children who are obese or overweight.

Obesity and overweight in children is a public health concern in PR. However, we don't know the rate of obesity or overweight in the Island. The information gathered through the YRBS does not answer this question. There is a need to design a study of a representative sample of the population of children and adolescents 0-19 years (N=1,485,004) to determine the percent of children and adolescents who are obese. To do this investigation we would need additional and appropriate human resources.

In conclusion, low-income pregnant women and children are one of the most vulnerable subgroups of the population in a community. This subgroup of the population requires access to a set of preventive services which include, but are not limited to, prenatal care, dental care and anticipatory guidance according to identified risk factors. On the other hand, CSHCN such as asthmatics require a higher level of services and specialty care to prevent complications requiring ER visits, hospitalizations, and as a result an increased rate of death.

Medicaid, SCHIP and SSI programs are federally financed programs pursuing access to health care services for individuals below the FPL. The implementation of both Medicaid and SCHIP program in PR is very different in comparison with the mainland. And as a matter of fact, the SSI program has never been implemented in PR, since US citizens living in the Island are not considered at the time of allocation of SSI monies. //2005//

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

//2004/ The PR MCH needs assessment process is a continuous activity carried out on a year round basis. It is aimed at identifying the specific and changing needs of the different MCH population groups. This activity provides the necessary feedback to readjust the MCH work plan to better respond to changes in health needs of the target population. The needs assessment is geared by the H.P. 2010 national objectives related to the MCH population (Focus Areas 9, 16 and others); national and state performance and outcomes measures, as well as the health status indicators established by the MCHB.

Another complementary activity to the needs assessment is the identification of all activities, services and programs according to the MCH pyramid levels for each of the population groups. These two activities allow us to match MCH health needs with available services and to identify gaps in services that should be filled.

Currently, the Title V program has a section staffed with a well-trained team of professionals whose main task is to gather the most accurate and timely data to monitor the progress of all performance and outcomes measures, as well as the level of progress in improving the health and well-being of the Puerto Rican MCH population.

After that, Title V funds are allocated to complement services, to conduct new activities or to implement new programs that will help us to achieve the established target of performance and long terms outcome measures.

The MCH priorities are determined based on the identified needs, the state capacity to address these needs, the political priorities and input from a broad array of partners including families. The trend analysis for at least five years of the rates of each national and negotiated state performance and outcome measures allow us to set expected targets for future years.

Selection of State Priority Needs:

A total of ten (10) priority needs were selected based on data analysis, number of persons affected, input from collaborators, state political priorities, availability of resources to address identified needs and reliable culturally sensitive treatment or management options.

The Puerto Rico MCH work plan is focused on the following priorities:

1. To reduce infant, child and maternal morbidity and mortality.
2. To increase availability and access to preventive and primary health care services for the MCH population, including CSHCN.
3. To develop and maintain an MCH infrastructure to adequately assess the health needs and to assure the delivery of appropriate and needed services for the MCH population, including CSHCN.
4. To improve collaboration among parents, public, private and community based organizations to further program coordination and integration into a system of services.
5. To reduce unintended adolescent pregnancies.
6. To reduce unintentional injuries among children and adolescents.
7. To increase awareness regarding MCH issues among health professionals and the public at large.
8. To prevent and reduce behavioral risk factors such as smoking, alcohol consumption and substance abuse among teens and pregnant women.
9. To diminish morbidity and mortality rates due to bronchial asthma.
10. To enhance competency of the primary care providers to better serve the at-risk MCH population. //2004//

//2005/ No changes in priority needs were considered for this year. //2005//

B. STATE PRIORITIES

/2004/ Figure 10a depicts the relationship among PR's selected priority needs, its capacity and resource capability, the national and State Negotiated Performance Measures and the long term health outcomes set for our mothers, children and adolescents (MCA).

Improving the health status, the well being and the quality of life of the MCA and their families is a great challenge for the MCH/CSHCN programs. To achieve this goal it is imperative to develop and implement a concerted action plan among a diversity of public agencies, private entities, CBOs with the involvement of the families themselves. This is so, because the health status and well being of an individual, or a selected population group, results as the intricate interaction of genetic, environmental and sociodemographic factors. Currently, there is not a single public or private entity with all the resources and capability to address by itself the multiple and complex socioeconomic and health needs of the MCA population. This conclusion is drawn from the comprehensive five (5) years needs assessment of the Puerto Rican MCA population. Their needs are diverse and very complex. The five years needs assessment was performed by means of in-depth analysis of quantitative data collected by the Demographic Registry and the Vital Statistic Office as well as other secondary data sources; by gathering primary and qualitative data; conducting applied research and gathering input through the participation of the MCH/CSHCN staff in hundreds of interagency meetings, coalitions, commissions, task forces, committees; and through focus groups of different MCA groups. Sadly, this process led us to realize that there is a wide gap between the current MCA health status and well being, and the expected goals set for 2010. In 2000, the IMR was 9.9/1000 live births compared to the established goal of 4.5/1000 by 2010. The MMR was 9/100,000 live births in comparison to 3.3/1000 by 2010.

The contributing (or risk factors) to these poor MCA health outcomes are not only in the realm of medical factors but also in the domain of sociodemographic, environmental and behavioral factors. It is imperative to highlight that in the epidemiology of the MCH, there are several independent variables such as heredity, race and ethnicity, income, education, marital status, culture, age groups and area of residence, that are not under the control of the primary role of the MCH/CSHCN programs. Additionally, the contributing factors of the epidemiologic model of the MCH are immense. These include medical risk factors, obstetric complications, behavioral risk factors and the quality of prenatal, perinatal, postpartum and pediatric care, among others. The interrelationship of both, the determinant and contributing factors lead to short term (<1 year), intermediate (1-5 years) and long term (5-10 years) MCH outcomes. The priority needs for PR were drawn based on the analysis of this MCH epidemiological model and the government's political priorities.

Figure 10a represents the PR Title V Block Grant Performance System. It shows at a glance the relationship of selected priority needs with current available services to address them by levels of the MCH pyramid. The National and State Negotiated Performance Measure are grouped by the level of the pyramid, which includes the programs services or activities that, if properly implemented, would result in achieving its set goals across the years. The cumulative achievements of the National and State Performance Measures should lead us to reach the ultimate goal of the Title V Program: "Improving the health and well-being of all women in their reproductive age, infants, children, adolescents and their families". The measures that will tell us how effective our efforts have been over the years are the maternal, infant and child death rates shown at the end of the PR Title V Measurement System.

After the earlier general description, we would like to be more specific describing the relationship among the priority needs with the components of PR Title V BG Performance Measurement System. Due to space limitations we will focus on the first five priorities.

1. To reduce maternal, infant and child mortality: in addressing this priority need, it is important to assure access to early comprehensive and regular quality prenatal care, appropriate perinatal care according to identified levels of risk, postpartum and interconceptional care, preventive pediatric care

and early intervention services. These are direct services located at the first level of the pyramid. The performance measures (PM) #1 (newborn hereditary diseases screening), #2 (CSHCN satisfaction with services) and PR 01 (HIV+ pregnant women) are the flags to monitor the programs and activities at this level.

Enabling Services: among the enabling services are the Home Visiting Program (PR #1), the toll free line, postpartum education provided by perinatal nurses, and others.

Population Based Services: Activities aimed at creating awareness of the effect of certain behaviors on pregnancy outcomes and population based programs such as immunizations, Newborn screening program, the NTDs Prevention Campaign are very important at this level. The associated PMs are #7 (Immunization), #10 (children <14 years MVC deaths), and PR #5 (rate of smoking among pregnant women).

Infrastructure Building Services: The PR Title V program staff is actively engaged at this level in activities pursuing the decrease of the maternal and infant mortality rates. Among the activities carried out are needs assessment, policy development, development of standards of care, quality assurance, participation in committees, coalitions, professional development and many others (Figure 10b). The PMs at this level are PM #11 (Breastfeeding), PM #13 (children with health insurance), PM #17 (Birth of VLBW at level III), PM #18 (first trimester admission rate), PR #03 (NTDs rate), PR #04 (NTDs Registry), and PR #09 (C/S rate).

2. To increase availability and access to preventive and primary health care services for the MCH population, including CSHCN. In 1993, the Commonwealth of PR approved Law 27 related to the HCR. The HCR includes among its strategies the GIP, which covers low-income persons under the 200% poverty level. The GIP's goal is to increase access to preventive services. The GIP does not allow co-payment for prenatal care nor for infant preventive services. An evaluation of the health plan of 33,575 Head Start children enrolled in 2002-2003 revealed that over 99% had either the GIP or private health insurance. Only 127 children (.38%) did not have a health insurance plan. These findings may be a proxy of what may be the reality with other low-income population groups. The GIP promotes the achievement of several performance measures at different levels of the pyramid.

Among these are:

- Enabling Services: PM #3 (medical home)
- Population Based: PM #4 (CSHCN with health insurance), PM #7 (Immunizations)
- Infrastructure Services: PM #13 (Children with no health insurance), and PM #18 (first trimester admissions rate).

3. Develop and maintain an MCH infrastructure to adequately assess the health needs and to assure the delivery of appropriate and needed services for the MCH populations, including CSHCN. Most of the MCH staff efforts are embedded within the base of the MCH pyramid. The activities include the core functions of public health such as needs assessment, planning, assurance of quality services and policy development. The monitoring and tracking of HP 2010 objectives related to the MCH population, the national and state performance and outcomes measures and Health Status Capacity Indicators, development of surveillance systems and conducting applied research are important priorities for the Title V Program Director. Data and information generated by the MCH program are shared with a broad number of partners.

Among the state and national performance measures monitored through the earlier activities are the followings: PM #8 (birth to teen 15-17 years), PM #09 (dental sealants), PM #10 (deaths to children <14 years due to MVC), PR #05 (rate of smoking pregnant women), PR #06 (rate of birth <15 years), and PR #07 (rate of children with asthma). PININES is carried out with the collaboration of the Medicaid program and ODSI. It is a tool that provides us the number of children with 13 selected conditions certified by Medicaid.

4. To improve collaboration and coordination among parents, public, private entities and CBOs to further program coordination and integration into a system of services. Services, programs, and

entities with which the MCH staff collaborate and coordinate are also found at the infrastructure level. These include interagency committees, coalitions, foundations, MOU, etc. The Breastfeeding Steering Committee, "Proyecto Lacta", the WIC Program and the MCH Training Program address PM #11. The Safe Kids Coalition, COPRAN, the Comprehensive Adolescent Health Program and the Traffic Safety Commission address PM #10 related to reducing MVC deaths in children less than 14 years.

5. To reduce unintended adolescent pregnancies. This is a very complex MCH issue. Its causes are multiple and cannot be addressed with a simple and single strategy. In addressing this MCH issue, we must engage the family, the adolescents themselves, the Department of Education, the Department of the Family, CBOs, the private sector, the media and many other non-traditional partners such as the faith community. This priority is addressed by the HVP (PR PM #2), the SISA Program, the Abstinence Only Education Program, implemented in collaboration with the Department of Education, by the provision of family planning services and many others. The PMs that allow us to monitor this priority are the NPM # 8 and PR #6 that track the rate of birth to teens 15-17 and <15 years old respectively. //2004//

//2005/ After reviewing this section, we understand that no changes are required.//2005//

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

a. Last Year's Accomplishments

Law No. 84, enacted in 1987, mandates that every infant born alive in Puerto Rico must be screened for PKU, hypothyroidism and sickle cell anemia. The Neonatal Screening Program for Hereditary Diseases is located at the University Pediatric Hospital. This program is supported with \$200,000 earmarked by the Legislature.

Form 6 summarizes the newborn screening activity and its results during calendar year 2003. During calendar year 2003, it served 48,468 out of 50,799 live births. This figure represents 95.4% of all live born during the reporting year. Thirty-six (36) cases were diagnosed for the four conditions screened for in Puerto Rico: PKU-5 cases; hypothyroidism-30 cases; sickle cell anemia-11 cases and galactosemia-0 cases. All these patients received appropriate counseling, treatment, referrals to the endocrinologist, metabolic clinics and the WIC program as required. The WIC program provides special formulas if recommended by the specialist for those under five (5) year age. The Pediatric Centers provide formulas for children over 5 years.

Other activities supported by the staff of the MCH program include, but are not limited to, anticipatory guidance to all participants of the Home Visiting Program during the prenatal period and postpartum education.

Postpartum Education: Title V funds are used to pay the salaries of 11 perinatal nurses stationed at area and regional hospitals. These nurses are key for the provision of postpartum education on an individual or group basis, making referrals to primary services, to home visiting nurses, disseminating educational materials and collecting information. During the reporting period the perinatal nurses conducted 13,898 individual orientations and 8,364 postpartum women were reached through group sessions. On the other hand, the Home Visiting Nurses served 9,408 (CY 2003) pregnant women and children under 2 years of age. Orientation regarding the importance of newborn screening for congenital diseases is a standard topic provided by the Home Visiting nurse to all pregnant women admitted to the program.

b. Current Activities

In section (a), it was mentioned that the Puerto Rico Newborn Screening for Hereditary Diseases program is mandated by law. The program is within the infrastructure of the Pediatric University Hospital. The MCH program is a partner in pursuing that all newborns be screened before hospital discharge.

It is important to highlight that the most important current activities concerning this performance measure are quite similar to those described earlier. These are the following:

- * To screen all newborns for congenital hereditary diseases such as hypothyroidism, PKU, sickle cell anemia and galactosemia.
- * To refer children with PKU and galactosemia to the WIC program for nutritional education and management.
- * To refer children with genetic and metabolic disorders to the Pediatric Habilitative Centers for specialized follow-up as required.
- * To provide prenatal counseling to all Home Visiting participants regarding the importance of the newborn screening.
- * To provide postpartum education stressing the importance of asking the pediatric providers for the newborn screening results during the first pediatric visit.
- * To disseminate appropriate educational materials.
- * To follow-up the institutions with low newborn screening rates by written communication.
- * To develop the mechanisms to link data from birth files with data from the Newborn Screening program.
- * To identify the barriers to achieving 100% newborn screening in all birthing institutions.

c. Plan for the Coming Year

Please refer to Figure 4a for the proposed activities for performance measure #1. Most activities proposed for FY 2004-2005 are quite similar to those described earlier in sections (1a) and (1b).

The most significant new activity to be highlighted for the coming year is a Pilot Project to begin screening for congenital adrenal hyperplasia and albinism with the Hermansky-Pudlack syndrome.

Performance Measure 02: The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

a. Last Year's Accomplishments

The SLAITS-CSHCN Spanish questionnaire version was obtained and is still being revised to select items to be included in the CSHCN family survey. In the process we identified the need to request TA for this process.

b. Current Activities

Activities are under way by the Epidemiologist and the Information System specialist to select the sample among the Title V population served at the Pediatric Centers.

c. Plan for the Coming Year

The medical home family survey will be revised and updated after revision of the SLAITS to include questions that will assist us to collect data for the national performance indicators related to CSHCN. The instrument will collect data related to health insurance coverage, utilization of services, measurement of child well being, need assessment of families on access to services their children need, among other useful information. After the questionnaire revision, it will be validated and tested before its administration.

The Champions for Progress grant, recently awarded to Puerto Rico, will set the initial steps to designate an interagency committee including families to develop and implement a strategic plan to achieve the six (6) CSHCN outcome measures.

Performance Measure 03: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

a. Last Year's Accomplishments

During the year 2002-2003, seven training sessions were held, one in each of the seven health regions with the participation of 556 people. Thirty-three facilitators were trained on the Medical Home concept, including parents and physicians who served as resources and presenters on the different regional sessions. One of the best rated and best received participations was that of family members. A total of seventy (70) families participated in the trainings island wide. Each region identified at least ten families who attended the sessions. We have to mention the Mayaguez area, which had 21 families attending their regional training. The training sessions that participants identified as their favorites were Families Alliances and Comprehensive Coordinated Care. Through the trainings we collected data on parents, agencies and volunteers who are willing to collaborate with the project. Having few physicians was a response well behind what we expected, but in tune with the usual reaction among physicians in Puerto Rico regardless of the efforts we made to create awareness and concern about their role as medical home providers. We also had 386 allied health professionals attending the sessions.

The Medical Home Coordinator remained in the position until December 2002. By 2003 the Early Childhood Comprehensive System Grant (ECCS) was approved and a coordinator was hired. Responsibilities to continue developing the medical home goals and objectives were included as part of the ECCS Coordinator duties. The ECCS grant provided the medical home project an excellent opportunity to continue collaboration between Title V, the health insurance agencies, providers, community agencies and families towards further development of regional support, awareness, education and therefore identification of community providers for medical homes. ECCS main goals are to provide leadership for the development of cross service systems to support children 0 to 5 years of age to enhance their ability to enter school healthy and ready to learn and to support communities to build early childhood service systems geared to critical components of comprehensive pediatric services. During 2003, the most significant achievement was the establishment of a State Interagency Planning Committee that includes key medical home leaders representing agencies and community members involved in delivering services to children 0 to 5 years of age. The project established coordination and collaboration with the following groups: Parent Training and Information Center; Title V; Healthy Start Program, Child Care Program, AAP, Health Services Administration; Public Health School

of Medicine; Puerto Rico Department of Education; Labor Department, "Fondos Unidos", and Mental Health Service Administration.

b. Current Activities

Strong collaboration has been established between the Puerto Rico ECCS Project, at present developing and sharing its vision, goals and objectives to address system partnerships for preschool children and families, and the medical home project. The Medical Home Steering Committee was already in place and its members developed into the ECCS Steering Committee with a Medical Home subcommittee. The School of Public Health and the AAP, active medical home collaborators, joined the committee strengthening the ECCS Interagency Planning Committee while securing a better development of Medical Home in Puerto Rico. We collaborate with the School of Public Health staff that is working in two Academic Pediatric Clinics implementing the Medical Home concept. We are presently working to complete the Medical Home report for the primary care providers and various meetings have been performed.

The MCH Director has been an active collaborator of the ECCS Project since its inception. In one of the ECCS Interagency Committee meetings he presented an overview of the child health status based on an analysis of birth and infant mortality rates for 2002. He also shared an instrument aimed at developing an MCH Profile by municipality. This instrument gathers information regarding the health and human services available at each municipality for the different segments of the MCH population as well as a socio demographic and health status data. The information collected with this instrument will allow us to estimate the number of primary pediatric providers available at the local community who serve low-income population. Other necessary services for children are identified allowing us to assess gaps in services.

Given this MCH data we will have a community mapping, an important resource that the medical home and ECCS partners and committee will make available to the Department of Health and other providers serving the children in Puerto Rico who are willing to collaborate with the medical home project.

c. Plan for the Coming Year

The Puerto Rico ECCS will continue working on the activities listed below:

- * Design a new brochure about the concept of medical home.
- * Include medical home information in the nursery discharge packets.
- * Continue distributing medical home educational materials to families receiving services.
- * Continue identifying physicians or mentors at each health region and train them to establish Medical Homes.
- * Promote incentives for the implementation of medical homes.
- * Meet with ASES and the health insurance agencies to further advance awareness of the medical home concept.
- * Certify medical practices as Medical Homes.
- * Train parents as interviewers to do the family interview of the survey.
- * Implement the pediatric center survey to obtain data on the national performance measures for CSHCN.

Performance Measure 04: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

a. Last Year's Accomplishments

The Puerto Rico Pediatric Centers provide services to children with special health care needs (CSHCN). The Division of Habilitation Services has been involved in establishing and updating the Pediatric Centers' electronic database information system.

b. Current Activities

This system provides continuous specific data on the number of CHSCN with health insurance that pays for the services they need. It also provides other information related to services provided to the patients from referral to exiting of the child from the Center.

c. Plan for the Coming Year

The medical home family survey will be revised and updated after revision of the SLAITS to include questions that will assist us to collect data for the national performance indicators related to CSHCN. The instrument will collect data related to health insurance coverage, utilization of services, measurement of child well being, need assessment of families on access to services their children need, among other useful information. After the questionnaire revision, it will be validated and tested before its administration.

Performance Measure 05: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

a. Last Year's Accomplishments

Puerto Rico is not included in the CSHCN Survey; consequently, data on the percent of CSHCN age 0-18 whose families report the community based service systems are organized so they can use them easily is not available.

The Early Childhood Comprehensive System (ECCS) grant was approved.

b. Current Activities

Puerto Rico is on the second year of the ECCS grant for the development of an early childhood comprehensive system. This project will facilitate the integration of services and resources for families and will coordinate efforts for the development of a system of services for families and children, including CSHCN. A need assessment on services available at the regional level will be performed as part of the strategic plan.

c. Plan for the Coming Year

The medical home family survey will be revised and updated after revision of the SLAITS to include questions that will assist us to collect data for the national performance indicators related to CSHCN. The instrument will collect data related to health insurance coverage, utilization of services, measurement of child well being, need assessment of families on access to services their children need, among other useful information. After the questionnaire revision, it will be validated and tested before its administration.

An activity of the recently awarded Champions for Progress Grant consists of a statewide conference to create public awareness among families on systems of care for CSHCN.

Performance Measure 06: The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)

a. Last Year's Accomplishments

Puerto Rico is not included in the CSHCN Survey; consequently, the percentage of adolescents with SHCN who received the services necessary to make transition to all aspects of adult life is unknown.

b. Current Activities

Activities are underway by the Epidemiologist and the Information System specialist to select the sample for a family survey among the Title V population served at the Pediatric Centers.

c. Plan for the Coming Year

A collaborative group will be identified during the current year, including the Department of Education, MCH Adolescent Program, Vocational Rehabilitation Program, parents and youth with CSHCN, Council on Developmental Disabilities, and the University Affiliated Program Center of Excellence to perform a needs assessment of this population, develop a baseline data and develop a work plan to improve outcomes for this population.

The medical home family survey will be revised and updated after revision of the SLAITS to include questions that will assist us in collecting data for the national performance indicators related to CSHCN. The instrument will collect data related to health insurance coverage, utilization of services, measurement of child well being, and needs assessment of families about access to services their children need, among other useful information. Once revised, the questionnaire will be validated and tested before it is submitted to families.

Performance Measure 07: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

a. Last Year's Accomplishments

Law 25 of 1983 mandates immunization of children according to the latest approved immunization schedule. Every year the Immunization Program of the PRDoH conducts an immunization coverage study. The study allows us to monitor compliance with established national guidelines. It is conducted by performing house to house interviews with parents of children included in a random sample. This year for the first time the age of children was altered to include 35 month old children. This change allows PR to use the same indicator as other states and territories. During the past year Puerto Rico began its catch up efforts to regain its former status as the state/territory with best level of coverage (94% in 2000-2001) that had been lost as a direct result of the DaTP shortage and the adoption of the CDC and ACIP recommendations to postpone fourth DaTP vaccine for 15 month olds.

In March 2002 the Immunization Program conducted its annual immunization coverage study to evaluate of adequately immunized 2 year olds. It revealed the percentage of adequately

immunized 2 year olds had decreased to 32%, although adequate coverage for other preventable diseases remained high. The most recent study, released in May 2004, demonstrated a significant improvement in the rate of children adequately immunized with 4 (DTaP), 3 (IPV/OPV), 3 (HiB) and 1 (MMR). At this time the percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations increased 78%, from 32% to 57%. A complete immunization status for the 35 month old infants included 4 (DTaP), 3 (IPV/OPV), 3 (HiB) and 1 (MMR). When only 3 (DTaP), 3 (IPV/OPV), 3 (HiB) and 1 (MMR) were taken into consideration, a 91% coverage rate was obtained. Coverage by individual antigens showed higher levels of coverage: four (4) DTaP (56.5%), three DTaP (96%), three (3) polio 97.8%, one (1) MMR 93.4%, three Hib 93.7% and three (3) Hep. B 93.2%. In addition, the PRDoH also monitors Varicella vaccine coverage. This year the level was reported at 86%.

This level of coverage is a reflection of the multiple collaborative efforts the PRDoH has been able to establish with public and private entities such as WIC, Private Insurance Companies, providers, schools, pharmacies, supermarket chains, pharmaceutical companies, among others, to provide leadership in conducting and promoting catch up activities. A key collaborator in this effort has been the Maternal and Child Health Division. Our Home Visiting Nurses and outreach workers are constantly reminding participants and the community at large of the importance of adequately immunizing their children during home visits, school activities and health fairs. During 2003, children from the 7,075 families in the HVP were evaluated for the adequacy of their immunization status, counseled and referred for vaccination if needed. In addition, 6,902 individuals participating in 591 group meetings received information on the importance of children's immunizations.

b. Current Activities

In May 2003 DaTP vaccine became available locally and catch up activities began. Initial efforts consisted of raising awareness of its availability and the need to start catch up immunizations among providers. Regional immunization staff began visiting the offices of the 270 providers that receive vaccines from the PRDoH Immunization Program and identifying all those children whose fourth DaTP dose had been postponed. Once identified, their parents were informed by mail and/or by telephone of the need to have their children immunized with the DaTP. In those MD offices with more than 20 children in need of the fourth DaTP, the IP staff provided immunizations during a special clinic organized for this purpose. In addition, Health Care Insurance Companies have been sending recall letters to those covered under the PR GIP. Community Health Centers have provided special catch up clinics and have extended the hours for such services. Throughout the year 2003, 1,290 special immunization clinics distributed in the 9 health care regions were held at local pharmacies, supermarkets, public housing, recreational and religious facilities. A total of 8,148 children two years of age or under received immunizations, 3,116 children between the ages of 3-5 and 7,430 between the ages of 6-19.

HVN and Outreach Workers support catch up efforts by promoting compliance with the established vaccine schedule during home visits, school activities and health fairs. They include this topic during educational interventions held at the community level. If they identify a particular need in the community, efforts are made to coordinate special clinics to fulfill the need. Currently, one of the main motivators to adequately immunize children is the requirement to present evidence of the immunization status of all children when they are enrolled in school every year. However, more educational efforts must be undertaken to increase awareness of the importance of protecting children against diseases early and not delaying immunizations until they are ready to enter school.

This year Puerto Rico celebrated concurrently the National Infant Immunization Week and PAHO Vaccination Week in the Americas during the last week in April. During this week the Immunization Program held a mass media tour to raise awareness of the need to have the

entire population protected against vaccine preventable diseases according to the PRDoH immunization schedule. These efforts were reinforced with educational and vaccination activities in all the PR health regions.

The IP offers providers CME accredited activities annually and provides a link to the IP in the PRDoH web page. This page includes their monthly publication INFOVAC. It offers health care providers and the general public up to date information on immunizations including vaccine shortages, new recommendations and guidelines for school entrance requirements and other topics of interest.

c. Plan for the Coming Year

The core program of the Puerto Rico Title V program is the Home Visiting Program. Its target population are pregnant women and children up to 2 years of age with complex health and social problems. During their daily activities Home Visiting Nurses evaluate participants for the adequacy of their immunization status, counsel and refer for vaccination those in need.

In addition to the HVN, Outreach Workers' efforts have been redefined and refocused. Their daily activities are directed toward achieving Title V and Healthy People 2010 Objectives. As part of these efforts they will continue to monitor and promote compliance with the established vaccine schedule during their interventions in school activities, health fairs, prenatal and parenting classes and in other community activities. In those cases where a significant need is identified in a community, Outreach Workers are expected to coordinate special immunization clinics with the Immunization Program to fill the need. Their close relation with the communities they work in will allow them to detect potential roadblocks and work to eliminate or reduce any barriers parents face when they attempt to vaccinate their children. They will provide the parents with updated information regarding the dates and places where special clinics will be conducted so they can take their children to be immunized.

The information gathered during the home visits, outreach activities and during those activities conducted by the regional immunization program will help us monitor immunization rates by municipalities and health regions more effectively. The information they gather will be shared with the IP in order to develop a strategic plan to eliminate disparities in the vaccine coverage by health care region.

In view of the frequent changes and emergence of new modalities in the field of childhood immunizations it is necessary to constantly update the information of the MCH staff (Home Visiting Nurses and Outreach Workers) and providers in general regarding immunizations. To accomplish this we will continue to update MCH Division's knowledge regarding the latest recommendations and vaccine availability status.

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

a. Last Year's Accomplishments

It is encouraging that the birth rate (per 1,000) to teens 15 to 17 in Puerto Rico has had a significant decrease from 59.9 in 1997 to 42.6 in 2002.

The MCH Staff carried out 2,878 small group orientations reaching 50,725 participants across the Island. Topics included: sex education, preventing teen pregnancy, and the risks associated with it. The topic of abstinence was offered to 16,329 people in 783 small groups.

The Abstinence Education Project (PRAEP) reached 44,370 people with the following activities:
1) "Sex Can Wait Curriculum" to 24,130 public school students; 2) Youth Encounter with 185

students, 24 teachers and 10 professional resources from 13 PRAEP peer groups; 3) socio-recreational, educational and youth development activities for 3,097 students; 4) attended by 826 parents 17 parent conferences on human sexuality and effective parent-child communication; 5) other sexuality communication activities reached 202 adults and 265 students.

The "Healthy Beginning" Project and PRAEP developed a plan to reduce health disparities in teen women that included: early identification of pregnant teens to link them early to prenatal care, enrollment into the MCH Nurse Home Visiting Program, orientation to prevent pregnancies and support to continue studying. Two regional activities gathered 393 professionals to raise awareness of teen pregnancy issues and ten municipalities started the Plan.

The Comprehensive Adolescent Health Program (SISA) includes teen pregnancy prevention in the Peer Teen Health Promoters' trainings. A total of 130 students of public schools were initiated as Promoters around the island raising the total number to 560 in 40 public schools. They carried out 233 activities reaching about 10,985 students. Two Promoters attended the "Young Women's Health Summit Parents as Partners" in Miami. During Teen Pregnancy Prevention Month, SISA Promoters held twenty-three activities reaching 870 adolescents island-wide. Activities at the state level included: Secretary of Health Proclamation of March as Teen Pregnancy Prevention Month and the Adolescents-Adults Forum: "Keeping Pregnant and Parenting Teens in School".

The SISA Program provided technical assistance to COPI, a community-based organization in the community of Pinones in Loiza. A peer health promoters' training based on positive youth development was offered to 15 teens and COPI personnel. Topics included: reproductive health, sexuality, communication, self-esteem, healthy relationships between teens and community self-development. A needs assessment of Pinones teen mothers was done to assess health and social supportive services. An anthropological applied research on teen pregnancy in Pinones was started.

SISA efforts continued to promote the establishment of the public policy to reduce teen pregnancies. Collaboration in the "Coalicion Pro Salud Sexual y Reproductiva del Adolescente" continued.

b. Current Activities

The MCH Staff has continued to provide teen pregnancy prevention educational activities and materials in schools and community programs.

The Abstinence Education Program (PRAEP) has continued the "Sex Can Wait Curriculum" and peer groups in public schools island-wide. The Spanish translation of the Elementary curriculum was finished and training to elementary teachers began. Five summer camps for 12-17 year old youths are in progress. Parental workshops will be offered in each camp.

The PRAEP and "Healthy Beginning" continued collaborating to promote early teen prenatal care, reduce school dropouts due to teen pregnancy and reduce repeated pregnancies. Ten new municipalities were chosen to start the plan while continuing with the previous ones. A regional meeting with educators and health professionals of four of the new sites was done to present the Plan and discuss teen pregnancy issues.

The SISA Program has continued the comprehensive adolescent school based health program, which includes training middle school students as peer health promoters and organizing varied activities to support them in their work with other students. The Program continues creating awareness regarding risk factors for adolescent pregnancy among the public at large, health

professionals and entities that serve adolescents. This included collaborating with four government agencies in the final document of the Public Policy to Decrease Teen Pregnancies and the Action Plan for Puerto Rico. The document is at the Governors' Office for her consideration. The Program continues collaborating with the "Coalicion Pro Salud Sexual del Adolescente" an interagency and community coalition that works with teen pregnancy issues in PR.

The partnership with the community-based organization COPI in Pinones continued. The Community Teen Promoters' Youth Organization, "Jovenes Creando Conciencia" was created by the teens who took SISA workshops. They developed a social theater about teen pregnancy, drugs and alcohol use that has been presented in schools, PR-TV Channel 6 and other localities. They are participating in a community leadership institute and are working as staff in COPI's Pinones Summer Camp for 6-12 year olds. The anthropological research continued with a focus group and individual in-depth interviews about teen pregnancy. Visits to the homes of identified teen mothers for the needs assessment started.

Efforts geared to promote the application of the "Community Youth Development Approach" as a national priority led SISA to offer a Positive Youth Development Training in collaboration with Konopka Institute for a group of government and community based organizations in PR. The Group will develop a culturally appropriate Spanish curriculum on Positive Youth Development and a train the trainer guide to spread it island-wide.

c. Plan for the Coming Year

The MCH Staff will continue to provide adolescent pregnancy prevention educational activities and materials in schools, community programs or other entities. A collaborative work will be started with the CSHCN Program to involve families and professionals to work in activities related to this priority need.

The Abstinence Only Education Program (PRAEP) in conjunction with the Department of Education will continue to provide the Sex Can Wait Curriculum in its Spanish translation. Training to elementary school teachers will continue so they can also offer the curriculum. Peer group (AMORES) meetings in public schools will continue. Youth Development training will be offered to teachers and students as soon as the culturally adapted train the trainer is developed by the Positive Youth Development Interagency Group. Workshops for parents of school-aged children on communication about sexuality issues with their children will continue. A poster and other media campaign will be used to promote sexual abstinence.

The collaboration to promote early prenatal care in teens, reduce school dropouts due to teen pregnancy and reduce repeated teen pregnancies will continue between PRAEP and "Healthy Beginning", the Department of Education and other agencies. The next ten municipalities to continue the Plan will be chosen. Efforts to recruit teens for the Program will include public residential communities, faith based and community based organizations.

The SISA Program will continue the peer training for health promoters and the organization of varied activities to support them in their work with other students. The Program will continue to work in developing awareness among the public at large, health professionals and other entities, about adolescent's needs. Collaboration in the "Coalicion Pro Salud Sexual Reproductiva del Adolescente" will continue. A Directory of Services available for the adolescent population in PR will be started in collaboration with government agencies and community based organizations.

The collaboration to the "Jovenes Creando Conciencia" Teen Health Promoters in Pinones, the anthropological research and the needs assessment and provision of services to pregnant teens and teen mothers will continue. A Home Visiting Nurse from the MCH Division was

requested to start visiting pregnant and parenting teens in this community.

The work of the Positive Youth Development Committee will include the promotion of the "Community Youth Development Approach" as a national priority, developing a culturally sensitive Spanish Youth Development Guide for PR, developing and providing trainings to organizations and communities so they can develop and increase the capacity of leaders to integrate this approach and develop a commitment to work with it in the development of activities addressing the health and psychosocial needs of the adolescent population.

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

a. Last Year's Accomplishments

As a result of the implementation of the Health Care Reform in Puerto Rico, all individuals under 200% of the poverty level hold a government-paid health plan. The government-paid health plan has an expanded coverage of direct health services which includes sealants for permanent molar teeth. Holders of the government insurance plan may access the dentist without a referral from their primary providers. A significant proportion of children hold private health insurance, which includes in its coverage the sealants for permanent molars.

The Office of Health Insurance Commissioner reported that in 2003, a total of 734,412 children and adolescents (0-18 years) had some form of health insurance. Of these, 322,680 hold the government insurance plan and 411,732 a private health plan. However, only a small number, 5,087 were reported to have received at least one protective sealant (CDT-3: D1351) in 2003.

During the reporting year, the Division of Oral Health carried out oral health promotion activities in schools and at the community level across the Island. Among the topics, the oral health promoters include the importance of the protection of permanent molars with sealants.

b. Current Activities

During the current year the Division of Oral Health has been very active in schools promoting the importance of dental sealants.

c. Plan for the Coming Year

During the coming year the MCH program will be collaborating with the Dental Health Office staff in the development and implementation of a plan to create awareness among parents about the importance of this preventive service. The other area that will be addressed is the development of a data collection mechanism to monitor this performance measure. To date, we have been confronting great difficulties in gathering the appropriate data, because the performance measure refers to third grade students. However, this information is not collected through claims. Again, we recommend to the MCHB to change "third grade" to "children aged 8-9".

Performance Measure 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

a. Last Year's Accomplishments

Unintentional injuries constitute a serious public health problem in Puerto Rico. As in previous years, unintentional injuries were the leading cause of death among children under 14 years of

age in 2002. The type of unintentional injury is related to the place where the child is found as well as his/her stage of growth and development.

In 2002, unintentional injuries claimed the life of 1,185 persons in the Island. Among these, 254 (21.4%) or 1:5 deaths were children, adolescents and young adults 1-24 years old. In PR the most common types of unintentional injuries are motor vehicle crashes (MVCs), poisoning, drowning, choking, fire/burns and falls. In 2002, 35 children under 14 years of age died as a result of an unintentional injury. This figure represents 2.9% of all deaths included in this category.

MVCs are the most common cause of injury among children under 14 years of age. The underlying reason for this is the inappropriate fixation of the infant seat restraint and lack of utilization of seatbelt among children. This is an issue that must be addressed from many fronts and with the collaboration of many partners besides MCH.

In PR there are several public and private entities working in partnership through the Safe Kids Coalition to promote the achievement of this performance measure. These include, but are not limited to, the Police Department, Traffic Safety Commission of the Department of Transportation, Department of Fire Control; PR Coalition for the Prevention of Alcohol Use Among Adolescents, Department of Education, EMSC Program, MCH program and many other private entities.

Reducing unintentional injuries among infants, children and adolescents is one of the 10 priorities of the PR MCH program. During the reporting period this priority was addressed through several activities. These included, but were not limited to:

- Analyses of deaths of all children 0-24 years due to unintentional injuries. The findings were shared with a wide variety of stakeholders such as the Safe Kids Coalition, EMSC program, and Regional MCH Staff among others. The information was used for a press conference, professional presentations and public awareness.
- The MCH personnel across the Island documented a total of 2,853 group educational activities reaching 37,194 individuals. Among the topics included in these educational activities were the importance of the use of the infant seat restraint and seatbelt; prevention of unintentional injuries in general; first aid, and poisoning prevention, among others.
- The Home Visiting Nurses provided anticipatory guidance to all families according to the stage of development of their children. A topic emphasized is the use of the infant seat restraint.
- The perinatal nurses emphasize also the use of the infant seat restraint at the time of newborn discharge from the hospital.
- Dissemination of educational materials including the topic of unintentional injuries.

b. Current Activities

During the current year, most of the activities described above have been conducted on an ongoing basis.

It is important to highlight two press conferences during the first semester of 2004:

* Poison Control Week was celebrated in April. The Secretary of Health conducted a press conference that was widely covered by radio, TV and newspapers of wide circulation.

* On June 4-11, 2004 Injury Prevention Week was celebrated. This is an activity led by the Safe Kids Coalition and supported by the Office of the First Lady. A wide variety of activities were conducted during the week. The report describing the number of death by type of injury, sex and age of the victims developed by the MCH program was used for the press conference as a mean to create public awareness regarding this public health issue.

c. Plan for the Coming Year

A new activity that we wish to underscore for the next year is aimed at providing training to a team of MCH staff on appropriate fixation and inspection of infant seats.

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

a. Last Year's Accomplishments

In 1995, the Secretary of Health established a public policy to promote breastfeeding, followed by an Administrative Order in 1998, requiring at least 3 CME credits on the subject for re-certification of all health professionals. A Steering Committee including partners from several entities which promote breastfeeding developed a 5-year plan with the purpose of reaching the year 2000 objectives related to breastfeeding. Since then we have been working hard toward the achievement of HP 2010 objectives regarding this issue.

During this reporting period the personnel paid with Title V funds conducted a variety of activities directed towards the promotion of breastfeeding across the Island, which include, among others:

* In collaboration with the MCH Training Program of the School of Public Health, a distance learning training was carried out in November 2002, intended for all MCH staff across the Island, and other partner programs, such as WIC, Immunization, and primary health care providers. Two hundred (200) participants were registered.

* Data collected through the Maternal and Child Health Survey (PRAMS-like) for 2002 were analyzed and the findings concerning breastfeeding during early postpartum period as well as other MCH issues were shared with 320 health professionals and key policy persons during the 3rd SSDI Conference held on September 10, 2003 in San Juan, PR.

* A follow-up telephone survey was carried out for the first time at 6 months and 12 months postpartum to mothers who authorized us to call them when they participated in the PRAMS-like survey.

* The Secretary of Health signed a proclamation on August 1, 2003 declaring the first week of August 2003 as National Breastfeeding Week. Personnel from the MCH staff, news media and community people were present at the event which took part in the largest shopping mall in PR.

* The MCH program in the Mayaguez Region held the First Breastfeeding Fair on August 1, 2003 with the collaboration of many partners, including the Mayor of the town of San German. A total of 392 persons participated in the event.

* On August 3, 2003, the MCH Division collaborated with a local breastfeeding promotion project, Proyecto LACTA, in the First Breastfeeding Promotion March that took place in San Juan, with the endorsement of the First Lady of Puerto Rico. MCH personnel provided group and individual orientations on the subject to those present at the activity.

- * The Breastfeeding Promotion Committee met 3 times during the reporting period.
- * The MCH staff took part in public hearings regarding 2 legislative bills dealing with breastfeeding issues and one on site visit to a local store where a controversy regarding breastfeeding practices arose.
- * A total of 830 women participants of the Home Visiting Program received breastfeeding orientation and counseling in 2003.
- * A total of 8,451 persons took part in breastfeeding group orientations carried out across the Island by outreach personnel of our MCH program.

b. Current Activities

Several activities mentioned earlier are being conducted on an ongoing basis during the current year. We want to highlight, however, the following activities:

- * The Healthy Start Project continues providing courses of "Comenzando Bien", which include the topic of breastfeeding, with the intervention of outreach personnel in our system. During calendar year 2003, forty three (43) courses were carried out reaching 530 persons in the community.
- * One course of "Comenzando Bien" was also provided by one of our staff members at the Department of Health for all personnel interested on the subject.
- * Breastfeeding group orientations have been available at community level across the Island with the distribution of educational material.
- * The Breastfeeding Committee has met on a regular basis. Its main efforts have been to develop a registry of educators in the field of breastfeeding in the Island; to promote the implementation of the Baby Friendly Hospital Initiative in PR; and to continue enforcing the Administrative Order that requires continued education on breastfeeding for re-certification of key health providers.
- * Due to delay in the approval by the Institutional Review Board in charge the ESMIPR (PRAMS-like) survey is expected will take place during the 3rd trimester of 2004 instead of the 2nd trimester, as scheduled. This study will continue providing useful data regarding breastfeeding rates in the Island, as well as help the MCH Program to monitor the breastfeeding HP 2010 objectives.
- * During FY 2003-2004, the MCH staff has actively participated in public hearings that deal with the promotion of breastfeeding. One of these legislative bills, which prohibits use of breast milk substitutes on infants without the mother's consent in all premises where obstetrics services are provided, was enacted recently (Law 79 of March 13, 2004). Those who do not abide by the Law will be fined. Information to health providers and institutions affected by this law and public announcements at three (3) major local newspapers was conducted.
- * The Department of Health, complying with the law that requires the availability of a breastfeeding room in all public facilities, is preparing an area at the Central Offices for staff interested in using it. A survey among the personnel was conducted via e-mail to identify their needs.
- * During June 2004, the MCH Division, in collaboration with the WIC Program, carried out two conferences on the subject of Legislation and Governmental Support on Breastfeeding

intended as a continued education for the WIC Program staff.

- * A distance learning course on breastfeeding aimed at the general public and health professionals is being offered by Proyecto LACTA, one of the leading breastfeeding promotion partners in the Island.

- * In collaboration with the MCH Division, Proyecto LACTA will hold a conference on breastfeeding issues during the fall of 2004 aimed at health professionals and key community partners.

c. Plan for the Coming Year

Our main efforts during this coming year will concentrate in the following activities to achieve our goals:

- * The data collected through the ESMIPR 2004 will be analyzed and the findings concerning breastfeeding issues will be available for sharing with key health partners.

- * The Healthy Start Project plans to carry out at least 50 courses of "Comenzando Bien", which includes breastfeeding promotion, by outreach personnel of our MCH program.

- * A registry of Breastfeeding Educators across the Island will be available to provide adequate services within reach for women and children at the community level.

- * The Department of Health will continue its efforts in establishing a public policy for the promotion of breastfeeding and use of human breast milk in the immediate postpartum period by all hospitals in Puerto Rico.

As part of this strategy, the MCH Program, in collaboration with the Breastfeeding Committee, and the Secretariat for Regulation and Certification of Health Facilities within the Department of Health, will get involved in the implementation of Law 79 mentioned in section (b) that prohibits the administration of breast milk substitutes to the newborn and infant without the mother's consent at health facilities, medical offices and child care centers along the Island. Violators of this Law will be fined \$500-\$2,000 per incident.

- * The Breastfeeding Committee will make a review of the courses being offered on the topic of breastfeeding to update the information provided as well as the curriculum requirements for the educators in charge at each level of training.

- * The MCH Program will collaborate with Proyecto LACTA in the National Breastfeeding Publicity Campaign during the fall of 2004.

- * Promotion and support of breastfeeding through group orientation and individual counseling, as needed, will be conducted by 11 perinatal nurses paid by Title V who are located at area and regional hospital facilities throughout the Island.

- * The Breastfeeding Committee will continue its regular meetings at least every other month.

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

a. Last Year's Accomplishments

Numerous meetings were held with the insurance carriers for the Health Care Reform to assure reimbursement for the neonatal hearing screening tests. At this moment the insurance companies were assigned a code that will allow them to bill for the newborn hearing-screening test performed before hospital discharge. A letter to inform the codes was sent to the insurance companies under contract with the Health Care Reform.

The Newborn Hearing Screening Guidelines were developed, approved and published with the endorsement of the Secretary of Health. These guidelines were developed to guarantee uniformity in the implementation at all the birthing hospitals in Puerto Rico.

Newborn Hearing Screening Protocols for hospitals were developed as well as pediatric audiological evaluation Protocols and educational material for families. These materials were submitted to the Advisory Committee for evaluation. We have purchased seven (7) OAE hearing screening tests units that will be loaned to some birthing hospitals that expressed interest in implementing a UNHSP and have been collaborating with the DOH. To assure compliance with expected objectives we developed a Memorandum of Understanding between the hospitals participating in the pilot group and the Puerto Rico Department of Health. Five (5) ABR's were also purchased for our Pediatric Centers to assure a complete evaluation of the infants referred by the hospitals UNHS programs. We established criteria for the selection of the UNHS program pilot group. At present a total of fourteen (14) birthing hospitals are interested in initiating a neonatal hearing-screening program.

Finally, at the DHS we have been advocating and supporting legislative projects for hearing screening including Bill #825, a senate project aimed at performing hearing test for all newborns and the reimbursement to the hospitals for these services. This project was approved in the Senate and is waiting for review by the House of Representatives.

b. Current Activities

During 2003 the Puerto Rico UNHSP faced great challenges affecting the implementation of some of the activities as planned. Nevertheless, we have been effective in making progress towards our main goal. The most significant achievement was the approval of a legislative mandate on December 19, 2003 requiring that hearing screening tests be performed to all newborns on the island before discharge from the hospital. The regulations for the implementation of this Law have been under development since January 2004. In April 2003, the insurance companies under Health Care Reform agreed to reimburse hospitals for the hearing screening tests for all newborns before discharge; a billing code and a reimbursement rate were established for this purpose. A MOU was developed for UNHSP that is actually a contract between the Puerto Rico Health Department and the seven (7) hospitals of the pilot group. It is called "Acuerdo para la realizacion del cernimiento auditivo a todo neonato antes de ser dado de alta". The seven (7) hospitals of the pilot group have already signed the agreement. During this year trainings were offered for the seven hospitals, one for the group of pilot hospitals and two on-site. Also an initial training for audiologists was offered in March 2003. Brochures for parents, as well as the materials to start the UNHSP in the hospitals, have been reproduced. We continued developing a tracking system, which accommodates our own needs and expectations.

Also during this year we received the technical assistance from MCHB. Various meetings were held to discuss the status and the implementation of the UNHSP in Puerto Rico. The Advisory Committee revised the procedural protocols to accommodate them to the recommendations given to this particular.

c. Plan for the Coming Year

During next year our main goal is to begin full implementation of the UNHSP in the 52 birthing

hospitals of the island [including the seven (7) hospitals of the pilot group]. In order to accomplish this goal the regulations for the implementation of Law #311 will be drafted and approved. We are also planning to continue to offer trainings on UNHS to participant hospitals staff. Through promotional and educational activities we expect to increase awareness of the UNHSP in the general population and health care providers including physicians, nurses, audiologists and speech and language pathologists, among others.

We expect to begin implementation of our electronic tracking system. This system was developed by the DHS Information System Administrator in collaboration with members of the Advisory Committee.

The new activities under consideration for this year include:

- * Invite health plans to participate in training activities in hospitals for the purpose of discussing reimbursement for neonatal hearing screening services.
- * Improve billing and collection for the hearing screening services.
- * Orientation about UNHS to private agencies and public forums.
- * Create awareness among families about the UNHS program and its costs.
- * Organize and implement a public awareness campaign on the importance of the UNHS.
- * Send letters and plan meetings with the labor union representatives to create awareness about UNSHP, expecting them to negotiate with the health insurance companies to assure that include neonatal hearing screening is included as a benefit.
- * Create a UNSHP web site with information for hospitals, health care providers and the general public.
- * With the support of professional organizations related to audiologists, create a pediatric audiologic evaluation certificate.
- * Develop Parent Advisory and Support groups.
- * Identify of new funding sources.

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

a. Last Year's Accomplishments

The estimated number of children and adolescents 0-19 years old was 1,183,569 in 2003. Of these, a total of 554,882 (46.9%) held the government insurance plan by December 2003. As mentioned elsewhere, Puerto Rico finished the implementation of the HCR in July 2000. Among the goals of the HCR was to assure equal access to quality services to all citizens through a government paid health insurance plan for the low-income population or a third party payor. Otherwise, health services must be paid out of pocket.

Within the new health care environment resulting from the implementation of the HCR, the role of the Title V program consists in identifying those children without health insurance, providing orientation at the community level and referring them to the Medicaid program for evaluation and certification. During the reporting period, a total of 75 small group orientations reaching 1,659 individuals across the Island were documented.

In estimating the proportion of children without health insurance we use the experience with Head Start children. This is a low-income population that can be used as a proxy to estimate the number of children without health insurance across the Island. Indeed, an evaluation of the health coverage of 37,571 preschool children enrolled in the Head Start Program during FY 2003-2004 demonstrated that 81.4% held the GIP; over seventeen percent (17.5%) had a private health plan; and only 1.1% (409) did not have health insurance.

Based on the above findings we estimate that approximately 13,019 children and adolescents do not hold a health insurance plan. This is the target population for our outreach activities.

b. Current Activities

The main involvement of the MCH staff consists in performing outreach activities at the community level aimed at the identification of children without health insurance. Those identified without a health plan are referred to the Medicaid program for evaluation and certification, if they qualify for the GIP.

c. Plan for the Coming Year

Ongoing outreach activities for the coming year as mentioned in 13b.

However, as a result of the elections scheduled for November 2004, there is uncertainty regarding new policies that will be implemented by the new administration that could impact this performance measure.

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

a. Last Year's Accomplishments

It is important to highlight that Puerto Rico should not be compared with the states regarding this performance measure. Puerto Rico is under a cap regarding the allocation of Medicaid funds. Medicaid funds are used to complement state monies allocated to buy the GIP for clients certified by the Medicaid Program. In 2002-2003, Medicaid funds represented only 13.2% of the total budget required by the GIP.

b. Current Activities

Due to the issue discussed in section 14a, the MCH Program has not designed any specific activity for this performance measure.

c. Plan for the Coming Year

As mentioned earlier, the Puerto Rico MCH Program does not have the capacity to promote this performance measure.

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

a. Last Year's Accomplishments

Very low birth weight and prematurity are the two determinant factors for high rates of infant mortality in Puerto Rico. There is a wide variety of contributing factors which are resistant to traditional medical care. These include, but are not limited to, factors associated with behaviors such as smoking, alcohol consumption, illicit drug use, stress, domestic violence, inadequate weight gain during pregnancy as well as multiple births.

During the reporting period we documented 900 educational activities reaching 11,458 pregnant women that may contribute to the prevention of this poor birth outcome. The topics included in these educational activities were: 1) Effects of smoking, alcohol and illicit drug use

during pregnancy; 2) Adequate nutrition in pregnancy; 3) Identification of signs and symptoms of preterm delivery; 4) Gingivitis during pregnancy; 5) The importance of prenatal care; and 6) "Comenzando Bien" prenatal care course.

In addition, the Home Visiting Program served 9,405 pregnant women, infants (0-24 months) and children with complex medical and social risk factors. All pregnant women were properly screened for smoking, alcohol consumption, illicit drug use, domestic violence and perinatal depression. Those women found positive for any these risk factors were given education and counseling by the Home Visiting Nurse and appropriate referrals were filled for diagnosis and treatment as required.

On the other hand, the WIC Program served a total of 26,822 pregnant and postpartum women with nutritional risk factors.

The MCH program conducted continued education activities for our Home Visiting Nurses as well as for private perinatal providers. These activities were aimed at increasing the awareness regarding the issue of the high levels of births of VLBW infants, as well as to develop their skills for the identification and management of pregnant women at risk of giving birth to a very low birth weight baby.

b. Current Activities

During the current year (2003-2004), most of the activities mentioned earlier are being conducted on an ongoing basis. The Home Visiting Program (HVP) is aimed at reducing the determinant factors of infant mortality: LBW and prematurity. It has been serving high-risk pregnant women across the Island in 86% of the municipalities. All pregnant women enrolled into the HVP receive a comprehensive health assessment. The assessment includes screening for tobacco, alcohol and drug use, which are behavioral risk factors contributing to low birth weight and prematurity; in addition to sociodemographics, medical and obstetrical complications. Following the assessment, all pregnant women participants of the HVP are appropriately educated/counseled and referrals are made for identified needs.

A "warning signs of premature labor" message board was developed to inform all pregnant women. This educational material is provided not only to HVP participants, but also to non-participants reached through a variety of educational activities at the community level.

Another risk factor that is being associated with preterm birth is poor oral health. During this year we began to emphasize the importance of oral health services during pregnancy. In collaboration with the Director of the Oral Health Services Division we conducted two presentations entitled "Preventing Prematurity through Oral Health Services". One presentation was geared to the Healthy Start Consortium and the other to MCH personnel (Home Visiting Nurses, CSHCN) and the staff of collaborating programs.

In February 2004, we were invited to present at the Sunshine Seminar reaching 390 Ob/Gyns. There we shared the profile of the MCH population based on 2002 data.

Birth outcome data has been shared with a wide number of partners.

c. Plan for the Coming Year

As stated elsewhere, a VLBW infant is an outcome of a broad number of risk factors that may lead to a premature delivery. These factors include chronic health conditions, obstetric complications, multiple births, behavioral risk factors such as smoking, alcohol consumption, illicit drug use, domestic violence and stress, low BMI at the time of conception and short intergenetic periods, among others.

A comprehensive prenatal history and a thorough physical examination are the best tools that help in the identification of most pregnant women at risk of premature delivery. The intervention should be tailored according to the identified risk factors associated with prematurity and VLBW babies.

It is expected that the Home Visiting Nurses will serve about 4,000 high risk pregnant women through case management and care coordination for needed services aimed at reducing poor pregnancy outcomes. In addition, about 4,000 postpartum women will receive services aimed at increasing the interconceptional period to at least 24 month. This is another strategy aimed at decreasing unintended pregnancy and LBW.

During 2004-2005, we will increase our efforts in collaboration with the Division of Oral Health creating awareness about the importance of oral health services during pregnancy, not only among pregnant women but also among prenatal providers and oral health professional as well.

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

a. Last Year's Accomplishments

During the reporting period, the final report of the "Abracemos la Vida", a pilot project on suicide prevention and postvention undertaken by the Comprehensive Adolescent Health Services Program, was submitted to the Administration of Mental Health and Anti-Addiction Services (ASSMCA, Spanish acronym). The main objective of the pilot project was to train schools' gatekeepers in the public school system on early identification, initial management and referrals of students showing suicidal behaviors.

b. Current Activities

In order to better serve the needs of Puerto Rican youth, the MCH Division has been developing a report about the health conditions of the adolescent population ages 10 to 19 that includes a section on suicidal behavior. An interdisciplinary team from the fields of health program evaluation, demography, health education, medicine, anthropology, nursing and social work is developing this report. According to the report, suicide is the third leading cause of deaths for adolescents in Puerto Rico. From 1990 to 2001, 189 adolescents ages 10-19 committed suicide, comprising 4.8% of all reported suicides in Puerto Rico. Over the past decade, suicide rates have remained relatively stable, fluctuating slightly for the age group 15-19. Males commit suicide much more frequently than females and tend to utilize firearms and hanging as a means to terminate their lives. Data gathered by YRBS reveal that in a ten-year period (1991-2001) an increasing number of adolescents of both sexes have attempted suicide requiring medical assistance.

A related activity organized by the Department of Health is the First Conference on Adolescent Mental Health held on March 30, 2004. The conference gathered a group of experts and researchers that addressed relevant mental health issues affecting the adolescent population. Five hundred persons from diverse human service fields attended the conference. This conference registered about 600 attendees.

c. Plan for the Coming Year

The mental health needs of adolescents in Puerto Rico, including suicide behavior, surpass the

ability of mental health agencies to respond to them alone. To help to fill this void in the prevention of suicide the MCH will collaborate with the Administration of Mental Health and Anti-Addiction Services (ASSMCA) and the Department of Education to plan the establishment of a partnership for the prevention of adolescent suicide in the public school system. Another important activity will be the dissemination of the Report on the Health Status of Adolescents in Puerto Rico that will further the knowledge base of health policy makers in the area of adolescent suicide behavior.

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

a. Last Year's Accomplishments

Data related with the place of birth of VLBW babies in 2002 was analyzed and the information was shared with concerned parties. All Home Visiting Nurses routinely assessed their clients for risk associated with premature delivery. They provided appropriate education/counseling regarding the signs and symptoms associated with premature labor. The nurses provided information to their clients regarding the closest birthing facility that provides level III perinatal services.

b. Current Activities

During the current year, we designed a culturally sensitive magnetic board with information aimed at creating awareness on the signs and symptoms of preterm delivery. This magnetic board has been distributed to all participants of the home visiting program as well as to pregnant women at the community level.

c. Plan for the Coming Year

An in-depth analysis of the findings of the "Study to Evaluate the Perinatal Service Capacity of Birthing Centers in Puerto Rico" will be performed. Experts in the field of neonatology, obstetrics as well as members of the PR Healthy Start Consortium will be invited to participate in the process. This panel of experts will be entrusted with the responsibility of developing an action plan to improve the perinatal system of care in Puerto Rico. Once the action plan is developed, both the findings and the plan will be presented to pertinent authorities and concerned stakeholders so that activities related to the plan may be initiated. A regionalized system of care in which women are managed according to their level of risk as close to their residence as possible should be a priority. Services should be provided in a coordinated manner. Providers should be able to determine over the course of prenatal the level of perinatal care the woman will need according to her level of risk and, if needed, provide her with a referral to the appropriate facility closest to her place of residence.

Until a systems approach that guarantees pregnant women and their offspring the expeditious, readily accessible, risk-appropriate perinatal services they need can be implemented, it is important to continue educating and empowering women to seek and access institutions that can provide them with the specialized, risk-appropriate perinatal services she requires. The MCH Division staff will continue providing pregnant women information and educational materials regarding the early signs and symptoms of a premature delivery and where to look for services should an emergency arise. The magnetic board previously mentioned stating this information will be distributed to pregnant women who receive services from the MCH staff so they can display them on their refrigerator door of their homes.

The MCH Division will be actively involved with the local March of Dimes campaign to prevent preterm deliveries. Included in their efforts are a mass media campaign, distribution of

educational material and continuing medical education activities directed at providers and prenatal course facilitators.

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

a. Last Year's Accomplishments

Early, regular and comprehensive prenatal care (PC) is one of the most cost-effective public health strategies to promote the health and well being of mothers and infants. During the past year we devoted our efforts towards reducing age-related disparities in access to PC. In 2002, only 70.4% of pregnant adolescents in PR began receiving PC during the 1st trimester, in comparison to the 80.9% rate for women of all ages. To address this issue the MCH program successfully submitted a proposal to National Office of March of Dimes for a Mission Investment Opportunity Grant. The main purpose of the project was to increase the rate of 1st trimester admission of pregnant teens by providing them free pregnancy tests. Difficulty obtaining the serological testing had been identified as one of the main barriers teens faced when attempting to access PC since Medicaid requires a positive pregnancy test in order to certify eligibility for GIP benefits. This project is a collaborative effort with the Department of Education, Medicaid, WIC, ASES, insurance companies and community clinical laboratories in PR. After establishing the service protocol and finalizing the laboratory contracting process, the project was implemented in 10 pilot sites. The sites selected for inclusion were those with the highest combined rates for teens births and prematurity.

The project has had two main accomplishments during this year that will benefit pregnant adolescents throughout PR. In first place, a protocol was established to give preferential treatment to adolescents requesting their own health insurance card. This was of utmost importance since most start to requesting services late in their 1st trimester. Secondly, in conjunction with our collaborators, a process was devised that allowed adolescents to get individual health insurance coverage without it adversely affecting their family's Medicaid eligibility.

An upward trend continues in the early PC rate. However, efforts are continuing towards achieving PR 2010 goal of 86%. Our Division monitors and disseminates information regarding our progress to concerned individuals and entities. Among the data we share with our collaborators and providers is the IIMIHS which includes the percentage of 1st trimester admission rate and the Kotelchuck Index. MCH Division staff and collaborators continue to promote the public policy requiring all pregnant women be admitted into PC as soon as they request it.

The Healthy Start Project has reinforced outreach activities and has established as it's first priority women who have not received PC. During the outreach activities and during home visits our staff continually stress the importance of early and continuous PC and disseminate educational information that promote 1st trimester admission rate.

In 2002-03, a total of 64 educational activities covering the topic of the importance of early and regular PC, reaching 6,570 participants, were recorded across the Island.

b. Current Activities

Currently, the Healthy Beginnings Project is being expanded to include 20 additional sites by the end of 2004. Laboratory contracts are being renewed for the initial 10 pilot sites. Regular follow up meetings and telephone conversations are being held in order to monitor project progress, identify those barriers to prenatal care adolescents may be facing when they attempt

to enter prenatal care, and work out alternative for them. Efforts have begun to lay the groundwork needed for the expansion phase of the project. Municipalities have been selected and preliminary meetings have begun with four additional sites.

Not all teens have access to Healthy Beginning Project. However, they are all benefiting from the modifications made to Medicaid eligibility procedures and from procedures established to expedite their enrollment into prenatal care.

All Medicaid eligible women are being covered through the Government Insurance Plan. They have prenatal care services available across the Island. To further eliminate economic barriers to care, no co-payment is required for prenatal care services for the clientele holding the GIP. During current year, ASES reported that the network of prenatal providers who serve the clients with the GIP served 43,984 pregnant women generating 198,063 encounters.

MCH outreachers have been re trained on how to more effectively conduct outreach activities and to prioritize interventions. Identifying women with no prenatal care is their number one priority during these outreach activities. Once identified, they are linked immediately with Medicaid, WIC and prenatal care providers.

Every year we assess the MCH health status by municipality by means of the tool called Integrated Index of Maternal and Infant Health Status (IIMIHS). The Index is comprised of 15 indicators: five sociodemographic, two related to the quality of prenatal care (1st trimester admission rate and the Kotelchuck Index) and eight concerning birth outcomes (Table 8). These data have been widely disseminated among health professionals, organizations, medical directors of health insurance, Head Start programs and many others partners. Regions identified as having the least favorable outcomes are encouraged and assisted in the development of a plan to improve these indicators.

c. Plan for the Coming Year

In Puerto Rico, almost 100% of pregnant women have either the Government Insurance Plan (63.6%) or a private health insurance (36.0%) that covers prenatal care. In addition, there is a public policy that pregnant women do not have to pay a co-payment. However, even though the first trimester admission rate has shown a slight increase during the last past five (5) years, it has not reached the expected level.

During the next fiscal year the MCH staff will be promoting or conducting several activities geared to improve the first trimester admission rate in the Island and to assessing the reasons for late entry into prenatal care. This is crucial for the design of more appropriate activities.

During 2004-2005, pregnant women with income below 200% of the poverty level will receive full comprehensive prenatal care by means of the GIP. The MCH staff across the Island will be vigilant that prenatal care providers comply with the public policy aimed at admitting the woman into care as soon as request the services. MCH outreachers have been trained to conduct a broad array of activities aimed at identifying pregnant women unlinked to prenatal care and to make appropriate referrals to service. They will also be looking at the local barriers to early prenatal care and to take action accordingly. A study by means of a self-administered questionnaire will be conducted with recent mothers who initiated prenatal care after the first trimester.

Other activities that are being carried out are to increase public awareness on the importance of early and continuous prenatal care, provision of a wide array of family planning methods free of charge to low income mothers in order to increase the interconceptional period up to 24 months after the last birth, and implementing the Healthy Beginnings Project supported by March of Dimes. This project allows us to provide free pregnancy test to pregnant teens. As

mentioned earlier, this is a requirement of Medicaid in order to certify the adolescent to obtain the GIP card needed to receive their prenatal care.

FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

General Instructions/Notes:

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Screen all newborns for congenital hereditary conditions: T4, PKU, Sickle Cell, Galactosemia.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Initiate screening for CAH and albinism with Humanasky-Pudlack syndrome.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Monitor compliance with the law at individual birthing institutions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Link infants with genetic and metabolic disorders with nutritional and specialized medical care.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Provide anticipatory guidance on newborn screening to women prior to delivery.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Provide genetic counseling to families of newborns with genetic or metabolic conditions.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Continue efforts directed at linking newborn screening data files with birth certificates.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Continue efforts to designate the new members of the Hereditary Diseases Screening Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Provide CME which include the management and control of hereditary diseases.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. Select a representative sample of the population who received services in Pediatric Centers.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Perform a family survey.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Identify strategies to obtain data for the 0-18 CSHCN population in Puerto Rico.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. Design a new brochure about the medical home concept.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Include medical home information in the nursery discharge packets.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Continue distributing medical home educational materials to families receiving services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Continue identifying physicians or mentors at each health region to establish Medical Homes.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Promote incentives for the implementation of medical homes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Meet with ASES and health insurance agencies to increase awareness of the medical home concept.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Certify medical practices as Medical Homes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Train parents as interviewers to do the family interview of the survey.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Implement the survey to get data on the national performance measures for CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. Develop a family survey comparable to SLAITS.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Collect information on health insurance coverage, utilization of services, measurement of child well being.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Select a sample of the CSHCN population who receives services in the pediatric centers.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Develop a family survey.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. Develop a family survey comparable to SLAITS to obtain the required information.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Select a sample from the pediatric center population.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Collect the information	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Identify agency representatives that can be part of a collaboration task force.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Identify families for participation in a task force for data collection and analysis.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Establish a working plan for the task force.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Implement a working plan for the task force.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. Assess and promote adequate immunization for children participating in				

the Home Visiting Program.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Collaborate with the immunization program in their effort to promote disease prevention.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Identify and address system barriers which affect access to immunizations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Monitor immunization rates by municipalities and health regions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Update the immunization knowledge of the MCH staff (Home Visiting Nurses and Outreach Workers).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Use diverse community level interventions to disseminate the current immunization schedule.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Coordinate educational activities to prevent teen pregnancies with schools and communities.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Distribute culturally appropriate educational material directed at preventing teen pregnancies.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Continue implementing the Abstinence Education Only Program in collaboration with the Department of Education .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide the Sex Can Wait Curriculum to at least 100,000 students during FY 2004-2005.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Provide information on the importance of family planning services and how to access them.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Provide trainings on sex education to parents of school age children.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Promote the adoption of a public policy directed at reducing the rate of adolescent pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Increase awareness on issues related with teen pregnancies among providers to this population.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Develop and implement a plan to increase parental awareness the importance of prev. sealants.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Improve the data collection mechanisms to monitor this performance measure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Develop and disseminate educational materials for families concerning				

the importance of sealants.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Promote adequate use of child restraints as part of anticipatory guidance at the community level.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Inform families with limited resources about local programs renting infant car seats.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Continue collaborating with the PR Safe Kids Coalition action plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Train Perinatal Nurses in installation and inspection of car seats.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Conduct the Maternal and Infant Health Survey (PRAMS-like) during the 2 semester of 2004.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Disseminate findings of ESMIPR 2004 among concerned providers of prenatal and perinatal services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Conduct approx. 100 courses of "Comenzando Bien" which includes the importance of breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Provide breastfeeding group orientations at the community level.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Increase awareness of the importance of breastfeeding among the participants of the HVP.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Distribute educational materials about breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Collaborate with other partners (WIC, Proyecto LACTA) in their efforts to promote breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Convene the Breastfeeding Committee at least every two months.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

9. Promote the implementation of the law prohibiting the use of breast milk substitutes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Develop and disseminate a directory of programs and groups that support breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Complete the development and approval process of the regulations for Law #311. (UNHS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Implement the UNHS programs in the seven (7) pilot group hospitals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Plan and develop training activities on UNHS for participant hospital staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Plan and develop training activities on UNHS for Audiologists, SLP, Nurses and Physicians.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Collaborate in the development of UNHS programs at all birthing hospitals in Puerto Rico.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Implement the tracking system for UNHS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Create a UNHS program website to facilitate the delivery of information regarding UNHS and the UNHS program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Plan and develop promotional and educational activities to create awareness of UNHS in the general population.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Conduct outreach activities to identify children with no health insurance and refer them to Medicaid.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				

1. No activity designed because of the Medicaid cap.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Promote early and comprehensive prenatal care among consumers and prenatal care providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Identify and address personal and health care system barriers to early prenatal care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Identify the reasons contributing to late enrollment in PNC among postpartum women.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide home visiting services to pregnant women at risk of having a LBW infant.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Refer to the WIC Program pregnant women with nutritional risk factors.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Promote the appropriate weight gain during pregnancy based on the pre-pregnancy BMI.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Screen HVP participants for high risk behaviors and intervene to eliminate or reduce them.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Promote an interconceptional period of at least 24 months.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Provide post partum women with contraceptive methods to promote a 24 mo interconceptional period.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Promote the importance of receiving a dental evaluation among pregnant women and their providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Evaluate and analyze available VS data on suicide by geographical areas.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Disseminate findings related to suicide among those entities responsible for addressing the issue.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provide SISA students with tools to help them identify peers at risk of suicide and how to help.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Increase teen awareness of the signs associated with suicide intention				

using educational materials.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Further analyze the findings of the study evaluating hospitals with maternity services according to levels of care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Disseminate results of hospital with maternity facilities study to providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Inform pregnant women at risk of preterm delivery where to go in case of an emergency.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Disseminate educational materials informing about signs and symptoms of PTB.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. Provide free comprehensive prenatal care to pregnant women with incomes under 200% poverty level.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Promote compliance with public policy requiring pregnant woman receive PNC services upon request.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Address local barriers contributing to first trimester admission rate of less than 75%.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Conduct outreach activities such as PSA and flyers directed at early enrollment in prenatal care.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Increase public awareness on the importance of early prenatal care.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Promote pregnancy planning and provide free contraceptive methods to GIP participants.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Implement Healthy Beginnings Project aimed at the 1st trimester admission rate in teen moms.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *The number of HIV positive pregnant women.*

a. Last Year's Accomplishments

The Department of Health has continued a close monitoring of the public policy established in 1994 to provide pre-counseling, testing and treatment with ZDV to all pregnant women on a voluntary basis. Special attention was given to the availability of ZDV for all patients identified and in need of therapy irrespective of their economic condition.

Guidelines were sent to the administrative component of the Health Reform (ASES) to be included in the contracts with health insurance companies. The insurance companies, in turn, made available the guidelines to their network of health providers.

Likewise the ZDV Therapy Advisory Committee has continued monitoring the implementation of the guidelines as well as conducting site visits to the health regions.

The MCH Program has continued supporting the work plan of the Perinatal HIV Prevention Program. Currently, the MCH OB Consultant and the Home Visiting Nurse Coordinator take part regularly in the scheduled visits to the regions.

In partnership with the HIV/AIDS Prevention Program, a pilot project was started in October 2002 and is in progress to perform rapid HIV testing using the SUDS test to patients admitted to the labor room at the University of Puerto Rico Hospital in the city of Carolina who had no evidence of being tested during pregnancy. This is an opportunity to identify and assure treatment for those patients whose results are positive.

The Perinatal HIV Prevention Program staff, in collaboration with the HIV/AIDS Prevention Program, produced a play called "Tiempo de Espera" intended for women of reproductive age to promote HIV testing as a strategy to lower the perinatal transmission of the disease. Also, an educational video was developed and forwarded to 40 agencies that are committed to its dissemination.

One-to-one orientation and counseling regarding HIV testing was provided to all pregnant participants of the Home Visiting Program as a strategy to identify and refer for adequate treatment available those with positive results.

A total of 3,136 persons took part in 194 orientations on the subject of HIV/ AIDS carried out across the Island by outreach personnel of our MCH program during FY 2002-2003.

Continued education activities on the subject of perinatal HIV guidelines were carried out in collaboration with the health insurances and pharmaceuticals corporations.

b. Current Activities

Most of the activities mentioned in section 1(a) have continued on an ongoing basis. Nevertheless, we want to give special attention to the following:

* In collaboration with the Perinatal HIV Prevention Program we have continued our efforts to assure that all pregnant women receive counseling for HIV prevention, testing, and treatment

of those found positive on a voluntary basis. A total of 70 pregnant women were found positive for HIV, and 67 (96%) of them received treatment with antiretroviral medications. Only two of the children delivered to these mothers were HIV positive.

Rapid HIV testing using the SUDS test through the Pilot Project mentioned in section (a) was changed to the Oraquik test in November 2003. During 2003 this test was offered to 74 pregnant women admitted to the labor room at the University of Puerto Rico Hospital in Carolina who were screened and had no prenatal HIV testing: seventy three (73) of them accepted being tested.

* The Perinatal HIV Prevention Program staff conducted site visits to five (5) regional hospitals where an educational update on the subject of perinatal HIV prevention and treatment was provided to 121 health providers, including physicians, nurses, cases managers, medical technologists and health educators.

* During 2003, all pregnant women participating in the Home Visiting Program (3,163) received prenatal orientation and counseling regarding the importance of HIV prevention; those identified as not having had an HIV test were referred for evaluation.

* In October 2003, the PR Department of Health, with the collaboration of the CDC and Region II STD/HIV Prevention Training Center, sponsored an educational workshop on the most recent data and issues related to HIV/AIDS in PR, including the perinatal population, aimed at primary health providers and outreach personnel working with HIV patients throughout the Island.

* During 2003, a total of 107 HIV pre- and post-counseling activities were offered throughout the Island by outreach personnel of the HIV/AIDS Prevention Program. Twenty two (22) of these activities were carried out by perinatal outreach personnel. A total of 744 women of reproductive age were reached by these activities.

* The Perinatal HIV Prevention Program staff, in collaboration with the HIV/AIDS Prevention Program, conducted ten (10) theater showings of the play called "Tiempo de Espera" mentioned in section (a) at several community based institutions throughout the Island, with the participation of 305 persons, 237 of them women of reproductive age.

c. Plan for the Coming Year

The MCH Program will continue providing support to those activities that have been essential in the process of meeting our objective regarding the number of pregnant women treated with AZT. The following activities will become our main target for the coming year:

* Continue providing one to one prenatal education to all participants of the Healthy Start Project regarding the importance of HIV testing and treatment of those found positive.

* In conjunction with the health insurance companies, provide continuing education activities addressing issues related to the need for universal screening of HIV and intervention during the prenatal period to primary health providers.

* Provide an educational activity aimed at primary health providers (obstetricians/gynecologists and pediatricians) island wide regarding all the issues concerning the care and follow up of pregnant women with HIV/AIDS.

* Continue the efforts of reaching pregnant women without prenatal HIV testing through the Rapid HIV testing Pilot Project during 2004-2005.

* Make outreach activities at Detoxification Centers to provide counseling on HIV prevention to women of reproductive age visiting those centers.

State Performance Measure 2: Establish a Home Visiting Program for at-risk pregnant women and children less than 3 years in last 95% of the municipalities by the year 2000.

a. Last Year's Accomplishments

The core program of the Puerto Rico Title V program is the Home Visiting Program. Its target population consists of pregnant women and children up to 2 years of age with complex health and social problems. During calendar year 2003, 91 Home Visiting Nurses (HVNs) provided services in 67 out of 78 municipalities. During this period, 5,929 families comprising 9,326 individual cases received home visiting services. Collectively the HVNs conducted a total of 40,255 visits. In addition, The HVNs and Community Outreach Workers (CHW) reached over 4,300 persons in the community through group orientations on diverse topics related to maternal and child health.

The HVNs and CHWs participated in various types of continuing education activities, including training sessions, workshops and distance education via satellite television. These training activities are sponsored by the PR Healthy Start Project and Title V to continue to develop their professional capacity to deliver quality services to the population. The topics included Post Partum Depression; Substance Use in Pregnancy; Family Planning and Contraceptive Update; Outreach Techniques Update; How to Plan an Effective Educational Activity; STD/HIV in Pregnancy; Intervention with Domestic Violence Survivors; Maternal and Child Health in Puerto Rico; Safe Motherhood; Breast Cancer Detection and Treatment; Human Growth and Development; Prevention of Preterm Labor; and Interconceptional Health Care.

In 2003, the Home Visiting Manual, Community Outreach Workers Manual, and the data collection forms (participant records and other reporting forms) were completely revised and redesigned to comply with the MCHB/Healthy Start Initiative's new directives regarding screening for perinatal depression, interconceptional care and pregnancy spacing, as well as the corresponding changes in reporting requirements. The Project Director, Coordinator, Evaluator and Health Educator visited each of the health regions to discuss the changes to the protocols and forms. These modifications have allowed for better documentation of efforts being made and contribute to better reporting of outcomes. The Outreach component within the MCH Division was also redesigned to complement HVP services. The role of the Community Health Workers is focused on identifying pregnant women with no prenatal care and infants who are not receiving preventive pediatric care, to be referred to the HVP and/or to prenatal or pediatric care services available in the community. Each CHW maintains an extensive directory of resources that exist in the community and how to access them, which they share with the HVNs to facilitate the referral and care coordination efforts.

b. Current Activities

Home Visiting Nurses continue to provide case management/care coordination services to pregnant women, women in the interconceptional period (up to 24 months after delivery), and their children up to 24 months of age. According to Healthy Start Initiative guidelines, emphasis is given to (1) increasing the use of preventive services, including early admission into prenatal care, regular pediatric and women's health visits to primary providers, and adequate immunizations; (2) screening for behavioral risk factors and maternal depression and addressing women who are at risk or engaging in risk behaviors appropriately through educational interventions by the HVNs and/or referrals to treatment services available in the community; and (3) promoting family planning, contraceptive use and an interconceptional period of at least 24 months after birth. HVNs have a caseload of 50 families each. This allows

them to dedicate sufficient time and effort to each family to ensure quality services.

Community Health Workers will continue to carry out outreach activities to identify pregnant women and children who are not connected to the available health care system. They will refer potential participants to the Home Visiting Program or to the services available in the community, according to the needs identified by them and the capacity of the HVN in the locality to admit new cases. They will also continue to assist HVN in their interventions, offering follow up to HVP clients when required by the HVN.

During the current year HVNs and CHWs will again receive continuing education on MCH topics. We are in the process of performing a training needs assessment to determine the specific topics that will be covered this year. The focus of the in-service training will be on identifying and managing those risk factors that have the greatest impact on preterm births, low birth weight and other poor birth outcomes.

Providing Home Visiting services in all the municipalities of the Island continues to be a great challenge. There have been several barriers that have prevented us from achieving this goal. The first one has been the aging population of Home Visiting Nurses. Many of our HVN have just recently completed their 30 years of public service and are therefore eligible for retirement. So far we have lost 11 of them and are in the process of losing more. Recruiting new ones is difficult due to the nursing shortage and the long bureaucratic process required to fill a vacant position. There is also a need to allocate funds to assign an adequate number of Home Visiting Nurses to each municipality according to the local demand for HVP services. As a result of these factors we continue to have an insufficient number of nurses. Currently there are 91 HVNs in PR, and 68 out of the 78 municipalities in Puerto Rico (87%) are receiving HVP services.

c. Plan for the Coming Year

The HVP will continue to provide services at a rate of 50 participant families per HVN. The quality of services and their impact on the health and well being of pregnant women, their infants and families will be closely monitored during the year. The evaluation component has been strengthened and the local supervisory role increased. Community Health Workers will continue to carry out outreach activities to identify pregnant women and children who are not connected to the available health care system, as described in the previous section.

Filling the vacant HVN positions will continue to be a priority. Candidates have been identified for many of the vacant positions, and the recruitment process has been initiated. One of the hardest positions to fill will be that of the HVN for the island municipality of Vieques. Despite repeated attempts, we have not been able to identify an interested candidate due to the remote and isolated location.

Since 2002 the PRDH has been undergoing a restructuring of its human resources structure. Regular and transitional positions are being created for many of the professionals currently working under contract, if their job description fills the requirements of a regular position. This has created a backlog in the Human Resources office, which in turn causes delays in the process of selecting and evaluating candidates and filling the positions. We will continue to work with the Human Resources office to fill these positions.

State Performance Measure 3: *The incidence rate of NTDs.*

a. Last Year's Accomplishments

We continue to promote the Folic Acid prevention messages among the population. In October

2002, we participated and contributed in the coordination of the folic acid awareness day at the University of PR main campus (assisting the local chapter of March of Dimes), and of the 10 campuses throughout the Island. Vitamins samples were distributed thanks to the collaboration of a private partner. The MCH Division staff was trained and offered orientation to participants in a one to one model. Approximately 1,500 college students received samples of vitamins. We participated with our exhibit at the OB-Gyn convention in February 2003. To promote the use of folic acid among the public school system girls, we trained school health teachers using the Teacher's Guide that offers strategies to promote folic acid among elementary school children; approximately 250 teachers were selected among the schools with a representation from each region, receiving a comprehensive training, the teacher's guide, and the folic acid video. A total of 150 school nurses, nurse assistants and social workers from the Department of Education were also trained. Approximately 3,500 professionals from the Public School System were trained thanks to a collaborative agreement in place since 1994. To promote the use of folic acid among girls, in 2003 we also trained 70 home economics teachers from the Department of Education. Other trainings were offered to private and public community based programs and agencies. In 2002 we trained approximately 600 of these health professionals. The folic acid messages were included in the web page of the Department of Health. Requests for information from the general public and students are referred to these resources. Other countries like Brazil, Mexico, and USA, have requested our information on folic acid. NTD Prevention of Recurrence: the counseling is given by phone in most cases to mothers of NTD babies. A total of 116 mothers were contacted. This represents 78% of the identified mothers in 1999, 79% in 2002, 77% in 2001 and 66% in 2002. The Medical Association Chapter of Puerto Rico invited us to participate in six (6) health fairs through the Island. We coordinated trainings to new staff and updated field staff from the MCH Division. A total of 6 trainings were offered as part of the new efforts in October 2003. Evaluation of folic acid awareness and use was possible through the folic acid module included in the BRFSS questionnaire. In 2002, 63% of the non-pregnant women knew why folic acid was recommended, but only 32% of them reported having used folic acid. The folic acid module was included for the BRFSS 2003.

b. Current Activities

From July 2003 through March 2004 we participated in 26 health fairs island wide, reaching approximately 2,065 persons. A study was conducted to evaluate behaviors. Six focus groups were conducted; in addition a survey was administered to 700 participants. Participants with no folic acid intake reported the following reasons: "I don't need them", "I forget", and "No particular reason". Public awareness was related to the benefits for pregnant women and the prevention of birth defects. From September through December 2003, we accomplished a successful mass media effort for the promotion of folic acid. The new message of the Folic Acid Campaign emphasized the early development of behaviors related to vitamin use. On October 10, 300 folic acid prevention kits were distributed to drugstores and supermarkets throughout the Island by professionals trained in folic acid messages. Private partners donated 13,000 bottles of folic acid. In these efforts the collaboration with the partners was crucial: the people from WIC, MCH, an insurance company, and volunteers, made possible the distribution of the packages. The remaining 1,000 kits were distributed as follow: 400 were distributed in 8 gymnasiums, 500 by the home visiting staff from MCH Division, 100 were distributed in our health fairs and presentations and 300 were distributed at the Department of Health. A media tour simultaneously occurred and we participated in short presentations at several TV programs with wide population coverage. Innovative folic acid radio ads were placed at the three radio stations with highest ratings. The collaborative effort with the Department of Education for the Folic Acid Campaign includes the permanent inclusion of the folic acid prevention messages in the public schools' health curriculum for the elementary, intermediate and high school levels. We continue our participation in health fairs, professional conventions and conferences, short talks, training for trainers, individual education, telephone requests, student's assignments, etc. Trainings include health educators of an insurance company that covers one of the health regions; MCH staff; WIC staff; community based programs;

Department of Education regional staff supervisors; birthing hospitals' staff; health professionals in training, accounting for approximately 550 professionals. We continue participating in professional conferences with folic acid exhibits: OB-GYN, Mental Health Conference, the Symposium for Sexual Health and NBDPN conference. The 3rd Folic Acid and Birth Defect Symposium will be held on June 17, 2004. We are expecting 500 participants. To promote awareness within the primary care physicians, a local family physician magazine section was dedicated to folic acid and the Birth Defects Surveillance System (6 pages). The magazine was mailed to 9,980 physicians around the island.

c. Plan for the Coming Year

We propose to reinforce strategies with insurance companies, to increase awareness among their groups of primary care physicians. We will continue our efforts to strengthen collaboration and train insurance company staff and to offer one to one information at the physician's offices at least once a year. We will coordinate a meeting with decision makers to develop strategies (August 2004). We plan to continue with the promotion of the use of the folic acid vitamin; and with the collaboration of the Department of Education and other agencies to maintain the folic acid messages up to date and to promote the behavioral changes needed to achieve the prevention of "preventable NTD's". Coordination of activities to promote the birth defects prevention month in Puerto Rico (October to January 2005). Conduct the post intervention survey at the Department of Education (Fall 2004-May 2005). Encourage use and implementation of FA peers curriculum (school year 2004-2005), promote awareness of folic acid messages among students of health and education through recommendations for inclusion in the curriculum and distribution of a kit with relevant educational material (Fall 2004-May 2005).

State Performance Measure 4: *Developing a surveillance system for selected birth outcomes.*

a. Last Year's Accomplishments

In January 2003 additional birth defects were added to the case definition: Omphalocele, Trisomy 18 and 13, albinism, ambiguous genitalia, congenital heart defects, and conjoined twins. We conducted trainings about the definition, diagnosis, natural history, habilitation and surveillance of these additional birth defects and developed guidelines for the case abstraction of these birth defects. We conducted a survey of all pediatric cardiologists and cardiovascular surgeons practicing in Puerto Rico to understand the complexity of the congenital heart defects identification in Puerto Rico, and requested their recommendations for the inclusion of these defects. We offered genetic counseling to affected families after consent and continued with the dissemination of the results related to birth defects occurrence in PR.

b. Current Activities

Continue surveillance of the 13 categories included in the case definition. We are currently offering in service trainings to health professionals at birthing hospitals including the definition of our system and that of the birth defects.

Continuous activities include: 1) dissemination of information related to the prevention of risk factors associated with the index cases in health fairs and talks, 2) collaborative activities between health agencies for the dissemination of the prevention efforts and the early diagnosis and access to habilitation services, 3) dissemination of data related to birth defects prevalence by request or by media, within agencies and the general public, 4) sharing our results in health professionals' conferences at local and national levels, 5) conducting a cleft lip and palate case control study with the assistance of the University of PR in Cayey, 6) sharing surveillance data

at the local and national levels (MCH, CSHCN, NBDPN and CDC) throughout the year, through reports, requests and presentations.

c. Plan for the Coming Year

We are planning to add new birth defects definitions for next year to complete a total of 23 conditions. We plan to continue with the surveillance activities and to promote the continuation of the activities. Coordinate activities to celebrate the birth defect prevention month in Puerto Rico (October to January 2005). Review and implement the ambiguous genitalia protocol (Dec 2004). Develop and implement the Maternal Risk Factor Surveillance Project related to birth defects (fall 2004). Develop educational material on the additional birth defects (Sept-Oct-2004). Offer trainings during 2003 and 2004 on the birth defects included in the System (Oct-Dec-2004).

State Performance Measure 5: *Prevalence of tobacco use among pregnant women.*

a. Last Year's Accomplishments

The MCH Division of the PRDH conducts a PRAMS-like surveillance study, the "Estudio de Salud Materno Infantil de PR" (PR Maternal and Child Health Study) biennially. The latest survey was conducted in 2002. In that study, interviews with 2,411 women in the immediate post partum period were carried out. The prevalence of tobacco use among pregnant women was calculated in the 2002 survey at 4.1%, significantly higher than the 1.0% reported by vital statistics (2001). Low birth weight is the number one cause associated with IM in PR. It has been scientifically corroborated that women who smoke are at a higher risk of having a LBW infant.

The HVNs have continued implementing the smoking cessation program that was designed in 2001 under the auspices of AMCHP's Tobacco-Free Futures Mini-Grant. This project allowed us to convene a panel of experts in smoking cessation and education to design a comprehensive program for our pregnant smokers. The smoking cessation program is based on the USPHS Guidelines for Smoking Cessation and uses DiClemente and Prochaska's Transtheoretical Model as the basis for designing the most appropriate intervention. The HVN uses the "Perfil de la Participante," which is the instrument designed to collect information regarding smoking status, to determine addiction severity, susceptibility to change and level of motivation and support. The self-help diary "Mi Gran Decision" is used as a complement to the HVN's intervention and is meant to guide the participant through a seven-day quitting process. In addition to this program, HVNs stress the importance of avoiding environmental tobacco smoke (ETS) for those women who, although not smokers themselves, live or work in proximity to smokers.

Educational materials regarding both smoking and exposure to ETS are distributed in health fairs and other community education activities.

b. Current Activities

Home Visiting Nurses continue reporting the smoking status of their HVP participants. In calendar year 2003, 3% of our pregnant HVP participants reported smoking during the current pregnancy. The HVNs provided smoking cessation interventions following the Smoking Cessation protocol. Of the women who were identified as smokers, 100% complied with the smoking cessation intervention and reduced or discontinued their smoking practices. During 2004, additional training will be provided to the HVNs to ensure continuing compliance with the expected protocol. Culturally appropriate material is distributed at the community level and among HVP participants. In addition, the effects of high risk behaviors, including smoking, on

the fetus is the topic of one of the two-hour sessions included as part of the "Comenzando Bien" Prenatal Curriculum.

The biennial PRAMS-like MCH survey ("Estudio de Salud Materno Infantil de PR") will be carried out in 2004. Among other topics, it has a section of questions used to determine the prevalence of behavioral risk factors during pregnancy, such as smoking, alcohol and drug use. Information gathered will be shared with all stakeholders so that intervention strategies can be modified to effectively decrease smoking among pregnant women.

The interagency Tobacco Coalition continues to be active and has recently sponsored the Tobacco Summit. Staff from the MCH Division has collaborated with the PR Lung Association in the development of an educational video regarding the effects of smoking on the fetus aimed at pregnant women. In addition, the School of Dentistry of the University of Puerto Rico, which has a specialized center for early detection of oral cancer and tobacco use prevention, is interested in establishing a collaborative project with the MCH Division that will allow them to use the smoking cessation materials developed by us.

c. Plan for the Coming Year

Training sessions on appropriate interventions to reduce high risk behaviors among pregnant women will be held again in the coming year. The goal of these continuing education activities will be to update provider's knowledge regarding importance of screening and providing their patients smoking cessation interventions directed at reducing the prevalence of smoking in general, but particularly during pregnancy and the postpartum period. HVNs and CHWs will continue to promote smoking cessation among all those they come in contact during their daily activities in the community. HVNs will screen all Home Visiting Program participants for tobacco use and provide management according to the level of risk. CHWs will include the topics of alcohol, tobacco and drug use in educational activities and individual orientations during their interventions in the community. These topics will be covered in depth during the prenatal and parenting courses the MCH staff offer in their respective municipalities.

MCH staff will also continue to develop the partnerships with the PR Lung Association and the School of Dentistry, which allows all parties to maximize the utilization of resources and to reach a wider audience with a clear message to stop smoking, as well as offering practical help to those who require it.

State Performance Measure 6: *The birth rate among girls 10-14 years of age.*

a. Last Year's Accomplishments

The birth rate (per 1,000) to teens 10 to 14 in Puerto Rico had a decrease from 2.6 in 1996 to 1.7 in 2002.

The MCH Staff carried out 2,878 small group orientations reaching 50,725 participants across the Island. Topics included: sex education, preventing teen pregnancy, and the risks associated with it. The topic of abstinence was offered to 16,329 people in 783 small groups.

The Abstinence Education Project (PRAEP) reached 44,370 people with the following activities: 1) "Sex Can Wait Curriculum" to 24,130 public school students; 2) Youth Encounter with 185 students, 24 teachers and 10 professional resources from 13 PRAEP peer groups; 3) socio-recreational, educational and youth development activities for 3,097 students; 4) attended by 826 parents 17 parent conferences on human sexuality and effective parent-child communication; 5) other sexuality communication activities reached 202 adults and 265 students.

The "Healthy Beginning" Project and PRAEP developed a plan to reduce health disparities in teen women that included: early identification of pregnant teens to link them early to prenatal care, enrollment into the MCH Nurse Home Visiting Program, orientation to prevent pregnancies and support to continue studying. Two regional activities gathered 393 professionals to raise awareness of teen pregnancy issues and ten municipalities started the Plan.

The Comprehensive Adolescent Health Program (SISA) includes teen pregnancy prevention in the Peer Teen Health Promoters' trainings. A total of 130 students of public schools were initiated as Promoters around the island raising the total number to 560 in 40 public schools. They carried out 233 activities reaching about 10,985 students. Two Promoters attended the "Young Women's Health Summit Parents as Partners" in Miami. During Teen Pregnancy Prevention Month, SISA Promoters held twenty-three activities reaching 870 adolescents islandwide. Activities at the state level included: Secretary of Health Proclamation of March as Teen Pregnancy Prevention Month and the Adolescents-Adults Forum: "Keeping Pregnant and Parenting Teens in School".

The SISA Program provided technical assistance to COPI, a community-based organization in the community of Pinones in Loiza. A peer health promoters' training based on positive youth development was offered to 15 teens and COPI personnel. Topics included: reproductive health, sexuality, communication, self-esteem, healthy relationships between teens and community self development. A needs assessment of Pinones teen mothers was done to assess health and social supportive services. An anthropological applied research on teen pregnancy in Pinones was started.

SISA efforts continued to promote the establishment of the public policy to reduce teen pregnancies. Collaboration in the "Coalicion Pro Salud Sexual y Reproductiva del Adolescente" continued.

b. Current Activities

The MCH Staff has continued to provide teen pregnancy prevention educational activities and materials in schools and community programs.

The Abstinence Education Program (PRAEP) has continued the "Sex Can Wait Curriculum" and peer groups in public schools islandwide. The Spanish translation of the Elementary curriculum was finished and training to elementary teachers began. Five summer camps for 12-17 year old youths are in progress. Parental workshops will be offered in each camp.

The PRAEP and "Healthy Beginning" continued collaborating to promote early teen prenatal care, reduce school dropouts due to teen pregnancy and reduce repeated pregnancies. Ten new municipalities were chosen to start the plan while continuing with the previous ones. A regional meeting with educators and health professionals of four of the new sites was done to present the Plan and discuss teen pregnancy issues.

The SISA Program has continued the comprehensive adolescent school based health program, which includes training middle school students as peer health promoters and organizing varied activities to support them in their work with other students. The Program continues creating awareness regarding risk factors for adolescent pregnancy among the public at large, health professionals and entities that serve adolescents. This included collaborating with four government agencies in the final document of the Public Policy to Decrease Teen Pregnancies and the Action Plan for Puerto Rico. The document is at the Governors' Office for her consideration. The Program continues collaborating with the "Coalicion Pro Salud Sexual del Adolescente" an interagency and community coalition that

works with teen pregnancy issues in PR.

The partnership with the community-based organization COPI in Pinones continued. The Community Teen Promoters' Youth Organization, "Jovenes Creando Conciencia" was created by the teens who took SISA workshops. They developed a social theater about teen pregnancy, drugs and alcohol use that has been presented in schools, PR-TV Channel 6 and other localities. They are participating in a community leadership institute and are working as staff in COPI's Pinones Summer Camp for 6-12 year olds. The anthropological research continued with a focus group and individual in-depth interviews about teen pregnancy. Visits to the homes of identified teen mothers for the needs assessment started.

Efforts geared to promote the application of the "Community Youth Development Approach" as a national priority led SISA to offer a Positive Youth Development Training in collaboration with Konopka Institute for a group of government and community based organizations in PR. The Group will develop a culturally appropriate Spanish curriculum on Positive Youth Development and a train the trainer guide to spread it island-wide.

c. Plan for the Coming Year

The MCH Staff will continue to provide adolescent pregnancy prevention educational activities and materials in schools, community programs or other entities. A collaborative work will be started with the CSHCN Program to involve families and professionals to work in activities related to this priority need.

The Abstinence Only Education Program (PRAEP) in conjunction with the Department of Education will continue to provide the Sex Can Wait Curriculum in its Spanish translation. Training to elementary school teachers will continue so they can also offer the curriculum. Peer group (AMORES) meetings in public schools will continue. Youth Development training will be offered to teachers and students as soon as the culturally adapted train the trainer is developed by the Positive Youth Development Interagency Group. Workshops for parents of school-aged children on communication about sexuality issues with their children will continue. A poster and other media campaign will be used to promote sexual abstinence.

The collaboration to promote early prenatal care in teens, reduce school dropouts due to teen pregnancy and reduce repeated teen pregnancies will continue between PRAEP and "Healthy Beginning", the Department of Education and other agencies. The next ten municipalities to continue the Plan will be chosen. Efforts to recruit teens for the Program will include public residential communities, faith based and community based organizations.

The SISA Program will continue the peer training for health promoters and the organization of varied activities to support them in their work with other students. The Program will continue to work in developing awareness among the public at large, health professionals and other entities, about adolescent's needs. Collaboration in the "Coalicion Pro Salud Sexual y Reproductiva del Adolescente" will continue. A Directory of Services available for the adolescent population in PR will be started in collaboration with government agencies and community based organizations.

The collaboration to the "Jovenes Creando Conciencia" Teen Health Promoters in Pinones, the anthropological research and the needs assessment and provision of services to pregnant teens and teen mothers will continue. A Home Visiting Nurse from the MCH Division was requested to start visiting pregnant and parenting teens in this community.

The work of the Positive Youth Development Committee will include the promotion of the "Community Youth Development Approach" as a national priority, developing a culturally sensitive Spanish Youth Development Guide for PR, developing and providing trainings to

organizations and communities so they can develop and increase the capacity of leaders to integrate this approach and develop a commitment to work with it in the development of activities addressing the health and psychosocial needs of the adolescent population.

State Performance Measure 7: *The rate of death of children aged 1-14 caused by asthma.*

a. Last Year's Accomplishments

The Puerto Rico Department of Health's (PRDoH) Division of Habilitative Services (DHS) continued to fund the Pediatric Pulmonary Program of the Cardiovascular Center with Title V monies to provide wrap-around services to asthmatic children. A total of 3,899 patients were evaluated by Pediatric Pulmonologists; 417 had nutritional evaluation; 403 had evaluations with the Social Worker; 605 had Pulmonary Function Tests; 174 had allergy tests performed.

PRDoH collaborates with a state regulatory agency - Health Insurance Administration - to implement policy changes that improve asthma treatment provided by Health Care Reform HMOs. DHS has succeeded in effecting policy changes that require HMOs to cover costs of referring severe asthmatics to pulmonologists and dispensing the first two days' dose of medications before patients obtain authorization from their physicians.

DHS developed the PININES questionnaire that identifies the prevalence of asthma and other conditions that affect Health Care Reform children with special care needs. As of March 2003, according to this questionnaire, asthma affects 54% of the 16,033 Health Care Reform children with special health care needs.

The PRDoH and members of the Puerto Rico Asthma Coalition (PRAC) continued efforts to control asthma and improve health care providers' and patients' ability to manage and control the condition effectively. During 2003 World Asthma Day, an itinerary of activities was developed including: educational conferences for patients, the general public and physicians, a media tour, clinics, and other awareness events.

DHS continued the development of a strategic plan to meet HP 2010 Objectives for respiratory diseases and held site visit meetings with the major Health Care Reform Insurance Companies to discuss updates on their asthma management programs and interventions provided to severe asthmatics.

An Environmental Protection Agency (EPA) funded asthma educational project called Proyecto Aire has been a collaborative effort of the University of Puerto Rico (UPR), PRDoH, and EPA. UPR has provided asthma education at community centers and schools to 500 asthmatics and their families; and PRDoH has followed up by recruiting and sending UPR-trained outreach workers to conduct in-home site visits to 100 of the families.

The CDC "Addressing Asthma From a Public Health Perspective" grant was approved. The program's objectives will be met through: 1) implementation and evaluation of the Puerto Rico Asthma Surveillance System (PRASS); 2) development of an Asthma Plan with the collaboration of the PR Asthma Coalition (PRAC); 3) intervention activities based on the State Asthma Plan recommendations; 4) implementation of an evaluation plan that measures the effectiveness of the program. The Surveillance System and the State Asthma Plan will provide direction for the implementation of activities directed toward the reduction of morbidity and mortality of the asthma population in PR.

b. Current Activities

"Addressing Asthma From a Public Health Perspective" grant award - We have an

infrastructure now in place to develop the State Asthma Plan collaboratively with partners from the PRAC within the three-year grant cycle. The infrastructure and computer program software for the PRASS have been created and are being strengthened. Meetings have also been held with the major insurance companies and Memorandums of Understandings have been signed to provide asthma utilization claims data to the PRASS. Claims include: hospitalizations, ER visits, outpatient clinic visits, prescription medications filled. This system will contribute to measure and monitor trends in the burden of asthma, guide immediate public health action, help in the establishment of the State Asthma Plan and evaluate asthma interventions.

The PRDoH, as an active member of the Puerto Rico Asthma Coalition, participated in the coordination of the 2004 World Asthma Day. A media tour was developed and also an itinerary of activities including three symposiums for physicians regarding the controversies in asthma management, educational activities in pharmacies, shopping malls, HMO's and schools. Two brochures were developed, one describing the PRAC and the other containing information about asthma and the action plan for asthma management. A press conference was held on May 3 and the special guest was the Secretary of Health who provided updated data on asthma morbidity and mortality in Puerto Rico from the PRASS.

The Environmental Protection Agency (EPA) funded asthma educational project called "Proyecto Aire" is still a collaborative effort of the University of Puerto Rico (UPR), PRDoH, and EPA. UPR continues to provide asthma education in group settings at community centers and schools to asthmatics and their families; and PRDoH will continue to follow up by recruiting and sending UPR-trained outreach workers to conduct in-home site visits with a number of the families.

The PRDoH's Division of Habilitative Services (DHS) continues funding the Pediatric Pulmonary Program of the Cardiovascular Center of PR with Title V monies in order to provide wrap-around services to asthmatic children from low income families.

DHS continues its involvement with the development of a strategic plan to meet the Healthy People 2010 objectives for Focus Area #24 Respiratory Diseases.

PRDoH will raise awareness and visibility about asthma in PR and the Asthma State Plan through the Chronic Diseases Conference to be held in June 2004 and the Public Health Conference to be held in September 2004.

PRDoH is represented at the steering committee meetings of Allies Against Asthma of Puerto Rico, which is a demonstration project funded by the Robert Wood Johnson Foundation. This project offers clinical and educational services to children from 0-17 years old at the Llorens Torres housing community.

c. Plan for the Coming Year

The PRDoH will have the ongoing asthma surveillance system that measures morbidity, mortality, and work-related asthma. The surveillance system will provide information on a continuous basis and will be helpful for the establishment of the islandwide, comprehensive asthma plan and to evaluate asthma interventions.

The DHS, with the collaboration of the PRAC and the PRDoH Division of Chronic Disease Prevention and Control, will implement a small-scale educational intervention for physicians. Primary care physicians (at least 50%) in an identified geographic area with high rates of asthma morbidity and mortality will be trained on the NAEPP (National Asthma Education and Prevention Program) asthma treatment guidelines. The major health insurance companies will help identify primary care physicians. Training needs will also be assessed and an expert team will develop a tailored curriculum. This will be the beginning of future interventions islandwide

with physicians once the State Asthma Plan is completed.

In terms of educational activities to asthmatics, we will continue updating and revising the existing educational programs and materials to be tailored to the needs of patients and their families', including the incorporation of clinical self-management and control components. As with primary care physicians, based on information provided by the surveillance system, a municipality with high prevalence of asthma will be identified in order to implement the asthma plan and educational interventions for patients and families.

The State Asthma Plan will be completed with the collaboration of the PRAC.

An Asthma Summit will be organized through a planning committee comprised of members of the PRAC and the PRDoH. This Summit will be the forum to raise awareness and visibility about asthma in PR and to present the State Asthma Plan and summary recommendations to the general public, providers, practitioners, patients, etc. The impact will be the evidence via verbal commitment from the PR Secretary of Health to support the establishment of an asthma program at the PRDoH.

State Performance Measure 8: *Developing standards of care for CSHCN.*

a. Last Year's Accomplishments

The Birth Defects Registry has already included 13 conditions. For each condition a packet of materials including definition, natural history, diagnosis and habilitation issues, among others, was prepared for training purposes to health professionals. We decided to include a section on standards of care for each of the conditions.

b. Current Activities

Meetings with the Birth Defects Program Coordinator to coordinate and schedule meetings with a group of expert physicians for the different conditions. The purpose of these meetings is for review of existing documentation on clinical management of the identified conditions.

c. Plan for the Coming Year

Prepare standards of care for two (2) conditions to be revised by a group of experts and distribute a packet of information to each of the health insurance companies for the Health Care Reform in the Island.

State Performance Measure 9: */2002/ The cesarean section rate.*

a. Last Year's Accomplishments

The continued increase in the rates of deliveries by cesarean section in Puerto Rico in the last decade has become a major public health issue in the Island as well as a main concern of the MCH program. A descriptive study of all deliveries performed by cesarean section during the 1990-1999 periods was carried out. The findings were shared with key partners. A Task Force including collaborators from the private and public health sectors engaged in analyzing and interpreting the findings to produce a strategic plan to gather and analyze helpful data and make recommendations on the subject. The Task Force identified 12 possible causes for the

problem and recommendations regarding new activities aimed at increasing our knowledge on this issue. Following the recommendations of the Task Force, the MCH Program conducted a chart review of a representative sample (N=560) of cases of live births delivered by C/S during 1999, with the help of selected personnel from the MCH Program in each health region. A C/S evaluation instrument developed by ACOG and translated into Spanish with their permission was used for the review. Data entry has been finished, as well as a descriptive analysis.

Also, in collaboration with other members of the C/S Task Force, the MCH Program developed a questionnaire aimed at postpartum women who delivered by C/S in order to get their perspective regarding this issue. For this survey, the Title V Information and Monitoring Section of our Program selected a representative sample of birthing hospitals across the Island. Unfortunately, the survey has been delayed, pending the approval by the Institutional Review Board in charge.

In partnership with the Maternal and Child Health Training Program of the School of Public Health of the UPR School of Medicine, a 3-hour CME activity regarding the topic of C/S was provided in September 2002 to the Title V, WIC, immunization staff, and other primary providers of the MCH population. It is expected that the information provided through this CME activity will help the professionals to educate our pregnant women in the decision of the method of delivery.

Increased public awareness on the topic and news media coverage on the issue of unnecessary C/S has continued. In December 2002, members of the MCH Division took part in an interview that was published in a newspaper of wide circulation in the Island.

b. Current Activities

Several of the activities mentioned in Section 9(a) are in progress. However, we want to highlight the following:

- * A descriptive analysis of the data collected through the chart review of 560 records of women who gave birth by C/S in 1999 was performed. Further statistical analysis of variables that are identified in the scientific literature as being related is pending.

- * The survey aimed at postpartum women who have delivered by C/S mentioned in 9(a) was recently approved by the Institutional Review Board of the PR School of Medicine. Several attempts were made to respond to the recommendations brought up by the IRB, which delayed the implementation of the study at the expected date. The survey will be carried out during the next FY 2004-2005.

- * To gain skills in analyzing the underlying causes of the increase of C/S rates more effectively, a team comprised of selected staff members from the MCH Division are taking part in a nine-month, online, analytic training program called MATRICHES (Multi-Disciplinary Analytic Training for Reproductive, Infant, and Child Health Services), developed by the AMCHP and the University of Rochester. Puerto Rico was selected, along with two other states (North Carolina and Massachusetts) to participate in this first analytic training program.

- * The topic of C/S rates continues being brought up in educational forums locally. The Director of the MCH Division was invited as a keynote speaker at the annual Conference for Obstetricians and Gynecologists sponsored by ACOG held in February 2003 and February 2004; data regarding maternal and child health issues, including C/S, was shared with 320 obstetricians taking part in the 2004 event.

- * Public awareness on the subject has continued. Members of the MCH Division and the Secretary of Health participated in an interview by a local magazine, "Buena Vida", which

specializes in health topics aimed at the community, especially the female population, where the issue of the increase in the C/S rates was the main topic. Other topics such as the empowerment of women on health issues that affect them, breastfeeding tendencies in the Island, and the demand for more natural birth processes were brought up during the interview. The article has already been released.

* The MCH Staff supported a legislative resolution ordering an investigation regarding the proportion of vaginal births in comparison with births via C/S in Puerto Rico. The DoH submitted a document that included a summary of the evaluation of births by C/S in the United States and the recommendations carried out by an ACOG Task Force in 2000; a summary of the results of the descriptive study of the births by C/S in PR in 1990-99 mentioned in section (a) and the recommendations offered by the DoH based on all the above information.

c. Plan for the Coming Year

The MCH Program will be engaged in the following activities as part of our efforts towards achieving the goal of decreasing the C/S rate in Puerto Rico:

- * To monitor the rate (2003) of C/S by institution and provide feedback to concerned partners.
- * To continue increasing our knowledge base regarding the rising trend of C/S rates in Puerto Rico through several activities:
 - a. The analysis of birth files for the years 1998-2003.
 - b. The statistical analysis of the data collected through the chart review from the 560 records of women who gave birth by C/S in 1999.
 - c. To administer the survey aimed at postpartum women who have delivered by cesarean section to get their viewpoint on this issue. Twenty (20) questionnaires were administered in a pilot study.
 - d. To complete the analytic training program designed to increase the capacity of the MCH staff members with adequate skills to address this issue in a more effective way.
- * To reactivate the C/S Committee and hold meetings at least 3 times during the year.
- * To convey a meeting with the C/S Committee to share the findings of the studies mentioned above and obtain their input to submit recommendations to the Secretary of Health.
- * To disseminate the findings and recommendations of data gathered from postpartum women among the health entities that include key health providers, such as the PR Chapters of ACOG and AAP, and the OB/GYN and Pediatrics Chapters of the Puerto Rico Medical Association.
- * To promote adequate public policy meant to decrease the tendency of cesarean section rates in Puerto Rico.
- * To continue educating and empowering women of reproductive age across the Island concerning the risks of this method of delivery.
- * To promote and provide continued education for perinatal health providers where the topic of the indications and risks of delivery by C/S is included.

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

STATE PERFORMANCE MEASURE	DHC	ES	PBS	IB
1) The number of HIV positive pregnant women.				
1. Collaborate with Perinatal HIV Prevention Program, to promote HIV screening/counseling of all pregnant women.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Offer HIV positive pregnant women further evaluation, counseling, and treatment.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Provide Healthy Start participants information regarding importance of being tested for HIV.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do HIV prevention outreach activities at detox centers for women of reproductive age.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Offer continuing education to health providers on universal prenatal HIV screening and follow up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Share with perinatal providers achievement of HIV testing and treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) Establish a Home Visiting Program for at-risk pregnant women and children less than 3 years in last 95% of the municipalities by the year 2000.				
1. Recruit home visiting nurses for the municipalities of Vieques, San Juan, and others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. If fiscally feasible, recruit additional nurses for municipalities with greatest need.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The incidence rate of NTDs.				
1. Reinforce strategies with insurance companies, to promote awareness among primary care physicians.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have trained staff of the insurance company to give information to the physician at their offices.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Coordinate a meeting with decision maker's staff to develop strategies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

4. Continue with the promotion and collaboration with the Department of Education.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Coordinate activities to promote the birth defect prevention month in Puerto Rico.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Conduct the post intervention survey at the Department of Education.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Encourage use and implementation of FA peers curriculum.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Promote awareness of folic acid messages among students of health allied professions.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Continue with the interagency collaboration to promote folic acid messages at all levels.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Developing a surveillance system for selected birth outcomes.				
1. Add additional birth defects definitions for next year, to complete a total of 23 categories.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Continue with the surveillance activities and to promote the continuation of the activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Coordinate activities to celebrate the birth defect prevention month in Puerto Rico.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Review and implementation of ambiguous genitalia protocol.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Develop and implement the Maternal Risk Factor Surveillance Project related to birth defects.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Development of educational material on the additional birth defects.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Offer trainings on 2003 and 2004 birth defects included in the System.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Continue with training to hospitals staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Prevalence of tobacco use among pregnant women.				
1. Conduct bi-annual survey to determine the prevalence of behavioral risk factors during pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Share information of the survey with concerned individuals (ESMIPR).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Screen HS participants for tobacco use and provide management according to the level of risk.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Update providers' knowledge regarding screening and management of tobacco use during pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Include the topics of alcohol, tobacco and illicit drug use in patient orientations.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Disseminate educational materials on adverse effect of high risk behaviors during pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Increase public awareness of poor birth outcomes associated with risky	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The birth rate among girls 10-14 years of age.				
1. In conjunction with the Education Department, continue the Abstinence Education Only Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Provide the Sex Can Wait curriculum to 100,000 students grades 5th-12th during FY 2004-2005.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Offer educational activities addressing teen pregnancy prevention in schools and community level.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Support students trained as health promoters in their work with their peers.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Identify and train teachers to develop after school activities promoting sexual abstinence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Distribute educational materials on topics of adolescent pregnancy, abstinence and self-esteem.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) The rate of death of children aged 1-14 caused by asthma.				
1. Provide wrap-around services to low-income children with asthma.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Promote policy changes for asthma care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Develop surveys to assess prevalence of asthma.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Train health professionals in asthma management.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Participate in other programs committees.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Collect asthma data, analyze, interpret and report findings and recommendations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Meet Healthy People 2010 objectives for respiratory diseases.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Collaborate with other asthma educational programs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Develop a collaborative State Asthma Plan as part of the CDC Asthma Grant.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Raise awareness and visibility about asthma in PR and the State Asthma Plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) Developing standards of care for CSHCN.				

1. Share guidelines developed for the surveillance of birth defects with the insurance agencies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) /2002/ The cesarean section rate.				
1. Continue analyzing C/S rates trend using birth files.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Monitor the trend of cesarean sections by institution and provide feedback to the directors.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Train key MCH staff to gain skills to analyze the underlying causes of rising rates of C/S.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Share findings of data analysis with the Cesarean Committee and get their recommendations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Present the findings and recommendations to the Secretary of Health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Share the findings with the presidents of the local OB/GYN and ACOG chapters.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Empower pregnant women with information on indications and risks associated with a C/S.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Promote public policies that may contribute to a decrease in the C/S trend.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Promote continued education for perinatal health providers where the C/S topic is included.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Conduct a study aimed at getting patient perspective about the C/S issue.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

E. OTHER PROGRAM ACTIVITIES

/2005/ Enabling services.

As required by law, the PR MCH program operates an Islandwide Toll-Free Line (TFL): 1-800-981-5721 aimed at providing information about the availability of health care and other human services provided through public and private entities. During the reporting period, the DoH changed the provider of the TFL services. This change led to a new TFL. This situation required a plan to promote the new number and develop the mechanisms to gather and report the numbers of calls related to different programs. Therefore, the number of calls reported in Form 9 are those that were received at the Division of MCH.

However, it is expected that as a result of the complete implementation of the HC Reform (July 1st, 2000) the number of calls received through the TFL of the DoH would decrease. This is so,

because currently, PR has six TFLs with the same objective as the MCH TFL. Now, the clientele, especially those holding the GIP, may call several TFLs for the needed information or whenever they confront any problem related to access of services. These numbers are:

1-800-981-2737 - This is the TFL of the ASES. This number is widely promoted among the 1.6 million participants of the GIP.

1-800-981-0031 - The Patient's Ombudsman Office has the responsibility for assuring that all participants of the GIP receive the services negotiated with the health insurance carriers.

In addition, the health insurance carriers are required to have a TFL and to promote it among their participants. In compliance with this charge there are other TFLs available for our clientele. These are the following:

**Triple C: 1-800-981-1352
1-800-255-4375 (Tele Consultation)**

MCS 1-800-981-2554

Humana 1-800-790-7305

These TFLs are printed on the health insurance card as well as in the oral and written information given to the clients at the time they are certified and awarded the GIP card. They are instructed to call these numbers for addressing any problem for accessing the services already paid for them through the GIP card.

Population Based Services

- 1. Close to 50 radio programs of one-hour duration addressing multiple issues related to the health of the MCH population were documented. In addition, 15 articles were published in newspapers of regional or Islandwide coverage. All of this without cost for the program.**
- 2. Our staff participated in 616 health fairs and multiphasic clinics across the Island, reaching 45,912 individuals.**
- 3. On the other hand, a total of 16,153 group education activities targeting 240,177 persons could be documented. Over 70 topics related to different national and state performance measures were presented.**

Infrastructure Building Activities

- 1. Ongoing needs assessment, data analysis and other related activities.**
 - * Development of the 2002 Integrated Index of MCH by municipality.**
 - * Analysis of deaths due to unintentional injuries in children and adolescents, 2002 (0-24 years).**
 - * Active participation in the development of the first Kids Count for PR (2003).**
 - * Surveillance of IM 1996-2000.**
 - * Descriptive Study of MM 1999-2002.**
 - * Analysis of data collected through the 2002 ESMIPR questionnaire.**
 - * Development of the questionnaire for survey ESMIPR 2004.**
 - * Poster presentations at the 9th Annual MCH Epi Conference: December 10-12, 2003 in Tempe, Arizona:**
 - PR IM Epi Surveillance System 1996-2000.**
 - PR M-I Health Survey 2002**
 - Pregnancy Related Deaths in PR, 1999 to 2001**
 - * Questionnaire of Study of C/S: Woman's Participation and Influence in the Decision Making and the Provider's Practice.**
 - * Publication of an article in the CDC MMWR:**
Varela, R., Perez, R., Sappenfield, V., Duerr, A., Hillis, S., Martin, J.A., Ventura, S.J., Grant, A.M., Whiteman, M.K. Infant Health Among Puerto Ricans -PR and the Mainland, 1989-2000. October

24, 2003. MMWR 2003; 52(42); 1012-1016.

2. Over 40 legislative bills dealing with health policies benefiting the MCH population were presented at the legislature. Several of these bills were enacted into law. Examples of these were:

*** Law 177-August 2003. Related with the interagency of the prevention of child abuse and neglect.**

*** Law 311-December 2003. Requires all health insurance plans in PR to provide coverage for screening and audiological diagnostic testing.**

*** Law 318-December 2003. Designates the PRDoH as responsible for developing and implementing public policy for evaluation, management and registry of children and adults with autism.**

*** Law 79-March 2004. Aimed at prohibiting the administration of any breast milk substitute to newborns without the written consent of the mother.**

*** Law 95-April 2004. Prohibits discrimination against women who breastfeed in any public setting.**

These public policies will help us toward the achievement of the NPM 11 and PM 12.

3. Standard development and guidances.

*** Development of the Manual of Norms and Procedures for outreach activities.**

*** Update of the Manual of Norms and Procedures for the HVP.**

*** Development of a curriculum for prenatal courses implemented at the Mayaguez Health Region.**

*** Development of a Manual for the distribution and monitoring of the utilization of contraceptive methods.**

*** Development of new records for home visiting participants.**

4. Program Evaluation/QA: A chart audit of all participants of the HVP during calendar year 2003 was carried out. A total of 9,408 charts were reviewed.

5. Professional development: CME activities were provided to all HV nurses, outreach workers, private prenatal, perinatal and pediatric providers. A number of critical topics were included such as:

*** Safe Motherhood**

*** Perinatal depression**

*** The importance of breastfeeding.**

*** HIV**

*** Child abuse and neglect**

*** Current profile of the PR maternal, infant and pediatric population.**

*** Unintentional injuries.**

6. The MCH staff at the state, regional and local levels participated in 1,000 meetings with different public and private partners.

7. The Healthy Start Consortium held 5 meetings. At the same time, the RWG of the SSDI Project met regularly during the reporting period.

8. Presentation outside the Island-the MCH Director presented at the Summit of Mental Health held in New York: "An Epi Model of Early Intervention Through the HVP".

9. Technical Assistance (TA)

*** We received TA supported by the CDC and AMCHP.**

*** We also provided TA to several students of the MPH, to ASES, and others.//2005//**

F. TECHNICAL ASSISTANCE

//2005/ The new Guidance set for the Title V Application and Annual Report requires that States report progress in achieving the established annual performance indicator for each of the 18 National Performance Measures, all the State Negotiated PMs (9 in PR), 11 HSCIs and other health status and sociodemographic indicators and 6 outcome measures. This is great challenge for those jurisdictions with limited resources and which at the same time are left out of national surveys that provide the data for some of the PMs. The latest example of a survey which did not consider the needs of the jurisdictions is the SLAITS. This survey will help the States by providing the data to monitor some of the PMs concerning the CSHCN population. However, the jurisdictions must report progress on performance measures #02, #03, #04, #05 and #6 even though they were not included in the SLAITS.

Currently, the PR CSHCN program does not have the needed data to monitor the progress of the five national performance measures mentioned earlier. There are no data for either the denominator nor the numerator of these performance measures.

Since in 2005-2006 states and jurisdictions will have to perform the comprehensive and mandated 5 year needs assessment, a TA concerning the needs assessment of the population of CSHCN is desperately needed. Some of the questions that we have to answer in relation to the CSHCN group are:

- 1. How many children with special health care needs are there in the Island?*
- 2. What is the distribution by age group?*
- 3. What are the most prevalent conditions?*
- 4. In which geographical areas do these children live?*
- 5. What services are available for them and where?*
- 6. How many providers are there according to identified prevalent conditions, and where do they practice across the Island?*
- 7. Others.*

The TA should be geared to help us in designing the most appropriate process to gather the needed information to answer the aforementioned questions, what are the minimal resources needed to carry out the task and to identify any available instrument designed for this purpose elsewhere.

In November 2004, elections will be held in Puerto Rico, which means that in January a new government administration will be on board. A new government administration means new priorities, goals and objectives in all state agencies including the Department of Health. Historically, this has been a challenge to MCH/CSHCN programs in trying to carry out the work plan approved by the MCHB. Based on past experience, we strongly suggest that early in 2005, our MCHB Project Officer come to Puerto Rico to meet with our new supervisors, and us to provide an overview of Title V priorities, performance measures and requirements. //2005//

V. BUDGET NARRATIVE

A. EXPENDITURES

/2005/ Completion of Budget Forms

Please refer to budget columns of Form 2, Form 3, Form 4 and Form 5 for FY 2002-2003. Estimates had to be used in providing budget and expenditure details. Breakdown of expenditures by type of services is a very difficult task when we try to assess the performance of a public health professional. This task is quite easy at the first level of the pyramid related to direct services. At this level, we know who serves the different groups of the MCH population and the amount of time dedicated to each of the subgroups, allowing us to determine the expenditures by type of individuals served. But trying to estimate the amount of time dedicated to each of the subgroups comprising the MCH population, as well as the time dedicated to perform enabling, population-based or infrastructure building services, is not an easy task. For this reason, estimates had to be made and this may lead to discrepancies between the budgeted and the expended figures by levels of the pyramid.

The implementation of the HCR finalized by July 2000. At this time, the process of relocation of personnel is almost complete and the categorical programs have more control in the recruitment of the appropriate personnel.//2005//

B. BUDGET

/2005/ Program allocations have taken into account the 30-30-30-10 requirements established by Title V. Efforts are made to match funds according to the identified needs through the four levels of the MCH pyramid, as well as the three groups of individuals that comprise the target population.

Puerto Rico assures that the MCH funds are used for the purposes outlined in Title V, Section 505 of the Social Security Act. Traditionally, a fair method has been used to allocate Title V funds among individuals and geographic areas having unmet needs. As the implementation phase of the HCR reached its final phase, the fair allocation of funds is guided by an Integrated Index of Maternal and Infant Health Status (IIMIHS) developed by the MCH Division to assess the health needs of the target population by municipality. One of the benefits of using this Index is that the information necessary to evaluate each of its variables is available on an ongoing basis through analysis of birth and death files. Definitely, the IIMIHS is a useful tool guiding the allocation of resources for Components A & B across geographical areas. (Table 8)

A total of 35% of Title V Block Grant Funds are allocated for the CSHCN program. Thirty percent (30%) is used to provide for services at the Pediatric Centers islandwide. This includes salaries and benefits of the staff, professional services contracts, medications not covered by GIP, nutritional supplements and assistive technology devices considering the established procedures. The other five percent (5%) is used to cover the administrative costs for central level and the seven (7) Pediatric Centers.

The needs of CSHCN identified through the needs assessment support our efforts to make specialized services available through the Pediatric Centers. The Metropolitan Area Pediatric Center, administratively under the Pediatric University Hospital for the past nine years, remains a supra tertiary referral center and serves the children and families referred by the other six Pediatric Centers. The Metropolitan Area Center offers a great variety of subspecialized services to our population.

The Pediatric Centers bill the insurance companies for the services provided to the CSHCN under the GIP. As the reimbursement process is becoming more efficient, an improvement in the amount of money collected is observed. We account for \$470,966.00 available at the DoH, income generated during 2003-2004. These funds will be used to support the billing unit and provide for their priority needs, to cover some of the non-recurrent expenses at the Centers, to

continue supporting the information system and to pay for additional subspecialty services at the pediatric centers.

The Division had a coordinator of fiscal affairs, an accountant with a MBA, until April of 2002. We recruited an accountant to assist the director and the deputy director to manage financial and budgeting affairs. The fiscal affairs for the Division are under continuous analysis and scrutiny given the changes in the PR Treasury regulations and procedures and consequently those of the Finance Office. Identifying providers for subspecialized services and therapy is still a challenge for some regions. We have been exploring different alternatives for compensation of these services and educating families and providers to understand the needs of this special population and to enhance concepts like medical home. Budget allocation follows a historic expenses pattern. It had not been possible to develop a different distribution system. A TA visit on this issue is to be scheduled in the future.

State dollars used to provide services to the MCH population surpass by many times the requirements for the match. State funds appropriations are used for the GIP and the implementation of a broad array of programs and services that contribute to improve the health and well being of the MCH populations. Table 6 presents a list of several programs supported by State dollars.

In addition to MCH dollars and the State funds listed in Table 6, there are other federal sources of funds that contribute to the achievement of the MCH outcomes. These are included in Form #2.

Budget documentation: The Fiscal Affairs Office of the Department of Health and the Office of Federal Affairs maintain budget documentation for Title V funding and expenditures consistent with section 505(a)(1).

Allocations for FY 2004-2005: The estimated amount of money to run the MCH/CSHCN programs during FY 2004-2005 is as follows:

**Federal : \$17,080,795.00
Unobligated : \$ 8,037,913.00
(FY 2003-2004)
State: Matching : \$18,839,031.00
Program Income : \$ 470,966.00
Total : \$44,428,705.00**

The unobligated balance allows us to continue running both MCH/CSHCN programs during the first trimester of FY 2004-2005. As everybody knows, the funds herein requested are not available until late November or early December of the fiscal year.

Allocation by MCH Population Groups:

- A) \$5,124,239(30%): for the provision of services to pregnant women, mothers & infants.**
- B) \$5,124,239 (30%): for the provision of preventive services for children.**
- C) \$5,124,239 (30%): for the provision of services to CSHCN.**
- D) \$1,708,078 (10%): From this amount, 5% is for program administration of Components A & B; and 5% for administration of the CSHCN program.**

Allocations by Levels of the Pyramid:

Direct Services: Funds will be used to purchase contraceptive methods to support the family planning services rendered through the health care reform for women holding the GIP. Even though the family planning services, including sterilization of males and females, are included in the GIP, the contraceptive methods are not included in the benefit package. Also, salaries of the 7 Pediatric Centers providers are included in this item.

Enabling Services: A significant amount of Title V funds is needed to support salaries of Home Visiting nurses, perinatal nurses, community health workers, health educators, payment of local travel expenses and for the Toll Free Information line.

Population-Based Services: Title V monies are used to sustain the NTD prevention campaign, injury prevention, public education, purchase of educational materials, incentives that promote the toll-free line and convey health promotion messages, the staff of the Comprehensive Adolescent Health Program (SISA) and a wide array of health promotion messages.

Infrastructure Building: To sustain the infrastructure of MCH/CSHCN programs, funds are used for the salaries of central and regional staff, for needs assessment and other core functions, equipment, professional development, the interactive education program, the purchase of computers, e-mail, support of applied investigations, surveillance, and other related activities.

Administration: Up to 10 percent of the federal allocation is used to support salaries of administrative staff, utilities, internal audit, newspaper announcements, travel to required meetings and conferences in the mainland, office supplies, duplication of documents, mailing, AMCHP annual membership and others. The CSHCN Program covers part of its administrative costs from the 35% allocated from the MCH Block Grant.

Other Requirements

Maintenance of Efforts: Puerto Rico is in compliance with maintenance of effort requirements as described in Section 505(a)(4). In fact, PR exceeded efforts of the 1989 program year. As of December 2003, there were 1,521,848 individuals with the GIP in Puerto Rico. Among these, 343,286 were women (15-44 years of age) and 21,038 were infants <1 years of age. Close to 533,844 were children (>1-19 years) including CSHCN.

During the FY 2003-2004, of all individuals holding the GIP, the MCH population represented 54.5%. The annual cost per person was \$877.20 (73.10 per month). The Table 7 summarizes the sources of the budget used to pay for the health services of the population holding the GIP.

Considering that 54.5% (828,806) of the beneficiaries of the GIP represent the MCH population, it is estimated that PR invested over \$727,028,623 million in state and local funds to pay for the MCH services. We assume that 33% or \$239,919,446 million were invested in preventive and primary services for the MCH population. In addition, about \$160 million of Medicaid and \$29 millions of CHIP were also used for this segment of the population.

Several earmarked state funds allocated for special services and programs were also identified. These include \$1.5 million for the immunization program, \$2,122,000 for the Pediatric AIDS program, \$200,000 for the Newborn Screening for Hereditary Diseases Program, \$100,000 for the EMSC program, \$5,406,453 to support 165 children and adolescents with Catastrophic Illnesses and others totaling \$252,961,973.00. Definitely, the Commonwealth of Puerto Rico surpasses the matching requirements of Title V. //2005//

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.