Maternal and Child Health Services
Title V Block Grant

State Narrative for
Louisiana

Application for 2010
Annual Report for 2008

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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.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications will be maintained on file in the MCH program's central office. Requests for copies of these documents may be obtained by sending a written request by fax to (504) 568-8162 or by mail to the following address:

MCH Block Grant Coordinator
Office of Public Health
Maternal and Child Health Section
325 Loyola Avenue, Room 612
New Orleans, LA 70112

/2007/
Assurances and Certifications will be maintained on file in the MCH program's central office. Requests for copies of these documents may be obtained by sending a written request by fax to (504) 219-4583 or by mail to the following address:

MCH Block Grant Coordinator
Office of Public Health
Maternal and Child Health Section
P.O. Box 60630
New Orleans, LA 70160
//2007//

/2008/
Assurances and Certifications will be maintained on file in the MCH program's central office. Requests for copies of these documents may be obtained by sending a written request by fax to (225) 342-2256 or by mail to the following address:

MCH Block Grant Coordinator
Office of Public Health
Maternal and Child Health Section
P.O. Box 3214
Baton Rouge, LA 70821
//2008//

/2009/ Assurances and Certifications will be maintained on file in the MCH program's central office. Requests for copies of these documents may be obtained by sending a written request by fax to (225) 342-2256 or by mail to the following address:

MCH Block Grant Coordinator
Office of Public Health
Maternal and Child Health Section

P.O. Box 3214
Baton Rouge, LA 70821 //2009//

/2010/ Assurances and Certifications will be maintained on file in the MCH program's central office. Requests for copies of these documents may be obtained by sending a written request by fax to (225) 342-2256 or by mail to the following address:

MCH Block Grant Coordinator
Office of Public Health
Maternal and Child Health Section
P.O. Box 3214
Baton Rouge, LA 70821 //2010//

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 March 2009; expires March 31, 2012.

E. Public Input

Input from MCH stakeholders was facilitated by publishing the MCH priority needs and program activities in the May 2005 issue of the Louisiana Maternal and Child Health (MCH) Coalition News. The 210 members of the Coalition represent public and private hospitals, and obstetric and pediatric providers. The Priority Needs were distributed and the Needs Assessment process discussed at a meeting of the MCH Coalition Board on April 27th, 2005. Questions and comments pertained to Oral Health, local and regional input and involvement in the Needs Assessment process, and the Fetal and Infant Mortality Review (FIMR).

The Title V Application has become more accessible to Louisiana's citizens via Internet access. A summarized version of the application was posted to the MCH website on 5/24/05 (see attachment or www.oph.dhh.state.la.us/maternalchild/index.html). The summary document was reviewed by 30 CSHS Stakeholders from all 9 administrative regions of the state. The Stakeholders suggested that we address access to health care, dental care and transportation; provide ongoing education to CSHS families; address transition of CSHCN to adult services; emphasize mental health issues and ensure healthy pregnancies.

/2007/The MCH Program Plan was distributed to the MCH Coalition and CSHS Stakeholders. Recipients were asked, in the context of the hurricanes, what changes they would like to see in the MCH program. Feedback included the needs of families in Special Needs Shelters, and statewide access to CSHS medical records. The Summary website was updated and a notice of the grant was posted to the Louisiana Register.//2007//

/2008/ Input from MCH stakeholders was facilitated by publishing the MCH priority needs and program activities in the May 2007 issue of the Louisiana Maternal and Child Health (MCH) Coalition News. Recipients were asked for feedback. The MCH Program Plan was distributed to CSHS Stakeholders. The Summary of the Block Grant was updated and posted to the MCH website on June 15, 2007and a notice of the posting of the grant was published in the Louisiana Register in June 2007.//2008//

/2009/ Input from MCH stakeholders was facilitated by publishing the MCH priority needs and program activities in the Louisiana Maternal and Child Health (MCH) Coalition News, and a presentation provided to the Coalition Board members. Recipients were asked for feedback. The Summary of the Block Grant was updated and posted to the MCH website on May 5, 2008 and a notice of the posting of the grant was published in the Louisiana Register in May 2008. (see

attachment) The summary document was reviewed by CSHS Stakeholders from all 9 administrative regions of the state. The Stakeholders suggested that we strongly emphasize the link or association between good prenatal care and children born with special health care needs. //2009//

/2010/ Input from MCH stakeholders was facilitated by publishing the MCH priority needs and program activities in the Louisiana Maternal and Child Health (MCH) Coalition Newsletter. The May 2009 Newsletter is attached. Recipients were asked for feedback. The Summary of the Block Grant was updated and posted to the MCH website on May 1, 2009 and a notice of the posting of the grant was published in the Louisiana Register in May 2009. The summary document was distributed to the Louisiana Parenting Network (LAPEN) Guidance Team. LAPEN is a professional association for parent educators in Louisiana. The guidance team consists of approximately 25 members who were asked for feedback. Members suggested that mothers who have premature babies in the neonatal intensive care units (NICU) be provided better resources to support breastfeeding via breastpumps through WIC. Also suggested were programs such as Nurse Family Partnership to address the needs of women who are not first time mothers and more parenting education classes should be provided specifically for teen moms. The summary document was also reviewed by CSHS Stakeholders from all 9 administrative regions of the state. The summary document is attached. //2010//
An attachment is included in this section.

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

An attachment is included in this section.

C. Needs Assessment Summary

Following the 2005 needs assessment process, the MCH and CSHS staff created the following priority needs for Louisiana's Title V Block Grant: (1) Decrease infant mortality and morbidity in collaboration with regional coalitions comprised of public and private health and social service providers; (2) Decrease intentional and unintentional injuries in the maternal, child, adolescent, and children with special health care needs populations; (3) Assure access to quality health care for the maternal, child, adolescent, and children with special health care needs populations, addressing barriers including Medicaid provider availability and lack of transportation; (4) Address the mental health needs of the maternal, child, adolescent, and children with special health care needs populations, through prevention and early intervention, screening, referral, and where appropriate, treatment; (5) Address the substance abuse related needs of the maternal and adolescent population, through prevention and early intervention, screening, and referral; (6) Promote comprehensive systems of care and seamless transition to adult services for the Children with Special Health Care Needs population by providing care coordination. (7) Promote pre-conceptional and inter-conceptional health care including family planning; (8) Address the oral health needs of the maternal, child, adolescent, and children with special health care needs populations; (9) Improve the health behaviors of the maternal, child, adolescent, and children with special health care needs populations, addressing healthy nutrition, proper prenatal weight gain, breastfeeding, and physical activity; (10) Obtain and utilize reliable evidence to: a) identify preventable causes of maternal, child and adolescent mortality and morbidity, b) develop preventive public health campaigns targeting high risk populations, and c) perform process and outcome evaluation.

Priority action steps and progress made with respect to each priority need is carefully reviewed every 3 months by key MCH stakeholders and program staff to assure that each remains a top priority for the Louisiana MCH Program. There has been no change in the top 10 priority needs for the MCH Program since the 2005 needs assessment. However, selected activities related to these goals have been updated or modified as appropriate and necessary to improve health in Louisiana based on input and experience from MCH Program staff and stakeholders.

The Maternal and Child Health (MCH) Program formed a needs assessment steering committee to discuss and plan the 2005 Title V Needs Assessment process. The steering committee decided to organize the needs assessment process into five subgroups: Adolescent Health, Child Health, Perinatal Health, Oral Health, and Children with Special Health Care Needs.

An update of the perinatal needs assessment is planned for Fall 2007 through Spring 2008. New data from vital records, PRAMS, and other programs will be shared with each of the 9 regions across Louisiana to assure that current priority needs are being addressed state-wide. An oral health screening of 3rd graders by school health nurses is planned for this year to determine dental sealant prevalence among these children. Results will be available in the next block grant year. In the Summer of 2006, a Graduate Student Intern (GSIP Program) assisted CSHS staff with a revised needs assessment to re-evaluate program activities post-hurricanes. This effort was finalized in the Fall by the CSHS epidemiologist and CSHS Medical Director. Internal data from the CSHS program was used to assess current resource allocation and utilization, and results were presented to CSHS stakeholders to help guide program planning for the 2007-08 years. Findings suggested that access to physicians was hindered in hurricane-affected areas, leaving some CSHS needs unmet for several months. It is believed that either services in these

areas have returned to pre-hurricane capacity or that the CSHS population has relocated such that the majority of known needs are being met. Access to care may have improved recently due to extensive outreach efforts targeting Medicaid enrollment of CSHS eligible individuals. No changes in program priorities resulted from the revised needs assessment.
Infant mortality, low birth weight, prenatal care, care coordination, oral health, intentional and unintentional injury remain focus areas of the MCH Program. The Oral Health program received funding for additional staff to work with priority activities targeting improved oral health in the MCH population. Recent revision of Injury Program staff within OPH provides new opportunity for targeted injury prevention outreach and education. Assuring access to primary care providers, for both the uninsured and Medicaid populations, also continues to be a major focus of the MCH and CSHS Programs.

New areas have emerged as priorities. These include Mental Health (Priority Need #4) and Substance Abuse (Priority Need #5). Additional funding for a perinatal depression counselor for high-risk women has allowed for improved capacity in the areas hardest hit by hurricane Katrina. Collaborative efforts with the Office of Mental Health and the Office for Addictive Disorders has lead to a joint effort to initiate use of a validated substance use and depression screening tool, the 4ps plus, along with a model for brief intervention and referral for clients who screen positive. This program is currently in place in 4 of the 9 public health regions (3 beginning within the past 2 months), and Medicaid will consider reimbursement for this screening/brief intervention once the program has been implemented state-wide. Both of these initiatives have incorporated strong program evaluation efforts to assure that these programs are achieving their stated goals. Results of this systematic data collection are expected in 1-2 years.

/2009/ Priority needs continue to be reviewed multiple times per year to assess progress and identify new opportunities. While no changes are reported in the top 10 MCH priority needs, selected activities implemented to address these needs have been updated or modified to continue effecting positive change. All MCH Programs strive to effectively address cultural diversity in the development of appropriately designed messages and interventions. //2009//

/2010/ Priority needs continue to be reviewed to assess program progress and identify changes in health status. No changes are reported in top MCH priority needs this year. Culturally appropriate MCH activities, including programs and data usage, remain ongoing in communities. Recent focus has been placed on stakeholder, program, and data preparations for the upcoming 5-year Title V MCH Needs Assessment. Continued advances in data driven program decisions are expected to remain a key goal for the MCH program. //2010//
An attachment is included in this section.

III. State Overview

A. Overview

/2007/ Louisiana's already poor health status took a tremendous blow from Hurricanes Katrina and Rita. As a result of both Hurricanes Katrina (August 29, 2005) and Rita (September 24, 2005), southeastern and southwestern Louisiana sustained unprecedented and extensive devastation of epic proportions. More than three million people were impacted and more than 1,300 lost their lives. The population in New Orleans has been reduced from 450,000 to a current population of about 185,000. The combined damage of the storms range from $100-$200 billion due to, but not limited to, the loss of homes, communities, businesses, jobs, schools, and significant impairment the state's healthcare infrastructure. The state's pre-existing health status and infrastructure problems coupled with the new post-hurricane provider exodus, population shifts and extensive damage to the pre-existing impaired healthcare system and communities, create huge challenges for the state health care delivery systems.

Both the private and public sector healthcare infrastructure sustained extensive damage from the storms, exacerbating challenges to the delivery of Title V services and all other healthcare services statewide. Louisiana's healthcare industry is currently functioning at or below 50 percent capacity as a result of the storms' devastation. Statewide, there was a loss of patients, more than 6,000 trained medical personnel, medical/dental clinics, hospitals (including the Medical Center of Louisiana's Charity Hospital, the Level 1 Trauma Center and public health hospital in New Orleans), pharmacies, medical/dental and other healthcare services, health information/medical records (continuity of care), and scientific research. Also of importance were the loss and/or disruption of medical, dental, pharmacy, and allied health education and training programs. /2008/ A study conducted by the LSU Public Policy Research Lab estimated that the total number of uninsured residents as of fall 2006 was 657,027. The 2006 Louisiana Health and Population Survey estimated that approximately 669,000 people reside in Region 1 compared to 1,000,000 prior to hurricane Katrina. The survey also estimated that 124,592 of these residents do not have any form of health insurance (estimated at 160,000 pre storm). Prior to the storm, 245,000 residents in the region were enrolled in Medicaid; February 2007, about 134,821 Region 1 residents were enrolled in Medicaid.//2008// /2009/ The Annual Louisiana Medicaid Report for State FY 2006-07 estimated that ~35% of Orleans, Jefferson, Plaquemines, St. Bernard Parishes residents and ~27% of Louisiana residents were enrolled in Medicaid. //2009// ***/2010/ According to the Annual Louisiana Medicaid Report for State FY 2007/08, 1,174,215 Louisianans (27%) were enrolled in Medicaid. The 2007 Louisiana Health Insurance Survey, revealed declines in the number and percent of uninsured adults to 546,348 or 21.2% (from 654,729 or 24% in 2005) and children to 64,355 or 5.4% uninsured (from 97,403 or 7.6% uninsured in 2005). //2010//***

The healthcare infrastructure of the Department of Health and Hospital's Region 1, which includes Orleans, Jefferson, St. Bernard, and Plaquemines Parishes was, and still remains, the most devastated. Orleans Parish had one of the largest concentrations of primary care providers and other health professionals in the state prior to Hurricane Katrina. As of April 2006 , the DHH Bureau of Primary Care and Rural Health has determined that Orleans Parish now has less than one primary care physician for every 3,200 residents, less than one psychiatrist for every 21,000 residents and less than one dentist for every 5,000 residents. Available acute care hospital beds remain at approximately 50 percent, and there is still a shortage of trauma, ambulatory care, and mental health services. The need for mental health services throughout the state has grown exponentially since the storms. Due to the population changes and the limited availability of health care services post-Katrina, New Orleans has been designated as a health professional shortage area (HPSA). Therefore, post-Katrina, the state's total Health Professional Shortage Areas (HPSA) designations are 404: primary care (243), mental health (108), and dental health (53), and they are located throughout the 64 state parishes, as of June 2006. /2008/ Currently, about 86% of Louisiana parishes are designated health professional shortage areas. The estimated provider shortage in Region 1 has a gap of 54 primary care physicians needed to treat

the Medicaid and uninsured populations, 42 dentists for the Medicaid population, 10 psychiatrists for the general, uninsured and Medicaid populations, and 53 pharmacists for the general population.//2008// /2009/ Louisiana has 257 HPSA designations for primary care, 154 for oral health, and 60 for mental health. //2009// ***/2010/ There are 520 Health Professional Shortage Areas (261 medical, 172 dental, and 87 mental health) throughout all 64 Louisiana parishes. //2010//***

The Louisiana Recovery Authority (LRA) is charged with post-hurricane healthcare reform and serves as the planning and coordinating body created in the aftermath of the hurricanes by the Governor. LRA Public Health and Healthcare Taskforce contracted with Price Waterhouse Coopers to assist with state health planning efforts post-Katrina. The key findings and recommendations presented in their "Report on Louisiana's Healthcare Delivery and Financing System" include: quality issues; removing the 2-system (public and private) model; address the impacted area's immediate need including long term care, mental health, trauma, and ambulatory care; address divergent interests between the LSU academic medical center and the other public hospitals; address the 2-system model impact on graduate medical education; 6 address shortage of primary care physicians and oversupply of specialty physicians; address shortage of registered nurses and allied health professionals; improve information technology infrastructure; address need for statewide health care emergency preparedness system including incorporating on-site preventive care and other health services into transitional housing communities' service delivery plans.

The DHH Bureau of Primary Care and Rural Health has been charged with making recommendations for redesigning and rebuilding the healthcare infrastructures in the impacted regions of the state. One approach is through community planning to restore access to healthcare services in the impacted areas, with a focus on integrative primary and preventive healthcare and behavioral healthcare services. /2009/ The LA Healthcare Quality Forum (LHCQF) was legislated in 2007 to facilitate a Medical Home (MH) system of care statewide. LHCQF adopted the National Committee for Quality Assurance Patient Centered MH Guidelines as the standard. In May 2008 the forum held a MH Summit for policy makers, where CSHS presented its Model MH Care Coordination (CC) findings. DHH has proposed adopting Florida's model of Provider Service Networks (PSN) with capitated Medicaid for CSHCN statewide. //2009// ***/2010/ Louisiana submitted an 1115 Medicaid waiver for Coordinated Care Networks to function like HMO's. Provider reimbursement would be capitated and linked to compliance with meeting NCQA Medical Home criteria. Providers would receive added reimbursement for Care Coordination (CC) activities. Whether medical care for CSHCN would be capitated or remain fee for service is not yet determined. CMS approval for the new plan, submitted in December 2008, is still pending. //2010//***

Despite some improvements from reform efforts, Louisiana still ranks as one of the three unhealthiest states for children. Poverty, inadequate income, and low education levels are just a few contributing factors affecting the state and the Title V Program's overall priorities, healthcare initiatives, and delivery of services. According to the 2005 KIDS COUNT Data Book, Louisiana was ranked 49th in the nation for its children's health status and well-being based upon 2004 data. Louisiana ranked the worst (50) for percent of teens not attending school and not working (ages 16-19); percent of children living in families where no parent has full-time, year--round employment; and percent of children in single-parent households. Louisiana was near the bottom ranking (49) for percent of low-birthweight babies and children in poverty. Compared to the previous year of data, Louisiana saw improvements in infant mortality, the child death rate and the percent of high school dropouts. It also saw a slight decline in the teen death rate. Teen births were not ranked in the 2006 report but Louisiana was 49th based upon 2002 data. The percent of children in poverty remained unchanged at 30% from 2003 to 2004. The negative economic impact of Hurricanes Katrina and Rita due to the loss of jobs, which resulted in the loss of income and health insurance; the loss of schools, which resulted in the loss of educational opportunities and eventually the opportunities for higher wage jobs; and the loss of healthcare providers/facilities, which resulted in the loss of healthcare access, will have a negative impact on

the health status of our children in Louisiana. The degree of the impact has yet to be determined. /2008/ Louisiana ranked 50th in the nation for infant mortality (2004 data) and 49th in the nation for overall children's health status (2004 data), low birth weight babies (2004 data), children in poverty (2005 data), children in single-parent families (2005 data), and children living in families where no parent has full-time, year-round employment (2005 data). Louisiana ranked 47th (2004 data) in child deaths, 45th in teen deaths from all causes (2004 data), 40th for teens not attending school and not working (2005 data), and teens who are high school dropouts. Compared to prior year's data, Louisiana saw improvements in teen births; teens who are high school dropouts; teens not attending school and not working; children in poverty; and children in single-parent families.//2008// /2009/ The 2008 KIDS COUNT Data Book, ranks Louisiana 49th in the nation for the health status and well-being of children (2005/06 data). Louisiana ranks 48th for teens not attending school and not working (2006 data); 49th for infant mortality (2005 data), low birth weight babies (2005 data), teen deaths from all causes (2005 data), children in poverty (2006 data), children in single-parent families (2006 data); and 50th for child deaths (2005 data), teen high school dropouts (2006 data), and children living in families where no parent has full time, year-round employment (2006 data). Improvements were seen in infant mortality, teen births in all age groups; and children in single-parent families. //2009// ***/2010/ KIDS COUNT 2009 Data Book ranks Louisiana 49th for children's overall health status and for all key indicators but child deaths-42nd, teen deaths-43rd, teen births-36th, high school dropouts-46th. //2010//***

Though Louisiana is ranked as one of the unhealthiest states, positive strides were being made in healthcare reform efforts prior to the storms. Louisiana had moved from last place (50th) in 2005 to 48th place, according to the 2006 Morgan Quitno National Report on states' healthcare status rankings. Of the 21 health status indicators, Louisiana improved its ranking on 13 factors. One of the areas where Louisiana showed the most improvement was on the percentage of children who do not have health insurance coverage. Louisiana improved 27 places and is now ranked 33rd nationwide. The reduction in the number of children without health insurance from 11 percent to 7.6 percent, and resulted from aggressive and targeted outreach efforts by Medicaid and LaCHIP staff, through the Louisiana Covering Kids Initiative. Targeted outreach resulted in the enrollment of more than 55,000 children over the last two years. With the national average being 12 percent and with the state's average being 7 percent, Louisiana is now one of the top 10 states with the lowest uninsured rates for children. Louisiana also improved its ranking on childhood immunizations. The state moved up three ranking positions and increased the number of children immunized by nearly 4 percent. Based on 2005 data from the parish health units, 66 percent of the children ages 19-35 months were up to date on their immunizations, which reflect an increase of 12 percent from 2004. The LINKS system, which tracks childhood immunizations in the state, is credited for improving this ranking. /2008/ The 2007 Morgan Quitno Report ranked Louisiana as the unhealthiest state in the nation. According to DHH, Louisiana is ranked 6th in the nation in the percent of the population lacking access to primary care; and 3rd highest in the percentage of uninsured residents in the nation at 19%. Almost 50% of Louisiana residents live at or below 200% of the federal poverty level, and 25% of Louisiana residents live in rural areas, but only 14% of primary care physicians practice in rural areas.//2008// /2009/ Louisiana is the second unhealthiest state in the nation according to the 2008 Morgan Quitno Press. //2009// ***/2010/ Louisiana remains the second unhealthiest state in the nation, according to the Congressional Quarterly Press' 2009 Healthcare State Ranking (formerly Morgan Quitno Press). United Health Foundation's 2008 edition of America's Health Ranking has Louisiana as the least healthy state, down from 49th in the 2007 Edition. The state ranked in the bottom five states on 10 of the 22 measures, including infant mortality, premature deaths, obesity rates, child poverty, uninsured population, and preventable hospitalizations. //2010//***

Racial and ethnic disparities, like poverty, negatively impact the health and social-emotional wellness of Louisiana children. According to the US Census 2004 American Community Survey, the percent of African American families living below poverty level is 29.9%, compared to 16.7% Hispanic, 3.5% Asians, and 8.2% Caucasian families. Overall, the infant mortality rate increased from 9.3 deaths per 1,000 live births in 2003 to 10.4 deaths per 1,000 live births in 2004. Though

there was an increase for both whites, from 6.4 to 7.7 deaths per 1,000 white births, and blacks, from 13.8 to 14.7 deaths per 1,000 black births from 2003 to 2004, the infant mortality rate for blacks is twice that of whites. In 2004, despite the increase in the percent of black women receiving prenatal care in the first trimester, from 75.5% to 79.2%, the percentage was significantly lower than the 91.6% of white women who received prenatal care in the first trimester. Despite the overall decrease in SIDS deaths in 2004 to 0.8 deaths per 1,000 live births, the rate for black infants, at 1.0 deaths per 1,000 live births, is still higher than the rate for white infants, which is at 0.7 deaths per 1,000. Reducing racial and ethnic disparities in the health status of mothers, children, and families is a priority of Louisiana's MCH Program. /2008/ According to the US Census 2005 American Community Survey, the percent of African American families living below poverty level in Louisiana is 32.3% compared to 17.9% Hispanic, and 8.7% Caucasian families. Preliminary 2005 state vital records data shows that Louisiana's infant mortality rate decreased to 10.0 deaths compared to 10.4 deaths per 1,000 live births in 2004. The percentage of infants born to pregnant women receiving prenatal care in the first trimester improved to 87.2% in 2005. Reducing racial and ethnic disparities, which negatively impact the physical, mental, and social-emotional wellness of children and families, remains a priority of Louisiana's MCH Program.//2008// ***/2010/ An unpublished analysis of the Louisiana 2006 NCSHCN data indicates that there is a disparity of 20.97% between ability of black and white CSHCN to meet MH composite criteria based on NPM's 1,2,3, and 5, with white infants more likely to meet the criteria. The average disparity for all 50 states was 10.24%. //2010//***

The aftermath of the hurricanes posed many other unique challenges for the state and the Title V MCH Program. There has been large population shifts within the state and out of Louisiana due to mass evacuation. Initially, more than a million people evacuated the southeastern and southwestern parts of the state for Hurricanes Katrina and Rita. Because repopulation and rebuilding are very slow in the heavily storm impacted areas, much of evacuated MCH population remains dispersed. Therefore, outreach efforts have increased to locate high risk MCH populations and identifying new populations. There is an influx of uninsured, undocumented, and non-English speaking workers and their families into the impacted areas of the state, which has very limited support services available and a very impaired and strained healthcare system. Housing for families in the impacted areas are very limited, unsafe (moldy, gutted), or unaffordable. Families are adjusting to living in trailers instead of homes and, in some cases, living in the federalized transitional housing (trailer) communities, which are very restrictive. Limited access to transportation, a challenge before the storms, has worsened post-hurricanes due to the loss of public transportation in such impacted areas as Orleans and Jefferson Parishes; the loss of personal vehicles to flood waters; and/or relocation of residents to rural areas where there is very limited or no access to public transit. ***/2010/ During the aftermaths of Hurricanes Gustav and Ike in September 2008, the Title V MCH Program was the safety net for the provision of food and personal care supplies for infants and toddlers in storm-impacted areas of the state. MCH and the WIC Program worked collaboratively to provide formula to infants in shelters during the storms and, just recently, to ensure that contracts for appropriate food provisions for infants were included in the state's emergency preparedness and response plan. //2010//***

MCH and public health has continued to function as the "safety net" for healthcare services, despite the state's fiscal constraints and budgetary cuts to state MCH funding. Title V services continue to be a primary resource for prenatal care, preventive pediatric, and subspecialty pediatric services in certain areas of the state, especially after the storms. For example, Title V funds help to support the only prenatal maternity services available for the uninsured of Orleans, Plaquemines, and St. Bernard Parishes since Hurricane Katrina, which is offered through the Jefferson Parish Public Health Unit. Additionally, the MCH Program has continued to monitor the health status of Louisiana's mothers and children and has developed, expanded, and/or supported programs targeting those areas of the State with the greatest MCH needs through outreach to low-income pregnant women and children; public education campaigns; newborn screening; lead poisoning and injury prevention; oral health services; services for children with

special health care needs; and support of contracted delivery of services by primary care centers, hospitals, medical schools and other community-based organizations in those areas.

The challenges facing Louisiana's healthcare system are many, but not impossible to overcome. Louisiana has an opportunity to rebuild its healthcare system and improve the health of all residents statewide. The MCH Program will actively participate in this rebuilding process to ensure that the healthcare needs of low income women, infants, and children are met. Operating within the context of the Office of Public Health and the changing health care environment, the Title V Program maintains its commitment to decreasing mortality and morbidity and assuring access to primary and preventive health care services for Louisiana's maternal and child health population including those with special health care needs. //2007// /2009/ Louisiana has a new Governor, Director and Deputy Director of Health, and Assistant Secretary of Office of Public Health. Proposals for much needed reform to Louisiana's behavioral health care system include a mental health crisis safety net infrastructure with a single point of entry, telemedicine use in provider shortage areas, and community-based system of care. The lack of providers trained in infant and child mental/behavioral health persists. //2009//

Louisiana is unique because of its history of a comprehensive publicly financed health care system to serve its large proportion of poor citizens. In the past, Louisiana has relied heavily on its regional, State-supported hospital system and large network of Maternal and Child Health (MCH) Block Grant and other federal and state funded public health clinics to directly provide preventive and primary health care for pregnant women, infants, children, and adolescents, as well as services for children with special health care needs, for its large medically indigent population. Maps 1, 2, and 3 of the attachment show existing Parish Health Units, State Charity Hospitals, and Federally Qualified Health Centers (FQHC), respectively. Additionally, the MCH Adolescent School Health Initiative began in the early 1990's and provides support for primary and preventive physical and mental health services in 54 state-funded, 1 federally-funded, and 1 private- foundation funded school-based health centers across the state. /2008/ There are currently 50 School Based Health Centers across the state. Six centers closed due to the hurricanes and 5 were in New Orleans.//2008// /2009/ Lousiaiana has 56 SBHC in 23 parishes serving 86 public schools and 20 Federally Qualified Health Centers, with 56 service sites. //2009// ***/2010/ In the 2007/08 school year, Louisiana had 62 SBHCs in 26 Parishes which served 95 public schools. Also, Louisiana has 22 FQHC's, with 64 service sites and 107 Rural Health Clinics. //2010//***

Changes in the financing of health care services through the State system and the infrastructure of health department services have occurred in the past decade, which have affected the role of Title V in the health care system within the state. Since the Omnibus Reconciliation Act of 1990, Medicaid reimbursement for obstetric and pediatric care has increased, resulting in a growing participation of private physicians and hospitals in providing health care to Louisiana's low-income poor women and children. More recently, the State Medicaid Program has enacted several changes that have had a positive impact on financing health services for the low-income population. These include expansion of income eligibility for Medicaid through the State Child Health Insurance Program (LaCHIP), expanded income eligibility for pregnant women (LaMOMS), and statewide implementation of a primary care case management program for Medicaid recipients (Community Care). This has resulted in a decrease in the need for direct services through the public health units. Simultaneously, over the past several years, the state has experienced budget shortages that have impacted the services provided through the Department of Health and Hospitals. Ongoing budget shortages have resulted in hiring and spending freezes for all government agencies, restrictions on purchases, contracting, out of state travel, and cuts to contract expenditures. Since 2000, the Office of Public Health (OPH) has experienced a lay-off resulting in approximately a 10% reduction of the entire agency workforce and discontinued the staffing of 25 parish health units with the turnover of 18 of these units by contract agencies including primary care centers or hospitals. Since 2003, the management of Part C of the Individuals with Disabilities Education Act (IDEA) by the Children's Special Health Services (CSHS) program has been very successful with a 43% increase in children from birth to

3 years identified with developmental disabilities. The success of the program with a resulting increased enrollment and demand for services has lead to a significant increase in expenditures, which has put a strain on the entire Office of Public Health budget. This has resulted in budget constraints for all programs and a restructuring of the Part C program, called EarlySteps, emphasizing cost containment. /2009/ The LaCHIP Affordable Plan is the new Medicaid health insurance program for uninsured children in families whose gross income is between 200 and 250 percent FPL. //2009// ***/2010/ In state fiscal year 2007/08, Louisiana Medicaid enacted several positive changes to ensure accessible, quality health care for its enrollees, such as a new Medicaid online application and an increase of physician reimbursement rates to at least 90% of Medicare allowable. Also, certain Medicaid-covered EPSDT dental and dental services for pregnant women rates were increased to 65% of the 2007 National Dental Advisory Service Comprehensive Fee. Coverage was expanded for uninsured children under age 19 yrs up to 250% FPL through the LaCHIP Affordable Plan, with monthly premiums/co-payments and through the Family Opportunity Act Medicaid Buy-In Program for children in families up to 300% FPL who have a disability and are ineligible for Supplemental Security Income (SSI), Medicaid, or LaCHIP. Reimbursement was added for immunizations to recipients age 21 years and older for influenza, pneumococcal, and HPV diseases. //2010//***

The reduction in staff has affected the MCH and CSHS Programs in several ways; one being a decrease in the number of MCH and CSHS visits. A comparison of visits in 2004 compared to 2003 shows a 7.8% reduction in child health visits and an 8.9% reduction in maternal health visits. However, the number of pregnant women and children receiving WIC and women receiving pregnancy testing services in parish health units increased from 129,031 to 137,144. The number of children served by CSHS continues to show gradual decline from 5,792 in 2002 to 5,360 in 2004. However, the number of clinic visits has remained stable, indicating that children with multiple special needs and more severe medical conditions are enrolled in the program. Enrollment in CSHS is also affected by income and eligibility criterion that has not changed in over 20 years. The CSHS program has completed 2 years of implementation of the EarlySteps program. This early intervention program has increased the staff and capacity of Title V in Louisiana in identifying and providing services to Children with Special Health Care Needs (CSHCN) and in establishing closer working relationships with other state agencies, parent advocacy groups and families.

/2008/ In 2006 CSHS clinics had 16,513 visits. This is a 6.9% drop in activity from the previous year, corresponding to an 8.7% decrease in patient numbers statewide. Efforts to enroll CSHCN in Medicaid have increased options in the private sector for many families. Transportation issues, refusal of about 50% of pediatricians and family practitioners to take Medicaid and/or CSHCN, and lack of sub-specialists in many areas of the state have continued to promote barriers. Region I lost approximately 28.9% of its patients and region V 14.3%.//2008// /2009/ According to the National Survey of CSHCN (NSCSHCN), between 2002 and 2006 there was a decrease in children of 9.4% and in CSHCN of 19.4%. Many families of CSHCN chose not to return after the hurricane. In CSHS clinics patients decreased to 4645 but visits increased to 17,874. CSHS serves more CSHCN in the private sector through CC, increasing by 9.1% the total number of patients served to 11,167. With addition of more CC's, this will increase rapidly. //2009// ***/2010/ CSHS clinic patients continued to decrease to 4421 but visits increased to 19,025, reflecting the increase in complexity of patients seen. The total served in the public and private sectors was 10,528. //2010//***

Recent national events have impacted public health in the area of emergency preparedness for natural and man-made disasters with a primary focus on bio-terrorism. State and National sources of funding have been used to build public health infrastructure. Approximately 50 new positions in the Office of Public Health have been added. The presence of these new staff in the areas of epidemiology, bio-terrorism coordinators, laboratory, and hospital nurse coordinators will have an overall impact of strengthening public health services. An example of how these efforts will complement Title V efforts is the use of a planned drill to test our capacity for mass

immunizations as a focused community-based effort to provide childhood immunizations, which will impact our immunization rates.***/2010/ As of 6/17/09, 153 cases of H1N1 were identified in Louisiana. DHH has continued to work closely with the CDC, the Governor's Office of Homeland Security and Emergency Preparedness, and other state and federal partners to respond to current cases and to plan and prepare for a potentially stronger, more aggressive re-emergence of H1N1 flu during the flu season. DHH conducted desktop drills to ready hospital response to a surge inpatient capacity and have developed, with partners, a web-based pandemic flu training course for physicians and nurses. //2010//***

Health Care Reform at the State and local level has been an issue addressed by the new Governor who took office in 2004. Utilizing information from Regional Summits with input from providers and citizens, the first Health Care Summit was held in March 2004. From this Summit has come initiatives to address the following areas: 1) Provide care to the uninsured which includes intensified outreach activities for LaCHIP, adult Medicaid outreach, looking at federal waiver opportunities, and obtaining a state planning grant to develop other options for providing access to affordable health insurance coverage; 2) Access to appropriate health care resources including transportation, improving access to Medicaid for pregnant women, and improving access to treatment services for addictive disorders; 3) Improving and restructuring long -term care, 4) Health education and awareness related to tobacco, obesity, and improving health in schools; 5) Improving administrative delivery of health care including the development of electronic Medicaid files and electronic prescribing and medical records; 6) Focus on performance outcomes using evidenced-based principles including the development of disease management initiatives and the development of decision support tools for Medicaid providers; 7) Reducing prescription drug costs and improving prescribing practices; and 8) Evaluation of the Medicaid Program. Regional Panels have been established to address these issues at the local as well as the State level. These Health Care Reform activities should have a significant long-term impact on the health care system in the state.

Nonetheless, even with improved financing of health services and changes in the public health delivery system, the need for MCH services continues. There remain areas where the Title V services continue to be a primary resource for prenatal care, preventive pediatric, and subspecialty pediatric services. Title V funds provide the wrap-around services for women and children receiving benefits from the Supplemental Food Program for Women, Infants, and Children (WIC) through 70 parish health units. These services include immunizations, prenatal and parenting education, case management, and referral for other health and social services. Although the numbers of women and children served through these clinics have decreased, services were provided to over 137,000 pregnant women and children, comprising a large percentage of the state's population of pregnant women and low income children under 5. Additionally, the MCH Program has continued to monitor the health status of Louisiana's mothers and children and has developed programs targeting those areas of the State with the greatest MCH needs. The savings in MCH funding resulting from the lay-off has been used to contract for the delivery of services by primary care centers, hospitals, medical schools and other community-based organizations in those areas. Thus, the Title V Agency continues to play the role of assuring access to needed services for the State MCH population.

1. Health Care Needs of the State's Population

Louisiana has ranked poorly on national comparisons related to health status and care. A 2005 national report published by Morgan Quitno Press titled "Health Care State Rankings 2005" ranked Louisiana 50th, worst in the nation in health indicators. The report is based on 21 factors that reflect access to health care providers, affordability of health care, and the generally health of the population. Examples of factors include births to teenage mothers, percent of population not covered by health insurance, death rate, and the sexually transmitted disease rate. Louisiana's ranking as the unhealthiest states stems from its high rate of uninsured, low rate of physical activity, high rate of diabetes, high infant mortality rate, high cancer death rate, and high rate of low birth weight babies. According to the 2004 National Kids Count Report, Louisiana ranks 49th of all states on indicators of child well-being. Although improvements occurred in 5 of 10 of the

indicators, Louisiana ranked 49th for percent of low-birth weight babies and for percent of families headed by a single parent and 48th for infant mortality rate, percent of children in poverty, and percent of children living where no-parent has full-time, year-around employment. On the national CSHCN Survey (SLAITS), Louisiana was found to have the 2nd highest percentage in the United States (U.S.) of CSHCN, suggesting that poor health indicators and general health of citizens results in a significantly higher than average percentage of children with special needs. /2009/ In NSCSHCN, LA decreased among states from 2nd to 26th in prevalence of CSHCN, from 14.8% to 15.8% of children. //2009// ***/2010/ According to the 2007 National Survey of Children's Health (NSCH), 80.4% of Louisiana children are in excellent or very good health, compared with 84.5% for the US. The percent at risk for developmental or behavioral problems is 35.2%, compared with only 26.4% for the US. The percent screened is higher than the national average (28.7% versus 19.5% US). This is most likely due to the requirement of developmental screening for Medicaid Community Care (Kidmed) reimbursement. The percent who had received a preventive healthcare visit in the past year was at the national average (88.6% Louisiana versus 88.5% US). //2010//***

a. Louisiana population

According to the US Census from 2000 to 2003, the total population of Louisiana grew by 1.0% to an estimated 4,496,334 people. In terms of racial make up, Louisiana has two main racial groups, white 63.9% and black 32.5%, with 3.6% as other. This is vastly different from the racial make up of the U.S., where 75.1% of the population is white, 12.3% of the population is black, and 12.6% is other. (Figures 1, 2 and 3) The total number of women of childbearing age has decreased from 1,006,947 (22.5%) in 2000 to 983,257 (21.9%) in 2003. Teenagers 15-19 years and children 0-14 years comprised approximately 7.7% and 21.6% of Louisiana's population in 2003. The parish population estimates from 2000 to 2004 can be found in Table 1 of the attachment. /2008/ According to the US Census, the population decreased by 4.87% to 4,287,768 in 2006. In 2005, racial makeup in Louisiana was about 64% white, 33% black, and 3% other, compared to a racial makeup of about 80.2% white, 12.8% black, and 7% other in the U.S. The total number of women of childbearing age decreased from 971,997 (21.6%) in 2004 to 898,065 (20.9%) in 2006.//2008//

Although 72.6%, of the of the state's population lives in an urban setting, geographically Louisiana is a predominantly rural state. Only 27% of the 64 Parishes have at least 70% of their population classified as urban (2000 U.S. Census). Six of those parishes are located in the greater New Orleans metropolitan area. Most of the parishes in the Central and Northern parts of the State are rural. /2008/ According to USDA-ERS data, in 2006, an estimated 26.5% (1,137,845) of Louisiana's population was classified as rural and 73.5% (3,149,923) as urban.//2008//

In 2003, the Bureau of Economic Analysis reported Louisiana a having a per capita personal income of $26,038 compared to the national average $31,459. This shows an increase of 2.9% from 2002. Over the past 3 years, 2000 to 2003, Louisiana has had relatively no change in its median household income of $34,307. The unemployment rate, reported by the Louisiana Department of Labor, in March of 2005 was 5.3% compared with a national rate of 5.2%. The overall poverty rate has not significantly changed in the past four years, 2000-2003. In 2003, Louisiana had an overall poverty rate of 17% or approximately 750,000 people. According to the U.S. Census Bureau, Louisiana had the 4th highest poverty rate in the U.S. for the period 2001-2002. Among the 50 states, Louisiana ranked 47th in child poverty. Only three states, West Virginia, Arkansas, and New Mexico had child poverty rates higher than Louisiana's rate of 25.5% in 2004. The 2004 national rate is 17.6% (United Health Foundation Rankings). /2008/ In 2005, the median household income increased to $36,729 compared to $46,242 U.S. average. According to the 2005 American Community Survey, Louisiana ranked 2nd highest in the nation for overall poverty, with a rate of 19.8% and 3rd highest for children under 18 years in poverty, with a rate of 28.4%. The 2005 U.S. child poverty rate is 17.6% (United Health Foundation Rankings).//2008// ***/2010/ The 2007American Community Survey ranked Louisiana as 2nd highest in the nation for overall poverty (rate of 18.6%) and children in poverty (rate of 26.8%). //2010//***

According to the 2000 Census, of the 64 Louisiana parishes, 19 have poverty rates greater than 25% with 3 with rates greater than 35%. Fifteen of these parishes are in the northern and central parts of the State. According to census data, 22.1% of families, with related children less than 18 years, live in poverty, as do 26.7% of families with related children under 5 years. According to the Census 2000, the Louisiana poverty rate for children aged 5 to 15 with disabilities was 35.3%, compared to 25.0% for those without disabilities. In the U.S., 25.4% of children with disabilities aged 5 to 15 lived in households with income below the poverty level, compared to 15.7% of children without disabilities. /2008/According to the 2005 American Community Survey, 24.1% of families with children less than 18 years and 26% of families with children under 5 years live in poverty. The Louisiana poverty rate for children aged 5 to 15 with disabilities was 37.23%, compared to 26.96% for those without disabilities. In the U.S., 28.74% of children with disabilities aged 5 to 15 lived in households with income below the poverty level, compared to 17.04% of children without disabilities.//2008// ***/2010/ According to the 2007 NSCH, 19.4% of children in Louisiana live in neighborhoods with poorly kept or dilapidated housing (14.6% nationally), and only 82.6% live in neighborhoods deemed safe, compared with 86.1% US. //2010//***

Also impacting on the status of Louisiana's mothers and children have been changes in Louisiana's cash assistance program related to welfare reform such as limiting welfare benefits to two years in any five years; capping benefits at five years in a lifetime; and requiring twenty hours per week of work or work training, unless exempt. This has led to an 82% decrease in the number of monthly cash assistance recipients to 22,612 from July 1998 to March 2005 through the Families in Temporary Assistance Program (FITAP) operated by the State Department of Social Services (DSS). In March 2005, 17,448 or 77% of the 22,612 FITAP recipients in the state were children and 5,164 (23%) were adults. Thus far during State Fiscal Year 2004-2005, an average of 12,659 grants were paid each month with the average grant being $194.67. A survey done in 2003 by the Department of Social Services of 2000 families at or below 200% of Federal Poverty level found that more than half of respondents who completed FITAP were still in poverty. Almost 36% of those completing the 24-month program reported income at or below 50% of poverty, and another 32% reported income between 51-100% of poverty.

Low education levels are also a problem in Louisiana. Data from the 2000 census indicates that 32% of the State's population over age 25 years had only a 12th grade education with 9.3% having less than a 9th grade education. /2008/ In 2005, 80 percent of people 25 years and over had at least graduated from high school; 21 percent had a bachelor's degree or higher; and about 6.8% had less than a 9th grade education.//2008//

b. MCH Health Status Indicators

Between 2000 and 2003, Louisiana experienced a 4.6% decline in the number of live births; most of the decrease (3.9%) in live births occurred between the years 2000 and 2001. In 2001, 2002 and 2003 Louisiana had 65,193, 64,755, and 64,689 births respectively. The infant mortality rate in Louisiana decreased from 10.2 in 2002 to 9.3 in 2003; this is the first decrease in Louisiana's infant mortality rate since 2000 and reverses the upward trend that had been seen since 2000. The black infant mortality rate of 13.8 is twice that of the rate of 6.4 for white infants (Figure 4). Disparities in the infant mortality rate are seen when looking at the nine different regions of the state (Figure 5). These disparities are reflective of differences in socioeconomic status and resource availability throughout the State with the poorer and more rural northern and central portions of Louisiana having worse indicators. /2008/ From 2004 to 2005, Louisiana experienced an 8.5% decline in the number of live births, with 64,956 and 59,446 births respectively. The infant mortality rate in Louisiana has increased from 9.3 in 2003 to 10.4 in 2004. The preliminary rate for 2005 is 10.0. Rural, northern, and central portions of Louisiana have the higher rates.//2008// /2009/ Preliminary 2006 state vital records data shows a decrease in Louisiana's infant mortality rate (IMR) to 9.7 deaths from 10.1 deaths per 1,000 live births in 2005. //2009// ***/2010/ Final 2006 data shows infant mortality rate of 10.0 deaths per 1,000 live births. //2010//***

Very low (VLBW) and low birth weight (LBW) are major risk factors associated with infant mortality. There has been very little change in the VLBW and LBW rates in Louisiana. In 2003, the VLBW rate was 2.2% and the LBW rate was 10.7%. In the black population, 15% of all births were LBW compared to 7.7% in the white population. This racial disparity can also be seen in the VLBW rate (black=3.5%, white=1.2%). (Figure 6 and Figure 7) See Section II. E., the Outcome Measures narrative, for more information on infant mortality and racial disparities in infant mortality. /2008/ Preliminary 2005 data shows the VLBW percent at 2.3%, with the percentage of black and white women at 3.6% and 1.4%, respectively. From 2003 to 2004, the percentage of LBW increased from 10.7% to 11.0%, and the percentages increased for black (15.0% to 15.2%) and white (7.7% to 8.0%) women. Preliminary 2005 data shows the percent LBW at 11.5%, with 16.0% for black and 8.6% for white women.//2008//

Prior to 2000, Louisiana experienced an overall decreasing trend in the child death rate. However, since 2000, the rate has increased from 30.8 deaths per 100,000 children to a rate of 34.8 deaths in 2002. Data for 2003 shows the increasing trend may be reversing with a child death rate of 26.5. Louisiana's child death rate remains higher than the 2002 national rate of 21.4 deaths per 100,000 children. The leading cause of deaths in children aged 1 to 14 was unintentional injury followed by congenital anomalies and homicide. Motor vehicle crash (MVC) deaths accounted for the largest number of unintentional injury deaths with fire and drowning the second and third leading causes. The 2004 Kids Count report ranked Louisiana 46th for violent deaths by accident, homicide, and suicide, for adolescents from 15 to 19 years of age. Violent deaths in both age groups disproportionately affect black children more than white children except for suicide. /2008/There was a 12.7% decrease in the child death rate in Louisiana from 34.8 in 2002 to 30.4 in 2005, though both rates were higher than the 2002 and 2004 national average of 21.4 and 20.0, respectively. Preliminary 2005 vital records data has unintentional injury followed by congenital anomalies and homicide as leading causes of death in children aged 1-14, and motor vehicle crash deaths accounted for the largest number of unintentional injury deaths, followed by fire and drowning in the same age group.//2008//

According to the 2000 census, Louisiana had the fourth highest percentage of children aged 5 to 15 with a disability (7%) as compared to the national rate of 5.8%. In Census 2002, children aged 5 to 15 were considered to have a disability if one or more of the following long-lasting conditions was reported: sensory disability, physical disability, mental disability or self-care disability. Louisiana disability rates for males and females aged 5 to 15 were 8.8% and 5.1% respectively. In comparison, the disability rates for U.S. males were 7.2% and females 4.3% for the ages 5 to 15 population. In Louisiana, mental disability was reported for 5.5%; sensory, physical and self-care disabilities were reported for 1.3%, 1.3% and 1.1% of the 5 to 15 aged group respectively. Louisiana 5-15 age group's disability rates by race and ethnicity are: 6.6% for White, 7.3% for Black; 8.3% for the combined categories of Asian, American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander, some other race alone and two or more races; and 6.4% for Hispanic or Latino.

Louisiana has an extremely high percentage of children with special health care needs as compared to other states. According to the SLAITS data, this state has the second highest percentage of CSHCN in the nation (15.9%). This is supported by statistics for the number of children under age 16 receiving federally administered SSI payments. Louisiana is the 11th highest state in the number of children receiving SSI while the 2004 U.S. Census indicates that Louisiana ranks 24th in population. /2007/ In 2005, Louisiana had the 10th highest number of children under age 16 receiving SSI and for 2004, the 3rd highest number of recipients as a percentage of resident population in the U.S.//2007//

For those Louisiana families of CSHCN in the SLAITS survey, 85.5% indicated that their child received SSI, compared to the national survey response of 70.7%. The 2004 SSI data shows that 26,671 children under age 16 in Louisiana received SSI. This is an increase of 3,671 children from the 2001 Louisiana SSI count of 23,000 for this age group. Since persons with disabilities

use significantly more medical services than those without disabilities, the high prevalence of disabilities among children in the state, indicates a tremendous need for health care services and resources for children with special health care needs. /2007/ The 2005 SSI data report Louisiana has 24,448 children under age 16 who received payments. This is a decrease of 2,223 from the previous year.//2007// /2009/ In 2007, 25,541 children under 16 years received SSI payments, an increase of 4.5% (1,093 children) since 2005. This does not reflect an increase in children with disabilities. //2009//

c. Access to health care
Louisiana has had one of the highest rates of uninsured population in the nation. According to the American Academy of Pediatrics, estimates of uninsured children in 2003, 15.4 % of Louisiana children through 18 years of age were uninsured, which placed Louisiana with the 5th highest rate of uninsured children. An estimated 77% of the remaining uninsured children were income eligible for Medicaid benefits. /2008/ The 2005 Louisiana Health Insurance Survey's estimates 7.6% of Louisiana children through 18 years of age were uninsured. The American Academy of Pediatrics' estimates in 2005, 9.9 % of Louisiana children through 18 years of age were uninsured, and 52.8% of these uninsured children were Medicaid income eligible.//2008// /2009/ The 2007 Louisiana Health Insurance Survey estimated the percentage of uninsured children in the state decreased to 5.4%. //2009// ***/2010/ According to the recently released 2007 NSCH,94.8% of children in Louisiana were insured (versus 90.9% nationwide) and only 9.4% lacked consistent insurance in the previous year (versus 15.1% US). //2010//***

Financial accessibility to health care for low income mothers and children has been through the state Medicaid Program. According to the 2002-2003 Fiscal Year Louisiana Medicaid Program Report, 990,544 Louisianans or 22% of Louisiana's population was eligible for Medicaid. Approximately 21% of Louisiana's population received Medicaid services. The percent of Medicaid recipients has increased by 4.2% since the 1999-2000 fiscal year. In State Fiscal Year 2002-2003, 722,430 or 69% of the Medicaid enrollees were under 21 years of age.

The State Medicaid Program has improved financial accessibility to health care for the MCH population through expansion of Medicaid eligibility for children as well as pregnant women. Improved access for children has largely been through the implementation of the State Child Health Insurance Program, LaCHIP. Louisiana's Child Health Insurance Program (LaCHIP) began on November 1, 1998, as a Medicaid expansion with a phase-in of income level eligibility to 200% of Federal Poverty Level (FPL) to age 19 on January 1, 2001. This program has been successful in increasing the numbers of children on Medicaid not just for the LaCHIP expansion but also for regular Medicaid. Since its inception, enrollment numbers have exceeded expectations with an increase of nearly 312,000 children from birth to 19 years of age enrolled in the Medicaid Program. As of March 2005 there were 669,575 Medicaid enrollees under age 19 through Medicaid/LaCHIP. Along with this, the percent of uninsured children in Louisiana has decreased from an estimated 22% in 1997 to 15.4% in 2003. Improved coverage for pregnant women began in January 2003 when income eligibility for pregnant women was increased from 133% to 200% of FPL.

Reasons for the success of LaCHIP include steps to streamline the eligibility process: 1) a simple, one page application form was created for both LaCHIP and Medicaid for children; 2) 12 month continuous eligibility was initiated; 3) the need for a face to face interview was removed and mail in applications are now accepted; and 4) a Central Processing Office was established to handle all child applications for Medicaid/LaCHIP. Medicaid has relied on regional outreach teams of existing Medicaid field staff to spearhead community-based outreach strategies statewide. Other steps taken since the beginning of the program include: 1) streamlining the LaCHIP/Medicaid recertification form, which is sent out to families after 12 months to re-apply for their children; 2) elimination of the three-month wait period after losing private health insurance before families can apply for LaCHIP; and 3) translation of the application form to Spanish and Vietnamese. With the implementation of the EarlySteps program, a new, shared application was developed for Medicaid, LaCHIP, the Office for Citizens with Developmental Disabilities, the CSHS Program

and EarlySteps.

In comparison to the national average, Louisiana consistently ranks below other states on most of the National CSHCN Survey (SLAITS) indicators for access to care. Families report that their children and youth with special health care needs have less access to health care, require more time and financial resources than their peers in other states. Because of the high poverty rate in Louisiana and the fact that Louisiana has the second highest percentage of children with special health care needs of any state, financial access to comprehensive health care is a greater need in Louisiana than in most states. According to the CSHCN National Survey (SLAITS) data, only 51.9% of Louisiana CSHCN families said they had adequate public or private insurance to pay for the services they need, compared with 59.6% nationally. Forty-nine percent of CSHCN families have an income that is less than or equal to 200% of the federal poverty level. Twenty-two percent have Medicaid as their only source of insurance, 28.1% have more than one type of insurance, 41.5% have private insurance, and 8.1% are uninsured. /2009/ NSCSHCN data in 2002 and 2006 shows percent LA CSHCN with adequate health insurance increased from 62.0% to 65.5%, above the 62.0% US average. Percent CSHCN families living below 200% FPL decreased from 54.8% to 51.0%. The percent of CSHCN without insurance decreased from 8.1% to 5.1%, however LA remains above the 3.5% US average. For CSHS patients in 2007, 82.8% had Medicaid, 12.7% had private insurance, and 4.2% had no insurance. //2009// ***/2010/ In 2008, 91% of CSHS patients served in OPH clinics had Medicaid, 4% had private insurance, and 4.2% were uninsured, reflecting a shift from private insurance to Medicaid in this population. For patients served in private clinics partially supported by CSHS, 88.66% had Medicaid, 8.85% had private insurance, and 2.61% were uninsured. //2010//***

Pediatric primary and subspecialty care are concentrated in the major urban areas of the state. CSHS Needs Assessment Data indicates that many of the pediatric sub-specialists were concentrated in the New Orleans area (27%) with many reporting that they traveled to more rural areas to provide care. Although the distribution of primary care for CSHCN was relatively equal by pediatricians and family practitioners across the state, only 52% of primary care physicians reported that they accepted Medicaid as compared to 69% of specialists. In addition, when further analyzed as to physicians offering access to CSHCN and CSHCN with Medicaid, data shows that in some rural regions of the state, access is restricted by half or more of the physicians not accepting patients with special needs and Medicaid. The most often reported barrier to care in focus groups of parents conducted in the CSHS Needs Assessment was lack of services or providers in an area. /2007/ Pediatric subspecialty care in Louisiana has experienced major changes following the Katrina/Rita disasters. Physicians at major medical institutions in New Orleans have relocated or left the state. Children's Hospital, New Orleans has opened satellite clinics in 2 other major cities, Baton Rouge and Lafayette, offering specialty services and accepting Medicaid patients.//2007// /2009/ Physician emigration continues despite incentives by the Greater New Orleans Health Service Corp to practice in New Orleans. Tulane and LSU Medical Schools have increased recruitment efforts. Shortage of sub-specialists has increased workloads of remaining physicians, perpetuating the cycle. Despite this shortage, NSCSHCN data indicates percent of CSHCN needing a referral who had difficulty getting it decreased from 23.7% in 2002 to 15.8% in 2006. //2009//

d. Availability of health care

The majority of the state is designated as a medically underserved area or having underserved populations, by the Office of Primary Care and Rural Health. (Map 4). Availability of primary care practitioners poses a significant problem for delivery of health care in the state. As of March 2004, 56 or the State's 64 Parishes are designated a geographic or population group qualifying as a Health Care Professional Shortage Area (HPSA) (Maps 4, 5 and 6) by the Office of Primary Care and Rural Health.

Beginning in August 2001, the State Medicaid Program began a Region-by-Region expansion of its Community Care Program, which had been operating in 20 Parishes in the State. Community Care is a primary care case management program for Medicaid recipients. Through this Program,

all Medicaid recipients are linked to a health care provider who serves as the client's primary care health provider as well as their primary care case manager. The primary care case manager is responsible for ensuring that all clients receive EPSDT services although the screenings may be done by another provider. However, maternity patients are exempted from this program and may select any provider. This process was completed in December 2003. This has resulted in an increase in the number of eligible clients who have received services.

The lack of availability of specialists in many areas of the state compounded with the fact that about one third do not take Medicaid means many CSHCN do not have access to specialty care at all. Because of the urban concentration of physicians in the state, access to Primary Care Physicians (PCP) and specialists in more rural areas of the state is extremely difficult for many CSHCN. Physicians who take CSHCN are concentrated around the two medical schools, children's hospitals, and leading medical institutions located in New Orleans and, to a lesser extent, Shreveport. A greater percent of specialists take Medicaid than PCP's. Of 631 specialists that take CSHCN, 409 or 65% take Medicaid. However, the lack of availability of specialists in many areas compounded with the fact that about one third do not take Medicaid means many CSHCN do not have access to specialty care at all. /2007/ The expansion of a few Medicaid providers in areas outside of New Orleans increases access for CSHCN in some areas. It is uncertain if these services will remain and expand or return to New Orleans as the population returns to that area.//2007//

Thus, budget shortfalls affecting the financing and therefore the system of health services in Louisiana present a challenge to the MCH Program for assuring the delivery of needed MCH services to the poor, predominantly rural, low education, minority MCH population in Louisiana and to our efforts to decrease the mortality and morbidity in this population. The MCH Program has responded to this by the development of initiatives to accommodate these changes. /2007/ The opportunity to increase access in the aftermath of the disasters with an expansion of health care providers who accept Medicaid is being addressed by the CSHS Program. This will also help to reduce disparities in health care for the CSHCN population.//2007// /2009/ Medicaid's Community Care has linked many CSHCN with a MH. CSHS continues to provide sub-specialty care in all nine regions, with larger clinics in shortage areas. //2009//

3. Current OPH Priorities and Initiatives and Title V's Role
Louisiana, as one of the poorest and unhealthiest states in the nation, has the challenge of using its limited resources for the highest priority activities. Prevention services are under-funded as compared to other health care services. The Office of Public Health has defined its mission as follows:
- To promote health through education that emphasizes the importance of individual responsibility for health and wellness.
- To enforce regulations that protect the environment and to investigate health hazards in the community.
- To collect and distribute information vital to informed decision-making on matters related to individual, community, and environmental health.
- To provide leadership for the prevention and control of disease, injury, and disability in the state.
- To assure universal access to essential health services.

Operating within the context of the Office of Public Health and the changing health care environment, the Title V Program maintains its commitment to decreasing mortality and morbidity and assuring access to primary and preventive health care services for Louisiana's maternal and child health population including those with special health care needs.

For the MCH Program, the development of program initiatives has evolved into a process where data is collected, analyzed, and synthesized with knowledge on best practices to determine what would work best in Louisiana's unique environment. Program directors and epidemiologists review birth and death statistics, Pregnancy Risk Assessment Monitoring System (PRAMS) data, Infant and Child Death Review panels' recommendations, Medicaid E.P.S.D.T. reports, and other

sources of information to determine the priority of competing factors impacting the health of pregnant women and children. Most data is analyzed by race and parish to determine racial or geographic disparities and trends in health status. Leading causes and associated factors of maternal, infant, and child death are reviewed and interventions are identified and implemented to address these problems. This year, the MCH Program has completed its five-year community-based assets/needs assessment, obtaining input from public health and community leaders from each region in the state. This has lead to determination of the priority needs for the State and the development of an operational plan to address each priority need.

CSHS implemented strategic planning in 2001 by establishing a Long Range Plan Advisory Committee with statewide stake holders including parents, private and public health care providers, elected officials, CSHS medical providers and local staff. The goal of the Long Range process was to improve the CSHS program by providing Medical Home and subspecialty clinical services by private providers in the community and monitoring, quality assurance and care coordination services to be provided by specialized OPH staff, where feasible. Critical to this process is the CSHS Needs Assessment completed in 2004 and used for the Block Grant and program planning. A statewide conference was held to analyze data for each region and make recommendations for changes in service delivery models. Work continues on recommendations for changes in the CSHS service delivery system for CSHCN to address areas identified in the Needs Assessment and through focus group and stakeholder participation. The provision of care coordination is one of the major goals to increase access to care and provide transition to adult services. /2009/ CC continues to be a priority. The current pilot will be expanded in CSHS clinics statewide over two years, first focusing on transition and then all CSHCN. //2009// ***/2010/ Care Coordination in CSHS clinics focusing on transition has begun in Regions 1 and 6. Expansion to at least two other regions is planned for 2010. //2010//***

Thus, the Title V Program addresses each aspect of the OPH mission for the maternal and child population, including children with special health care needs, in the following ways:
- Health promotion is a major priority of the Title V Program, and includes public information and media campaigns on parenting, prenatal care, SIDS, and injury prevention. Public health staff provide health education and counseling to 137,000 pregnant women and children each year in individual patient counseling or group sessions.
- Some of the health hazards addressed by the Title V Program include lead poisoning, car safety and other injury prevention, and child care health and safety.
- The Title V Program shares vital statistics information widely as well as information from the Pregnancy Risk Assessment Monitoring System (PRAMS) which began in 1998. The Child Death Review process informs legislators and policymakers on the needs of children and families in the state.
- The Title V staff lead and participate in various task forces related to the health of women and children, including child abuse prevention, perinatal care, childcare health and safety, child death review, oral health, injury prevention, and birth defects. Title V works with professional and advocacy organizations to promote legislation and regulations to protect and promote the health of women and children.
- Through its system of parish health units, contract sites and school-based health centers, Title V is able to provide a statewide safety net of direct health services for women, children, and adolescents who are uninsured or have no access to other health care providers. With the largest number of poor children of any state, Title V resources continue to be dedicated to direct health care services. Children with special health care needs have access to a comprehensive, family-centered, community-based network of pediatric specialists, including physicians, nurses, social workers, and other health care providers throughout the state through the CSHS clinics and community based services.
- "Every Child Deserves a Medical Home" is a priority of the CSHS program. CSHS Central Office and OPH Regional staff have participated in several regional presentations of the AAP program, "Every Child Deserves a Medical Home." This initiative included the formation of regional committees to address the issue of primary and preventive health care of CSHCN within the specified area of the state. Medical Home training has been incorporated into medical school

training and as a pilot project funding care coordinators in three physician practices. /2009/ CSHS will continue to assist PCP's to meet the NCQA Patient Centered MH Guidelines through residency training, CC and parent advocacy. //2009// ***/2010/ CSHS recently hired a statewide Care Coordination (CC) supervisor to develop teaching materials for CC's in private pediatric offices to help replicate successful Medical Home CC models in the state. //2010//***

An attachment is included in this section.

B. Agency Capacity

/2010/ Louisiana's Department of Health and Hospitals submitted an 1115 Medicaid waiver to reform the health care delivery system from a fee for service method to a managed care-medical home system for recipients in Baton Rouge, Lake Charles, New Orleans, and Shreveport and expansion of eligibility to 50 percent of the federal poverty level for parents/caretakers of Medicaid eligible children and an expansion for adults in Lake Charles to 200 percent of the poverty level. //2010//

/2008/ To address the large dislocation of 4,486 physicians in the hurricane Katrina ravaged New Orleans region, the Greater New Orleans Health Services Corps was established. A $15 million grant from the U.S. Department of Health and Human Services will provide financial incentives to primary care physicians and other health providers who commit to work in the New Orleans region for the next 3 years. To address the health care needs of the migrant population who arrived in the New Orleans region to work on the rebuilding effort, prenatal services were covered by Medicaid for non-citizens under Title XXI State Child Health Insurance Program.//2008//

The State Title V Maternal and Child Health Program is housed in the Office of Public Health (OPH), Department of Health and Hospitals (DHH). The mission of DHH is "to protect and promote health and to ensure access to medical, preventive, and rehabilitative services for all citizens of the State of Louisiana. The Department fulfills its mission through direct provision of quality services, the development and stimulation of services of others, and the utilization of available resources in the most effective manner." The other agencies under the Department include the Office of Mental Health, Bureau of Health Services Financing (Medicaid), Office for Citizens with Developmental Disabilities, and the Office for Addictive Disorders. The Assistant Secretaries for each of these Offices meet weekly to collaborate and coordinate services for the citizens of Louisiana.

Personal health services and local public health functions are provided by 70 OPH parish health units distributed throughout the state, except in New Orleans and Plaquemines Parish, which have their own independent health departments (See Map 1 of attachment for map of parish health units). OPH has nine Regional Directors who supervise the health units, regional CSHS clinic sites, and regional health staff in their respective regions. The MCH Adolescent School Health Initiative provides funding and technical assistance to 51 contract school-based health centers, and 1 federally funded school-based health center. Infant Mortality Reduction Initiatives have been funded in each region, including a staff person to coordinate and direct Fetal-Infant Mortality Review, needs assessment and strategic planning for the maternal and child population.

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

/2007/Hurricane Katrina, this nation's worst natural disaster, has devastated the New Orleans metropolitan area and has severely impacted the capacity of the Office of Public Health (OPH) and the Department of Health and Hospitals (DHH). Hurricane Rita added to the destruction in southwest Louisiana. The Office of Public Health was particularly affected due to the location of its headquarters in New Orleans. A smaller office of OPH is located with DHH and its other Offices in Baton Rouge. Prior to Hurricane Katrina and in the months following, all OPH nurses and physicians carried out their mandated responsibility to manage the special needs shelters located in each region of the state. These shelters care for the sick and medically fragile individuals who have no other resources. During this time, the State Title V Medical and Program Directors were assigned to the state's Emergency Operations Center in Baton Rouge. OPH was dedicating all its capacity to recovery. As shelters closed, parish health unit staff returned to increased demand for public health services. State OPH headquarters staff was unable to return to the New Orleans office as it was severely damaged by the flooding. Alternative work places were developed near New Orleans and in Baton Rouge as staff was required to return to work in mid-October. Fortunately, MCH only lost 2 staff members due to the hurricane. Although many of the MCH staff lost their homes, work continued immediately following the storm via email, telephone, and with weekly teleconferencing provided by the Centers for Disease Control and Prevention. As access to computer files resumed, and contact was made with the MCH contractors and other partner agencies, some sense of normalcy began.

Katrina caused the shutdown of most hospitals and the near-total disruption of the public health and medical infrastructure in the greater New Orleans area. Nine months after the hurricane, most of the hospitals in New Orleans remain closed including Charity Hospital, with 98% of its patients being without health insurance. As the population of New Orleans decreased to less than half due to 40% of the city being uninhabitable, those remaining relocated to adjoining parishes. Migrant workers and their families have moved into these areas and without any source of health coverage, depend on OPH for public health services including MCH funded prenatal care. Many of the MCH contracts serving the New Orleans area population have been disrupted due to providers not returning post-Katrina. The prenatal care contracts have been moved to parish health unit locations in Metairie and Marrero (Jefferson Parish), both within close proximity to the population in need. The New Orleans Health Department hired an MCH medical director and eliminated the nurse consultant position. MCH-funded prenatal services in Orleans and St. Bernard parishes are expected to restart during this summer. Plaquemines Parish Health Department is providing immunization services, but until the site providing EPSDT and WIC services is rebuilt, residents access those services in Jefferson Parish.//2007//

CSHS provides family-centered, community-based, coordinated care for children with special health care needs and their families, including rehabilitation services for children receiving SSI benefits, through its network of 175 pediatric subspecialty providers and facilities at the regional and local levels. Parents acting as family liaisons enhance the care coordination provided by the CSHS regional team and provide needed support.

CSHS has implemented a Long Range Plan to improve the system of services to CSHCN and their families in Louisiana. The goal of this process is to enhance community-based, private provider Medical Home and subspecialty clinical services. As CSHS strives to facilitate the development of systems of care for families, services are being merged with existing facilities or moved to local sites to complement the already existing service network established by the staff. CSHS has already begun the process of transitioning some clinical services to community private sub-specialists in the New Orleans and Alexandria areas. A pilot is planned for one region of the state to convert staff to care coordination duties and transition children to private providers. CSHS has also been working with the AAP to work with local communities on capacity of primary health care services for CSHCN by facilitating Medical Home trainings statewide. /2007/ The CSHS Long Range Plan has been adjusted to deal with changes that have taken place after the recent disasters. Transition of services to the private sector has had to be increased at a faster rate as some physicians have resigned and left the state. Care coordination will be increased quicker to

assist families to transition to the private sector and to adjust to recovery from disasters. The health care system in Louisiana has an opportunity to transition traditional public health care to the private sector and the CSHS plan will complement that movement as it unfolds.//2007//

/2008/ Families and providers continue to relocate post-Katrina, with some returning to New Orleans, some remaining in other parts of the state, and some leaving the state. Imbalances in numbers of providers per population to be served continue to change, making access to healthcare a continuing problem which is accentuated for CSHCN. For these reasons, CSHS continues to provide direct services in all regions of the state, bringing sub-specialists into underserved areas. Physician contracts have decreased from 95 to 72 since Katrina. Initiatives to improve access to care such as care coordination and medical home activities have new urgency. Training for a second pilot in region VI will begin in August, with the goal of statewide care coordination by the end of 2008. Medical home training in the future will focus on in-services for individual pediatric practices with emphasis on available public and private resources in the community for CSHCN.//2008// /2009/ A 2nd pilot of the revised CC system is being conducted in region I. CSHS presented data on the effect of a CC in improving family satisfaction and MH criteria at the state's MH Summit. Medicaid is planning to create capitated Service Provider Networks (PSN's) for pediatric providers to create MHs for CSHCN, modeling after Florida beginning in 2010. CSHS' role in the new system is being negotiated. //2009// ***/2010/ CSHS expanded its CC in CSHS clinics to Region 6 (Alexandria). CSHS continues to be active in DHH Healthcare Reform MH initiatives. PSN's have been renamed "Coordinated Care Networks" (CCN's). The Waiver to restructure Medicaid services was submitted to CMS in December 2008. The CSHS director is on the DHH Healthcare Reform CSHCN Work Group, the AAP's CSHCN work group convened to assist DHH in developing the new plan, and the Advisory Group for the MH Committee of the state's Health Care Quality Forum (LHCQF) stakeholder group. LHCQF has adopted the NCQA MH Criteria for Louisiana. To date 37 clinics received NCQA certification. CSHS will continue to assist clinics with care coordination. //2010//***

Enrollment in CSHS services have decreased 23% 2000. This is due to decreased numbers of families eligible for services based on static income criteria for the program. Some CSHS services have been reduced due to difficulty finding physicians to provide community-based services. The CSHS Long Range Plan Needs Assessment identified the capacity of private providers to serve CSHCN statewide and has led to the formation of a plan to address these issues. /2007/ Enrollment continues to decrease slightly through 2005.//2007//

The Hearing, Speech and Vision Program (HSV) also experienced a decline in the number of staff and patients. Private contractors, including the Lions Eye Foundation and other individual private providers, now provide vision screening services. Audiology services are provided by remaining staff and have been reduced by 50% since 2000. Presently, services are those for infants, toddlers and medically indigent children with hearing loss. Regional audiologists have performed regional needs assessments regarding available audiological services. Transition of these services will be incorporated into the CSHS plan. /2007/ Additional loss of staff occurred in the aftermath of the disasters.//2007// /2009/ HSV staff is stable at 7 FTE's, including 4 contract staff. Three Audiologists serve 9 regions. A 4th position was denied. In 2007 there were 634 visits for CSHS audiology and speech services and 333 speech and hearing screenings for toddlers. Over 96% of infants were screened at birth for hearing loss and over 780 school staff were trained to provide vision screening to toddlers and school children. //2009// ***/2010/ HSV staff are unchanged. In 2008 there were 742 visits for CSHS audiology and speech services and 370 speech and hearing screenings for toddlers. Hearing aids were dispensed to 220 children. Over 97% of infants were screened at birth for hearing loss and over 1063 professionals and volunteers were trained to provide vision screening in daycares and schools. //2010//***

Although the number of patients receiving prenatal and preventive child health services is decreasing, enabling and population-based services provided by contract agencies continue to increase. The State Title V Maternal and Child Health (MCH) Program has been able to shift

significant resources from the funding of local parish health unit personnel to contract agencies, targeting services and areas of highest need as identified in the latest MCH Needs Assessments and other current maternal and child health data. This shift is due in part to the downsizing of the Office of Public Health parish health unit infrastructure and the new priority setting of parish health unit services to be offered to the public. In the past few years there has been a dramatic increase in Medicaid coverage of the maternal and child population in Louisiana through the Child Health Insurance Program, LaCHIP and LaMOMS (pregnant women coverage), expanding eligibility to 200% of the federal poverty guidelines. This health coverage and the statewide expansion of Community Care, Louisiana's Medicaid Managed Care system using a primary care case manager model has reduced the need for MCH to provide direct medical services in most areas of the state. The high priority services being delivered by the parish health units include WIC, Family Planning, Immunization, Tuberculosis Control, and Sexually Transmitted Diseases Programs. These Programs have greater difficulty finding community providers with whom to contract. MCH funded prenatal services are still provided in parishes without obstetric medical providers.

However, with a high poverty rate and its associated health problems, Louisiana's pregnant women and children continue to fall at the bottom of most studies that rank the states according to their population's health status. MCH is targeting areas of the state with the worst infant mortality problem by providing preventive and primary care services for pregnant women and infants. Contracts with health and social service agencies have been developed and services initiated to improve the health status of this population in cities including Shreveport, Alexandria, Baton Rouge, Lake Charles, Monroe, Lafayette and New Orleans, as well as Terrebonne, Jefferson and St. Tammany Parishes. Services include fetal-infant mortality review (FIMR) including a community advisory committee for needs assessment and strategic planning, prenatal clinical services, outreach, and case management including the evidenced based intervention, Nurse Family Partnership home visiting program. In some of these locations, the contract agency is the Louisiana State University Health Sciences Center (LSUHSC) that administers the services at the nine regional state operated hospitals in the major metropolitan areas of the state. The state hospitals and LSU have a long history of providing services to the low-income population.

In addition, MCH provides supplemental funding in the four Healthy Start Program areas in order to provide comprehensive services for this high-risk population. Six social worker case managers were added to the New Orleans Healthy Start Program last year and a FIMR coordinator has been hired for the newly funded Lafayette Healthy Start Program. MCH continues to fund a Nurse Family Partnership team of nurses for the Baton Rouge Healthy Start Program and a team of outreach workers for the North Louisiana Healthy Start Program. /2007/ The New Orleans Healthy Start program has been reorganized due to the hurricane devastation, and the contract for the six social workers has been discontinued. Negotiations are underway with New Orleans Healthy Start to restart a FIMR project and case management services.//2007// /2008/ A FIMR coordinator has been hired by the Healthy Start Program in New Orleans, funded by Title V. The March of Dimes funded a mobile health van for prenatal care services in hurricane ravaged areas including New Orleans, Lake Charles, and St. Tammany Parish.//2008//

A contract with the Medical Center of Louisiana in New Orleans has been established to address the finding in the New Orleans' FIMR that 25% of the infant deaths reviewed had maternal substance abuse involved. The perinatal substance abuse prevention/case management project being implemented is based on Ira Chasnoff's model, which utilizes a comprehensive evidenced-based approach. A similar intervention was initiated this year in Monroe through an interagency collaboration between MCH, Office of Addictive Disorders, LSUHSC, and the Office of Mental Health. Louisiana has among the highest rate of low birth weight in the nation. PRAMS analysis showed that smoking and inadequate weight gain in pregnancy were the primary risk factors for low birth weight. MCH addresses gaps in smoking cessation services for perinatal populations through a contract with the Louisiana Public Health Institute, the recipient of the Louisiana Tobacco Tax Fund. This partnership has allowed expansion of the American Cancer Society's Make Yours a Fresh Start Family, a comprehensive smoking cessation program for perinatal

populations. MCH contracts with an advertising agency to administer the Partners for Healthy Babies campaign. This is an outreach effort to link women with prenatal care and promote healthy behaviors. The program utilizes multiple partnerships, media messages, a toll-free information and referral hotline and other promotional activities to reach pregnant women and impact the determinants of low birth weight and infant mortality. This year, proper weight gain was one of the primary media messages. /2007/ Due to the closure of the Medical Center of Louisiana, the contract for maternal substance abuse treatment services has been discontinued. A contract has been established between MCH, Louisiana Office of Addictive Disorders, and Ira Chasnoff to build a statewide system of perinatal substance abuse services. The new MCH hotline contractor, American Pregnancy Association, was operational immediately after Katrina and was instrumental in reaching Louisiana evacuees in-state and out-of-state. Radio and television messages in adjoining states and within Louisiana, resulted in 8 times the average number of calls during the months following the storm.//2007// /2008/ Perinatal Substance Abuse services have been added in St. Tammany Parish and Alexandria and enhanced in Monroe.//2008// /2009/ The American Cancer Society has phased out Make Yours a Fresh Start Family Program, changing Louisiana Public Health Institute contract to a policy focus on smoking prevention and other MCH issues. Perinatal substance abuse services have been added to New Orleans and Lafayette and cover perinatal depression and domestic violence. //2009// ***/2010/ Screening, Brief Intervention, Referral, and Treatment for perinatal substance abuse, depression, and domestic violence is expanding through public health clinic sites throughout the state. //2010//***

Infant death data, PRAMS information, and FIMR studies show SIDS and prone infant sleeping position to be a problem in Louisiana. The MCH Program contracts with Tulane University School of Medicine, Pediatric Pulmonary Section, for the position of Sudden Infant Death Syndrome (SIDS) Medical Director. This partnership has allowed improved MCH Program state capacity to identify, counsel and follow-up with families of SIDS infants and monitor the functioning of the overall program. ***/2010/ The Louisiana Child Death Review Panel sponsored the first annual "Infant and Child Fatality Investigation" conference to educate coroners, death scene investigators, first responders, and stakeholders on conducting death scene investigations consistent with standard protocol. //2010//*** The MCH Program staff includes a SIDS Program Coordinator who conducts state and community-based education on SIDS risk reduction, including a statewide media campaign. /2007/ Educational materials were distributed to shelters statewide to promote safe sleep environments.//2007//

To improve Louisiana's low breastfeeding rate, MCH has a contract with the Louisiana Maternal and Child Health Coalition to promote The Gift, a program to certify hospitals as breastfeeding-friendly facilities if they comply with a list of breastfeeding related policies and activities. Educational materials and incentives are included in this intervention.

MCH is targeting the leading causes of child morbidity and mortality by providing preventive and primary care services for children. Comprehensive preventive child health services, including physical examinations, laboratory and other screening procedures, immunizations, nutritional assessments and counseling, health education, and WIC services will continue to be provided in parish health units for children whose families are uninsured or are Medicaid eligible and have no access to private care. WIC services, immunizations, psychosocial risk assessment, and health and parenting education will continue to be provided in parish health units to patients referred by other health providers. MCH has a contract with Medicaid to conduct EPSDT screening in parish health units. Although private provider participation has decreased the number of children screened by MCH, there are still areas of the state where access is a problem and EPSDT services in parish health units continue to exist. MCH funds will continue to contract with St. Thomas Health Services, Inc. in New Orleans to provide support to community-based child health programs which provide pediatric primary care. ***/2010/ MCH focuses on oral health of children by organizing school based sealant programs and promoting fluoridation of water systems. //2010//***

Through an interagency agreement with the Office of Community Services (Child Protection Agency), MCH utilizes public health nurses to assist child protection workers in investigating suspected cases of medical neglect, malnutrition and failure to thrive. Nurses assess the child in the clinic or home within 24 hours of request.

The state mandated Newborn Screening and Follow-up Program ensures that all newborns are screened before discharge from the hospital and again at the first medical visit, if the baby was initially screened before 48 hours old. The newborn screening battery consists of tests for the detection of Phenylketonuria (PKU), congenital hypothyroidism, hemoglobinopathies (sickle cell disease), biotinidase deficiency, Maple Syrup Urine Disease, homocystinuria, medium chain AcylCoA dehydrogenace deficiency (MCADD), citrullinemia, argininosuccinic aciduria, and galactosemia. For infants with abnormal tests, Genetics Program staff assist the primary medical provider through the follow-up process to ensure timely and appropriate confirmatory testing and if determined to be diseased, treatment. The Genetics Program follows patients for specific time periods depending on their disorder. Contracts with three Louisiana medical schools will continue to provide laboratory testing and specialized clinical services for these patients.

/2008/ The newborn screening panel was expanded in August 2006 to include congenital adrenal hyperplasia, Carnitine uptake defect, Long-chain 3 hydroxyacyl-CoA dehydrogenase deficiency, Trifunctional protein deficiency, Very long-chain acyl-CoA dehydrogenase deficiency, Glutaric academia type I, 3-hydroxy-3-methylglutaryl-CoA lyase deficiency, Isovaleric academia, 3-methylcrotonyl-CoA carboxylase deficiency, methylmalonic academia (CBL A,B), Beta ketothiolase, Methylmalonic academia (MUT), Proprionic academia, Multiple carboxylase deficiency, Tyrosinemia type 1. July 2007 screening for Cystic fibrosis will begin.//2008//

MCH has initiated a new program entitled, Best Start, a therapeutic health/infant mental health intervention, utilizing a nurse, social worker and case manager to provide 8-10 week small group interventions during the prenatal, newborn and toddler periods Rapides, East Baton Rouge, Iberia, Ouachita, and Calcasieu parishes. Limited home visitation and ongoing treatment for mother-infant dyads in need of those services will be available on a limited basis. /2007/ Best Start services have been absorbed by the state mental health agency's Early Childhood Supports and Services program in East Baton Rouge and Ouachita parishes. Services continue in Rapides and Calcasieu parishes.//2007//

/2008/ A HRSA funded Perinatal Depression Grant has resulted in the addition of mental health services in the New Orleans region in conjunction with New Orleans Healthy Start Program and Jefferson Parish Human Services Authority. Mental health services have been identified as a leading need in Post-Katrina New Orleans. The Rapides Parish Best Start Program is not currently functioning due to the inability to recruit a qualified mental health provider.//2008//

MCH also funds nurse home visiting programs that follow the model for first-time mothers of low socio-economic status, entitled Nurse Family Partnership (NFP). Nurse visitors follow program guidelines that include regular visits to the family starting prior to twenty-eight weeks gestation until the child is 2 years of age. Nurses provide health education, referrals, case management and other support to women during and after their pregnancies, and their baby. Initiated in 1999 in four regions, the program now provides services in all regions of the state, including 18 parishes. Services are delivered in Region I (Jefferson Parish), Region II (Baton Rouge), Region III (Terrebonne and LaFourche parishes), Region IV (Iberia, St. Martin, Lafayette, and Vermilion parishes), Region V (Calcasieu, Beauregard and Allen parishes), Region VI (Rapides parish), Region VII (Caddo Parish), Region VIII (Franklin, Morehouse, Ouachita, and Richland Parishes), and Region IX (St. Tammany Parish). /2008/ Additional parishes now receiving Nurse Family Partnership services include (Region III) Assumption and St. Mary; (Region VI) Acadia, St. Landry, Evangeline; (Region V) Jefferson Davis; (Region VI) Grant; (Region VII) Bossier and DeSoto; (Region VIII) Lincoln and Jackson; (Region IX) Washington.//2008// /2009/ Nurse Family Partnership services have been added in: Orleans, St. James, Cameron, Avoyelles, Catahoula, Concordia, Lasalle, Vernon, Winn, Natchitoches, Red River, Sabine, and Webster parishes.

//2009// ***/2010/ Additional parishes now receiving Nurse Family Partnership services include Livingston, Ascension, East and West Feliciana, Pointe Coupee, Iberville, and West Baton Rouge. The 2008 state legislative session enacted a Senate Concurrent Resolution to study the expansion of this evidence-based preventive intervention. //2010//***

MCH funds Louisiana's SAFE KIDS program, a comprehensive injury prevention program that organizes local chapters throughout the state, distributes newsletters and pamphlets, conducts special events, and participates in health fairs. Interventions address car, gun and fire safety, childproofing homes, bicycle helmet use, and sports injury prevention. To implement stronger prevention efforts, the MCH Program has established Regional MCH Injury Prevention Coordinators through contracts with social service agencies. These coordinators work to decrease unintentional injuries in children in each of the nine regions to establish and coordinate a region wide system of childhood injury prevention initiatives targeted at preventing injuries in children focusing on the most common causes of injuries in their areas. These Coordinators provide general child safety education and program development through coordinated efforts of MCH, EMS, Injury Prevention Programs and the local SAFE KIDS Coalitions and Chapters. They also provide support to local Child Death Review Panels.

MCH administers the Child Care Health Consultant Program by training, certifying, and facilitating the work of 170 health professionals who provide consultation and training on health and safety for childcare providers statewide. The Child Care Health Consultant Program trains and certifies consultants who provide the three hours of health and safety training required by Child Care Licensing in the Department of Social Services. Social and emotional health are being incorporated into this program's efforts. /2008/ There are currently 117 certified child care consultants operating in Louisiana.//2008//

MCH will continue to provide supplemental funding to the OPH Family Planning Program, which provides comprehensive medical, educational, nutritional, psychosocial and family planning services to adolescents and adults. MCH funds the Teen Advocacy Program in Baton Rouge, a community-based case management program for pregnant and parenting teens. A Medicaid waiver is being developed to continue coverage of family planning services for women past the current postpartum period and to include reproductive age women up to 200 percent of the Federal Poverty Level. /2007/ The Teen Advocacy Program has been absorbed by the Baton Rouge Healthy Start Program. The Family Planning waiver is expected to be implemented in July 2006.//2007// /2008/ The Family Planning waiver was implemented October 2006. Both Medicaid and the Office of Public Health have hired coordinators for each region to facilitate eligibility and provider outreach.//2008// ***/2010/ MCH provided additional funding to the Family Planning Program to distribute folic acid to female clients. //2010//***

MCH funds the Louisiana Adolescent Suicide Prevention Task Force to develop and implement a Louisiana statewide plan on adolescent suicide prevention. MCH contracts with social service agencies to provide training on suicide prevention to school personnel statewide. /2007/ MCH collaborated with the Office of Mental Health on a grant to expand these services statewide.//2007// /2008/ Louisiana was successfully awarded a suicide prevention grant aimed at the hurricane Katrina and Rita impacted areas of Orleans, Jefferson, Plaquemines, St. Bernard, Vermillion, Calcasieu, Cameron and East Baton Rouge parishes. Statewide awareness, education, training and community mobilization will occur.//2008//

The Adolescent School Health Initiative Program will continue to collaborate with the Department of Education (DOE), the Office of Mental Health (OMH), the Office of Addictive Disorders (OAD) and the Excellence in Health and Education Project (EHEP) at Southeastern Louisiana University. Goals of the collaboration include providing state-of-the-art teaching and learning opportunities, advocating for the health and well-being of individuals in schools and communities, conducting research and evaluating services, and establishing a clearinghouse of resources for coordinated health and education.

CSHS provides rehabilitation services for CSHCN in nine clinic sites statewide, including services to children receiving SSI. CSHS provided services to 5,360 children in 17,088 clinic visits. Although the number of children enrolled has decreased, the number of visits has decreased at a slower rate, indicating the more complex and medically fragile patients remain on the program. /2007/ In FFY 2005, CSHS provided services to 5,236 children in 17,742 visits continuing the trend of decreasing patient population with increased number of visits.//2007// /2008/ In 2006 CSHS provided 16,513 visits, which was a 6.94% decrease from 2005. Increases in Medicaid enrollment allowed some patients to move to the private sector, and some patients moved out of state. The number of new patient visits increased slightly in 2006.//2008// /2009/ The number of CSHCN in the state has decreased 19.1% and more CSHCN have Medicaid, however the number of children receiving CSHS services has increased because of CC. CSHCN seen in CSHS clinics in 2008 was 4645 with 17,874 visits. The total served was 11,167, which is an increase of 9.1%. //2009// ***/2010/ CSHS clinics served 4421 patients with 19,025 visits. The number of patients served including private sector patients was 10,528. //2010//***

CSHS funds a specialty Dental Clinic for children with special health care needs in the New Orleans area. Services are provided by LSU School of Dentistry (LSUSD) and are specially designed to be readily accessible to this population, known to have barriers to accessing regular dental care. CSHS provides assistance through DHH/OPH Regional Offices for non-Medicaid eligible children to receive routine dental services through the private sector.

The CSHS Program provides parent support through all clinic team members including nurses, social workers, clerical staff, physicians, nutritionists, audiologists, other allied health staff and Parent Liaisons. Parent Liaisons are paid parents of CSHCN who attend clinics to give parent to parent support and organize and participate in support groups for families of CSHCN. In addition, the CSHS Parent Liaison staff work with the CSHS staff in identifying and incorporating culturally appropriate services to the diverse population served in CSHS clinics. Parent Liaison staff have provided community programs on cultural diversity and continue to work with families to identify better ways to improve services to families. All Parent Liaisons have undergone leadership training to increase their capacity to promote independence in families of CSHCN. /2007/ The leadership training for the Parent Liaison staff has resulted in some graduates moving to advocacy leadership positions in the state, increasing the capacity for parent involvement and direction in Louisiana.//2007// /2008/ Parent liaisons continue to be a vital part of each CSHS clinic team. In 2006 13 parents completed the 16 hour parent liaison training.//2008// /2009/ CSHS has 12 parent liaisons who received 18 hours of training in 2007. This included 6 hours in QUEST, a curriculum to enable parents to navigate the healthcare system to meet their needs. //2009// ***/2010/ In 2008, 13 parent liaisons received 24 hours of training each. Four trainings were offered with a total of 376 participants, including parent liaisons, guests, social workers, and Part C Family Service Coordinators. //2010//***

CSHS care coordination is family-centered and supportive of the child and caregiver needs through a plan that improves the quality of life by providing family support and enhancing family well-being. The inclusion of transition services into care coordination supports the self-determination and independence of adolescents with CSHCN. /2007/ Care Coordination procedures will include a focus on fostering independence in families to navigate the health care and other systems of services as well as become good consumers of services. The Parent Liaison staff will play an integral role in care coordination and provide parent to parent training to encourage independence and stability.//2007//

As of July 1, 2003, DHH became the lead agency for the Part C/Early Intervention System, now called EarlySteps. This system transitioned from the Department of Education, which had been the lead agency since 1986. CSHS works with agencies statewide to build the system capacity to provide quality early intention services for infants and toddlers with developmental disabilities. DHH has established interagency agreements with the Department of Education/Special Populations, Office of Health Services Financing (Medicaid) and Office of Citizens with Developmental Disabilities to provide funding for Part C services. CSHS will also continue to work

with other agencies to access additional funding, which will increase the capacity to serve infants and toddlers with developmental disabilities. In the first year of implementation, the number of children identified increased by 43% due to the longstanding emphasis on early identification within the Office of Public Health and the MCH and CSHS programs. A significant indicator of the impact of Part C being managed under a health agency is the dramatic increase in the number of children from birth to one year enrolled. In 2002 331 children under the age of one year were enrolled in Part C, in 2004 that number increased to 2,934, an 89% increase in 2 years. Budget issues with the tremendous increase in the number of children identified have triggered a significant restructuring of the program to make the best use of limited funding. /2007/ The number of children served and expenditures have decreased after recent disasters. In addition, EarlySteps is implementing changes to the system to a more moderate eligibility criteria and to begin family cost participation. Best practices promote family-centered intervention and involvement. The major changes to this system and disaster effects on the population will make the current year a pivotal point in early intervention.//2007//

State legislation in 1999 established the LA Birth Defects Monitoring Network (LBDMN). Under the CSHS program, data collection started in 4 areas of the state in January 2005. Parents of children identified through the system will be offered information and referral to health care systems, as appropriate to their child's identified birth defect. /2009/ The Birth Defects program received state funding in 2008 for two additional staff, permitting coverage of over 70% of births and mailing of resource guides to families as of later this year. //2009// ***/2010/ LBDMN will require 2 FTE data collection specialists and an epidemiologist to obtain statewide coverage. Further expansion is temporarily on hold due to state CSHS budget cuts in 2009 and 2010. //2010//***

The Early Hearing Detection and Intervention (EHDI Program), within the Hearing, Speech and Vision Program, works closely will all birthing hospitals in the state to ensure hearing screening for all newborns. Newborn hearing screening results are reported on the electronic birth certificate. The EHDI program matches initial hospital hearing screening and follow-up results and is able to identify infants that have not had a screening test. Follow-up is provided for all infants with an abnormal newborn hearing screening, as well as infants that have not had a screening test. EHDI staff provided training and technical support to hospital personnel and also work with private providers to facilitate follow-up hearing evaluations. /2007/ Newborn Hearing Screening and Birth Defects have had to adjust to shifting birth populations after the disasters. Birthing services continue to change as the health care system in the state adjusts. A recent announcement of discontinued birthing services at a major public hospital in Baton Rouge is an example of significant shifts in service delivery and surveillance.//2007//

CSHS funds a clinic at University Hospital in New Orleans to provide developmental services to children of mothers who are substance abusers. In addition to assessments, families are assisted with information, referral and follow-up to programs and agencies as determined by the needs of the child and family.

CSHS funds a program for specialized care of children with diabetes at Children's Hospital in New Orleans. This goal of this multidisciplinary program is to reduce emergency room visits, improve growth and development of the children, as well as decrease the average blood glucose level of the enrolled children. /2009/ This program demonstrated a decrease in children's Hgb A1c levels with increased staffing provided by CSHS funding. //2009//

The Louisiana Medical Home project under CSHS has participated in the National Medical Home Learning Collaborative. It currently funds a care coordinator in 3 pediatric practices in the state. In addition, training of medical school residents has been incorporated through the CSHS Medical Director who is on faculty at LSU Medical School. /2009/ All pediatric residents in LSU and Tulane Medical Schools are trained in MH. CSHS provides CC's for two pediatric practices with plans for expansion. //2009// ***/2010/ CSHS provides CC's for 3 pediatric practices, including the LSU faculty practice clinic. Practices involved in medical resident training are given***

priority. CSHS hired a statewide CC supervisor for MH CC to assist practices with care coordination. //2010//

/2009/ The MCH and CHSCN Programs disseminate data on racial and ethnic sub-populations to state, regional, and local public health leaders in order to inform program development, including the regional Fetal Infant Mortality Review's (FIMR) 9 Case Review Teams and Community Action Teams. Latino Health Access Network (LHAN) in the New Orleans region conducted a "secret shopper" survey of OPH Parish Health Units and reported the findings to MCH who provided this information to OPH administrative leadership. One of the bi-monthly trainings for MCH and CSHCN staff addressed cultural competency and the content was incorporated into the MCH new hire orientation process. Training on cultural competency for MCH central office, local field staff and contractors was provided by the Tulane University MCH Leadership grant program, Michael Lu, M.D. (focused on the effects of maternal stress and racism), and MCH's Infant Mental Health trainers. MCH toll free information services and related public relations campaign and Perinatal Substance Abuse program provide Spanish language materials and both use Spanish speaking translators. FIMR and SIDS initiatives include faith-based components. MCH Oral Health Program works with the minority dental society and African American churches Louisiana's to reduce Louisiana's racial disparities in health status. //2009// ***/2010/ Training for MCH staff was held on cultural competence focusing on the impact of personal and institutional cultural insensitivity on staff and clients. Cultural competency is included in all MCH conducted infant mental health trainings addressing family development and the impact of culture on parenting offered twice a year to OPH/NFP staff and professionals from other state agencies. Child Care Health Consultant annual training includes cultural and linguistic competency //2010//***.

The following State statutes are relevant to the Title V program:
1. LSA-R.S. 46:971-973 - Administration of MCH Services in State of Louisiana - Health Department Responsible
2. LSA-R.S. 17:2111-2112 - Vision and hearing screening - Health Department and Department of Education Responsible
3. LSA-R.S. 33:1563 - SIDS autopsy; reporting to Health Department Required
4. LSA-R.S. 40:1299 - Mandated Genetics - Newborn screening - Health Department Responsible
5. LSA-R.S. 40:1299.111-.120 - Children's Special Health Services - Health Department Responsible
6. LSA-R.S. 40:5 - State Board of Health authority to create MCH & CC Agency
7. LSA-R.S. 40:31.3 - Adolescent School Health - School Based Clinics - Health Department Responsible
8. LSA-R.S. 46:2261 - The Identification of Hearing Impairment in Infants Law - Health Department Responsible
9. LSA-R.S. 40:31.41-.48 -- The Births Defects Monitoring Network - Health Department Responsible

An attachment is included in this section.

C. Organizational Structure

The Department of Health and Hospitals is one of twenty departments under the direct control of the Governor. The State Health Agency, the Office of Public Health is one of the five major agencies within the Department of Health and Hospitals (DHH). The State Medicaid Agency, Bureau of Health Services Financing, is also located in this Department as well as the Office of Mental Health, Office of Addictive Disorders and the Office for Citizens with Developmental Disabilities. The Title V programs, the Maternal and Child Health Program and Children's Special Health Services, are located in the Center for Preventive Health in the Office of Public Health, along with Family Planning, Nutrition, Genetics, Tuberculosis Control, Immunization, Sexually Transmitted Diseases and HIV/AIDS, and Adolescent and School Health Programs. The organizational charts in Figure 1 of the attachment illustrate the structure of the departments

under the Governor, DHH, Office of Public Health, Center for Preventive Health, MCH, and CSHS.

The Children's Cabinet in the Office of the Governor provides a monthly forum for the Secretaries of the child serving departments to meet and address the needs of children in Louisiana. The Children's Cabinet Advisory Board consists of the Assistant Secretaries of the agencies within the departments that serve children, as well as non-profit and advocacy organizations. This Board meets monthly and makes recommendations for policy, program development, and funding for child issues. MCH is represented on subcommittees of the Board. The Early Childhood Comprehensive Systems grant is being administered as a joint project of the Children's Cabinet and the MCH Program. /2009/ The Genetics Program is responsible for the proper administration of the Title V funds allocated to this program and provides annual reports and plans related to their particular performance measures. //2009//

The Office of Public Health is organized into five centers, Center for Preventive Health; Center for Environmental Health; Center for Health Policy, Information, and Promotion; Center for Administrative and Technical Support; and Center for Community Health. The Center Directors, Program Directors, and Regional Directors meet regularly. The MCH and CHSCN Program and Medical Directors are the individuals primarily responsible for administering the programs funded by Title V. These staff report to the Director of the Center for Preventive Health, who in turn reports to the Assistant Secretary of OPH. The Directors of the Family Planning, Immunization, and Adolescent and School Health Programs are responsible for the proper administration of the Title V funds allocated to these programs and provide to the Title V Director annual reports and plans related to their particular performance measures. /2008/The Office of Public Health is organized into six centers, Center for Preventive Health; Center for Environmental Health; Center for Health Policy and Information; Center for Administrative and Technical Support; Center for Community Preparedness and Center for Community Health.//2008//

MCH conducted an internal assessment of its organizational structure during last fiscal year. Fifteen lead MCH staff members attended a 4-day assessment and planning process, facilitated by a local consultant. Needs identified included new positions, staff recruiting, orientation, and retention, mentoring programs for new staff, communication and collaboration, contract development and monitoring, and physical space. A strategic plan was developed and subcommittees were formed to address each of these areas. As a result, a new orientation process was implemented for all new staff including a manual; a mentoring program was developed; new positions and vacancies were all filled; a contract manual and training module was presented to all MCH staff; a physical space plan was developed and most of the changes have been put in place. To address the communication/collaboration needs the MCH Program was re-structured by population and functional areas including Maternal Health, Child Health, Nurse Family Partnership, Epidemiology, Health Education, and Mental Health. The Team Leaders for Maternal Health, Child Health, Nurse Family Partnership, Epidemiology, and Mental Health meet with the MCH Director and assistant MCH Director every other week for a MCH Management Team meeting to foster collaboration among these programmatic and functional areas and to keep the MCH Director and each other informed. The Team Leader for Health Education meets with the health education team once a month and with the MCH Director once a month. The Maternal Health, Child Health, and Nurse Family Partnership Teams meet separately once a month and the Epidemiology Team meets weekly. MCH began a monthly series of meetings under the banner of "MCH Issues and Approaches." MCH staff and MCH stakeholders are invited to hear a focused presentation on an MCH topic, followed by a question and answer session. Over 200 people attended these meetings in the last year. An MCH Office Operations and Communications Committee meets bi-monthly to discuss any issues with the building or work environment that need addressing.
/2010/ The state office building that housed the Office of Public Health including the Maternal and Child Health and Children's Special Health Services Programs closed after hurricane Katrina and staff were housed in two different locations in the New Orleans area. In February 2009 the MCH Central Office staff were moved into the same office building

with CSHS. //2010//

The CSHS staff has undergone a rapid expansion with the addition of the Part C program, EarlySteps, and new staff dedicated to early interventions. CSHS staff meets monthly and individual work units, such as EarlySteps, Hearing Speech and Vision, and Birth Defects meet as needed. The CSHS administrative team of Program Manager, Medical Director, Nurse Consultant, Social Work Consultant and Parent Consultant meet frequently about policy issues and to approve special requests for services. The CSHS Management Team makes periodic visits to regional clinic sites to offer technical assistance and to gain input for program planning. CSHS and MCH collaborate through the MCH Epidemiology section where technical assistance is provided to the CSHS Epidemiologist and the Birth Defects Monitoring Network Coordinator. /2007/After Hurricane Katrina Office of Public Health staff from the affected area were dispersed throughout the state and across many states. The subsequent reorganization of office space including locating space for critical staff and re-establishing communication systems has been difficult and continues. A governor's freeze on travel restricted program operations and hindered progress on program goals. CSHS Central Office staff have had as many as 4 temporary office locations and are still waiting for more permanent housing. This has required changes in the way office team members communicate and work together.//2007//

/2008/The Oral Health Director is part of the MCH Team Leadership and was successful at obtaining an infrastructure grant from HRSA that will add two central office management and evaluation staff.//2008// ***/2010/ The MCH Program was successful at obtaining an Oral Health grant from the Centers for Disease Control and Prevention adding a Fluoridation Engineer and a Dental Sealant Program Coordinator. //2010//***

/2008/ The CSHS staff has undergone a reorganization with the departure of the CSHS director/ program manager. The CSHS staff was organized into four programs with a CSHS Medical Director overseeing the four. The programs were CSHS, Hearing Speech and Vision (HSV), Birth Defects, and Early Steps (Part C program). The Early Steps program was moved to OCDD as of July 1, 2007. The three program directors meet frequently with the medical director about the overall direction of the programs and how to integrate services of the three programs for families. Central to this concept is developing integrated data systems. The CSHS Management Team of Program Manager, Medical Director, Nurse Consultant, Social Work Consultant and Parent Consultant make periodic visits to regional clinic sites to offer technical assistance and to gain input for program planning. CSHS and MCH collaborate through the MCH Epidemiology section where technical assistance is provided to the CSHS and HSV Epidemiologists and the Birth Defects Monitoring Network program manager. Vacancies in the social work consultant position and the CSHS program manager position from September of 2006 until August 2007 resulting from worker shortages made it difficult to start new initiatives in post-Katrina New Orleans. These have now been filled and/or posted at higher levels, and a new position has been approved for the Birth Defects program to assist with statewide expansion of the program.//2008// /2009/ CSHS structure remains unchanged with program managers for the CSHS program, the Hearing Speech and Vision program and La Birth Defects Monitoring Network (LBDMN) reporting to the Title V CSHS Director. Of the 10 vacancies in the program post Katrina, 9 were filled before a hiring freeze was instituted in 2008. Two new positions were added for LBDMN using new state funding, including a Family Resource Coordinator and an additional data collection specialist. These will permit this program to cover approximately 70% of births and meet the legislative mandate to provide resource materials to families in the registry. Requests for a fourth audiologist for the HSV program for regions I and III and a social worker for region V for the CSHS program were denied when OPH positions were recently cut by the new administration. Staff shortages in the regions has resulted in staff increasingly being pulled for duties in other programs, leaving few staff dedicated to CSHS clinics and care coordination activities. //2009//

/2010/ The DHH hiring freeze continued for all of 2008. CSHS was given special permission to fill two central office positions, however constant freezes have resulted in a decrease in state positions for central office from 18 in 2006 to 11 in 2008. CSHS has responded by

increasing the number of contract employees. Currently there are 19.5 central office staff including 12.5 state positions (11 CSHS, 1.5 from nursing and nutrition) and 7 contract positions. Regional CSHS staff continue to be pulled to other programs that are short staffed due to hiring freezes.

In 2008 CSHS instituted quarterly conference calls with each region to provide program guidance and to stay abreast of staffing and other issues. CSHS holds an annual statewide training/ conference for regional staff. In 2008 this was used to standardize procedures and initiate the CSHS Program Manual revision. CSHS staff traveled to Regions I and 6 to provide intense trainings on the new care coordination program focusing on transition. The CSHS and HSV Parent Consultants participate as needed to ensure that parent perspective is incorporated into all decision making. The 13 Parent Liaisons participated in the CSHS manual revision conference and all CSHS clinics.

CSHS created a new Care Coordinator Supervisor position in central office to supervise care coordinators placed in pediatric practices. This person is a nurse and certified case manager contracted through LSU.

Recently, at our request, CSHS was invited to participate in the administration's Department of Social Services Data Integration Project pilot to create a Master Patient Index of clients served by CSHS and DSS and OCDD programs. This data sharing will facilitate Care Coordination for CSHS patients.

The CSHS Director, Nurse Consultant, and Program Manager also participate on the DHH Healthcare Reform CSHCN Workgroup. This workgroup is responsible for designing a system of care for CSHCN within Care Coordinated Networks, which are like HMO's. In the new system, reimbursement will be linked to providers meeting NCQA criteria for Medical Home. The new plan is temporarily on hold pending CMS approval. The CSHS Director and the CSHS Statewide Care Coordinator Supervisor participate on the Louisiana Healthcare Quality Forum (LHCQF) Medical Home Committee Advisory Group. LHCQF is the legislated stakeholder group to advise the administration on best practices for healthcare reform. Thus, CSHS program activities are incorporated into the administration's healthcare reform initiatives centered on Medical Home, and CSHS can ensure that the needs of CSHCN and their families are met with the new policies. CSHS also participates in the Issues and Approaches meetings organized by MCH and the ECCS Steering Committee. //2010//

The Nurse Family Partnership (NFP) team meets quarterly with the supervisors of the OPH and contract sites and conducts annual training with all NFP nurses. /2009/ The Nurse Family Partnership Program received additional funding in fiscal year 2009 from the Department of Social Services, Temporary Assistance For Needy Families Program and added 32 nurse home visitors. Two quality improvement nurses were hired to provide training, technical assistance, monitoring, and evaluation. //2009// State MCH staff spends a great deal of time providing consultation and technical assistance with other public agencies, contract agencies, advisory boards and commissions. ***/2010/ The Nurse Family Partnership Program received additional state funding for fiscal year 2009 adding 11 nurse home visiting staff. //2010//***

The state is divided into nine administrative regions (see Map 1), with OPH Regional Directors in each of the regions responsible for identifying and addressing the health needs of the population, assuring the quality of care, and providing monitoring and reporting of MCH services delivered through parish health units and contracts. State MCH Medical Directors and Nurse Consultants are responsible for the quality of the clinical services funded by MCH. Each contract funded by MCH has an MCH staff member responsible for ongoing performance monitoring. Program and contract monitoring consists of monthly review of fiscal information and performance indicators; and quarterly to annual on-site meetings with contract agencies to determine the quality of the

service. Training and technical assistance is provided on a regular basis by MCH staff.

Health status information is shared with state, regional, and local public and private health and community leaders in an effort to engage stakeholders to partner with MCH to improve the maternal, infant, child, and adolescent morbidity and mortality rates. State MCH staff provides technical assistance and consultation to help local stakeholders in assessing needs and developing plans to address the needs. MCH provides funding to local entities or assists these groups in obtaining other sources of funding to address their maternal and child health needs. In order to strengthen MCH infrastructure in each of Louisiana's 9 regions, MCH has established regional Infant Mortality Reduction Initiatives, including contracts for the hiring of a coordinator for each region. The Initiative includes Fetal-Infant Mortality Review, needs assessment, strategic planning, and advocacy for the maternal and child population.

An attachment is included in this section.

D. Other MCH Capacity

In addition to the Regional Administrator, each region has a Medical Director, Regional Nurse Consultant, Administrative Manager, Social Worker, Nutritionist, and Regional CSHS Staff. Although policy development and programmatic direction are provided by the State MCH Program staff, regional and local staff provide significant input. The State MCH/CSHS Program staff includes a Maternity Program Medical Director, Child Health Medical Director, MCH Program - Title V Director, CSHS Program Director and CSHS Medical Director. Staffing also includes a Statewide Maternity Nursing Consultant, Pediatric Nursing Consultant, CSHS Nursing Consultant, CSHS Social Work Consultant, CSHS Statewide Parent Coordinator, CSHS Statewide Part C Early Intervention Program Manager and Parent Consultant, Hearing, Speech, and Vision Program Director, Newborn Hearing Screening Statewide Parent Coordinator, MCH Assistant Administrator, MCH Nutritionist, SIDS Program Coordinator, Mental Health Coordinator, two CSHS accounting and contract monitoring staff, an Oral Health Director, a part-time Dental Consultant and Fluoridation Coordinator, three PRAMS staff, a Birth Defects Registry Coordinator, a CDC assignee MCH epidemiologist, MCH Health Education Coordinator, MCH Health Educator, Nurse Family Partnership (NFP) Director, NFP Nursing Consultant and NFP Program Manager, Child Death Review Nurse, Adolescent Health Initiative Coordinator, Folic Acid Coordinator, Adolescent Health Medical Director, four Adolescent and School Health staff, and ten clerical staff. Through MCH and CDC grants, The MCH Epidemiology Program also includes a CSHS epidemiologist, an Epidemiologist Coordinator for the Newborn Hearing Screening program, two Systems Development Initiative Epidemiologists, two CDC fellows, and an MCH Epidemiologist for the City of New Orleans Health Department. /2007/ Changes to the staffing in MCH include a decrease in PRAMS to 2 epidemiologists and no current Folic Acid Coordinator. The MCH Epidemiologist for the City of New Orleans has expanded to a statewide focus, assuming the responsibilities of the CDC assignee MCH epidemiologist. A statewide freeze on hiring was enacted after the disasters in Louisiana. CSHS had a vacant Epidemiologist position and has since lost several vital contract staff. Hearing, Speech and Vision lost several contract staff including the Newborn Hearing Epidemiologist. The freeze is expected to be lifted July 1, 2006 and recruitment has been initiated in anticipation of replacing positions as soon as possible in July.//2007//

/2008/ A grant is being submitted to reestablish the Folic Acid program. There is currently one CDC fellow and an epidemiologist-evaluator funded by the Perinatal Depression grant. The Child Death Review nurse responsibilities have been assumed by the Pediatric Nursing Consultant. A Program Manager and a Program Monitor are in the process of being hired for the Oral Health Program, funded by a HRSA grant.//2008//

/2009/ The Oral Health Program Manager and Program Monitor were hired in June 2008. The part time fluoridation coordinator has been replaced by the full time Program Manager. The CDC fellowship expired and there is currently no CDC fellow in MCH. Adolescent and School Health

Program has an evaluation/data manager. The MCH Health Education team has been reorganized and has added a Child Safety Coordinator whose duties include Child Death Review and Injury Prevention. The SIDS Risk Reduction Coordinator's responsibilities include the MCH parenting newsletter and other MCH health education materials for the public. An additional nurse consultant has been hired to provide training, technical assistance, and monitoring for the new Nurse Family Partnership programs added in the northwest and central regions. //2009//

/2008/ When Linda Pippins, CSHS Director, retired in September 2007, Dr. Susan Berry, CSHS Medical Director, took her position. This resulted in a reorganization of CSHS with program directors for each of the four CSHS programs reporting to Dr. Berry. This, combined with vacancies created by loss of staff post-Katrina, left many key positions vacant for several months, including the CSHS program director, the CSHS social worker, and a program monitor position responsible for helping with contracts. In recent months much progress has been made in filling these positions: the contract monitor is moving into the CSHS program director position, two epidemiologist positions and the program monitor position have been filled. The contract monitor position will be posted in August 2007. A new position has been approved for birth defects monitoring. Filling these key positions is essential for continued progress on initiatives such as care coordination and medical home.//2008//
/2009/ All vacancies have been filled except for one program monitor position, which has since been cut. The CSHS social worker hired in late 2007 has taken the lead with care coordination in CSHS clinics. Two additional positions were added for La Birth Defects Monitoring Network (LBDMN) utilizing new funding. This has permitted this program to fulfill more of its legislated mandate by increasing the percent of births captured in the surveillance system to 70% and providing families in the network with resource materials. //2009//

/2010/ The LBDMN Family Resource Coordinator (FRC), with MPH in MCH and epidemiology, was promoted to CSHS Program Manager. The CSHS Social Worker left and was filled with a LCSW from OCDD. A Care Coordinator Supervisor position was created and filled with a contracted nurse from LSU. CSHS and HSV have epidemiologists who receive guidance from MCH Epidemiology.

CSHS continues to have CSHCN parent involvement at all levels. Twelve parent liaisons contracted from Families Helping Families attend all CSHS clinics and participate on Care Coordination teams to link families with community resources. A 13th parent has been hired for HSV. All parents are supervised by the statewide CSHS Parent Consultant (PC) and the Parent Training Coordinator. The PC participates in central office executive staff meetings. //2010//

In addition to program consultation, the CSHS Medical Director will work on special projects, such as Medical Home for CSHCN. One of the Medical Home priorities is to work with the Medical Home Learning Collaborative grant, which will enhance the capacity of Medical Home practices in the state. Medical Home training is being incorporated into the training of medical residents at state medical schools. A medical home project coordinator and social work consultant are also under contract to enhance primary core services through the Medical Home Project. /2007/ The Medical Director has taken a leadership role in the CSHS Long Range Plan in conjunction with the changes to the state health systems after the disasters. The Medical Home Project coordinator and social work consultant have also left and those contract positions will be reevaluated.//2007// /2008/ The Medical Director has continued to lead the Medical Home Initiative and the social worker position should be filled shortly.//2008//

Early Steps, the Part C Early Intervention system, has 16 positions, including Program Manager. Seven of these positions are in Central Office and 9 positions are in the field, with one Regional Coordinator in each of the nine OPH regions. Some CSHS and EarlySteps staff work across programs to make the most efficient use of time and effective use of expertise. Parent Community Outreach specialists are also employed in each region as well as a full time Parent Consultant for Early Steps. /2007/EarlySteps has also experienced several vacancies due to staff resigning after

relocations and changing jobs after Katrina. These positions are in the process of being replaced.//2007//
/2008/ Early Steps will move to the Office for Citizens with Developmental Disabilities (OCDD), which is under DHH but not under OPH, as of July 1, 2007. This will mean a transfer of 18 positions statewide, of which only 4 are in central office. These positions were dedicated to Early Steps, and their loss will not detract from CSHS activities.//2008//

The number of OPH Parish Health Unit staff resources (FTEs) funded by the MCH and CSHS Programs is approximately 77 and 46 respectively. As the number of staff decreases in the direct health care portions of the program, staff is being hired through contracts to initiate nurse home visiting programs and other initiatives across the state. Contracts are now in place to begin to build MCH services in areas of greatest need through contract agencies and institutions including medical schools, state operated and other hospitals, regional health and human service entities, and non-profit social service agencies. /2007/ The number of Parish Health Units FTEs funded by MCH and CSHS Programs is approximately 63 and 46 respectively. //2007//
/2008/ The number of Parish Health Units FTEs funded by MCH and CSHS Programs is approximately 61 and 43 respectively.//2008// /2009/ The number of Parish Health Units FTEs funded by the MCH Program is approximately 38, plus 40 Nurse Family Partnership home visiting nurses hired by OPH. The number of regional staff that code time to CSHS is 65, however these are not all FTE's. CSHS also contracts for 12 parent liaison, an epidemiologist and follow-up coordinator for EHDI, 3.5 data collections specialists for LBDMN, a care coordinator (CC) for a pediatric practice, and pediatric sub-specialists for its clinics. A second CC for the LSU faculty practice medical home, who was slated to train CC's for other practices, has left the state. CSHS is interviewing for this position and has initiated a contract for a CC supervisor to be hired through a contract with LSU. Requests for an audiologist for Regions I and III for HSV and a social worker for Region V to assist with CC in CSHS clinics were denied during recent position cuts to OPH. //2009//

/2008/ A CSHS nurse and staff training will be held in September 2007. This training will cover not only CSHS skills and CSHS emergency preparedness training, but also policies and procedures for the new Care Coordination Initiative.//2008// /2009/ The CSHS nurses training was held in conjunction with the first CSHS annual conference since Katrina. These were attended by 14 nurses and 85 CSHS staff respectively, and focused on Care Coordination and Transition services. The 2008 CSHS nurses training is scheduled for July 2008. An annual conference is scheduled for October 2008 in Lafayette. //2009//

Previously dedicated CSHS field staff had been integrated into the health units and cross-trained with other programs so that they can perform multiple duties. Additional health unit staff had been trained to assist in CSHS clinics. The CSHS program has provided two weeklong trainings and one clinical training for nurses to foster quality services for CSHCN. /2007/ The training for nurses in special needs issues benefited the agency when Special Needs Shelters were opened around the state.//2007//

/2010/ The number of Parish Health Units FTEs funded by the MCH Program is approximately 35, plus 39 Nurse Family Partnership home visiting nurses hired by OPH. //2010//

Please refer to the attachment for brief biographies of the MCH Senior Level Management Team (Table 1). As of October 1, 2005, the current Child Health Medical Director, Dr. Jean Takenaka will be retiring. Dr. Gina Lagarde has been hired for this position as of July 1, 2005. Dr. Lagarde has 15 years of experience in pediatrics including one as the Director of MCH services for the New Orleans Health Department and a Masters in Business Administration. The double encumbrance period will allow a period of transitional training for Dr. Lagarde.

CSHS employs parents as Family Liaisons in all 9 Regional Offices. In addition to providing one

to one family support and information, the Family Liaisons promote the issues critical to families with children with special needs in local communities and at a state level. The CSHS Statewide Parent Coordinator has been instrumental in providing input to policy and establishing links with other consumer organizations at the state and national level. In addition, a position has been established for a CSHS Statewide Parent Training Coordinator to provide consistent training for and communication among CSHS Parent Liaisons.

Nine Parent Community Outreach Specialists were added in 2003 to work in the EarlySteps Early Intervention System. These parents have gone through extensive training and will work closely with the EarlySteps OPH Regional Coordinator. A Statewide Parent Consultant has also been hired to coordinate the services of the Regional EarlySteps parents and to collaborate on policy development. /2007/ The EarlySteps Parent consultant was integral in the development of new policy that affected family cost participation.//2007// /2008/ Parent liaison training is ongoing to provide parent liaisons for CSHS Subspecialty Clinic and Care Coordination activities.//2008// /2009/ Parent liaisons received 18 hours of training in 2007 and have received 12 to date in 2008. //2009//

To enhance MCH capacity at the regional and urban areas in order to address priority needs, staff have been added through contract agencies. Contracts have been used because there is a strict limit on the number of state employees that can be hired in the DHH agencies. In order to address injury prevention, the leading cause of child death, Injury Prevention Coordinators have been hired in each of the nine regions of the state. These staff work under the direction of the Regional Medical Director. Likewise, to address areas of high infant mortality, Infant Mortality Reduction Initiative (IMRI) coordinators have been hired in all regions of the state. Those hired as coordinators are either obstetricians or nurses. The Regional Medical Directors play a lead role in collaboration with the IMRI coordinators to conduct Fetal-Infant Mortality Review, needs assessment, and strategic planning to address infant death, prenatal care, SIDS, and the interventions to address these problems. In the four Healthy Start projects, MCH has supplemented those programs with funding for prenatal care, or for enabling services such as outreach and case management, or infrastructure.

/2008/ In addition to the Nurse Family Partnership (NFP) staff funded by MCH for the Healthy Start Programs in New Orleans, Baton Rouge, and Lafayette, 4 outreach workers are funded by MCH for the Healthy Start Program in North Louisiana parishes. In addition to the OPH staff working in NFP, another 50 nurse positions are hired through contracts. Contracts for prenatal providers and support staff in areas with access problems fund approximately 8 full time equivalents (FTEs). A part time pediatrician is hired under contract to provide services to low income children in a primary care center. Approximately 4 social workers are hired through social service agencies to address maternal and infant mental health issues. Contracts with universities, social service agencies, and Louisiana's Public Health Institute, add 5 FTEs to address perinatal smoking cessation, breastfeeding promotion, local and state MCH systems development, SIDS case review, and infant mental health training.//2008//

In the past year or more, there has been some transitioning of WIC services at the parish health unit away from the traditional use of nurses toward increased use of health educators. MCH is working with the OPH Regional Administrators to identify opportunities to utilize the resulting time available from the nurses who will no longer work in WIC services. The MCH services that nurses will devote their time to includes psycho-social risk assessment of pregnant women and infants and referral of those at risk to social workers, case managers, or other agencies such as the Office of Mental Health or Office of Addictive Disorders.

The MCH Management Team consists of the Maternity and Child Health Medical Directors and Nurse Coordinators, MCH Program Director, Assistant MCH Administrator, MCH Medical Epidemiologist, Mental Health Coordinator, and Nurse Family Partnership Director. Policy and program direction are developed in Management Team meetings held twice a month. The 2005 MCH Needs Assessment was led by the members of the Management Team and this group,

along with the Needs Assessment Coordinator and a consultant, are using the Needs Assessment results to create a strategic plan for the next five years and an operational plan for the next 1-2 years. /2007/ The Oral Health Director is a member of the MCH Management Team. The strategic and operational plan for MCH has been completed and monitoring of the plan occurs during the Management Team meetings.//2007//

An attachment is included in this section.

E. State Agency Coordination

/2007/Hurricane Katrina amplified the need for strong coordination among governmental and non-governmental agencies. State MCH Maternal Health staff worked closely with Family Road (Baton Rouge Health Start agency) who took the lead in coordinating the MCH service providers in the Baton Rouge area, whose population doubled due to the hurricane. Provider representatives included hospitals, clinics, local health department, March of Dimes, and the agencies established to assist families displaced by the hurricane such as the Louisiana Family Recovery Corps (LFRC). Brochures on prenatal/postnatal health, provider surveys, and other public information was distributed to each of the 9 regional Infant Mortality Reduction Initiatives who in turn disseminated this information to the broader provider and consumer community via their Community Action Teams. The Alexandria and Baton Rouge Initiatives received national recognition for their assistance to displaced pregnant women and their families. The MCH Mental Health Coordinator distributed materials and provided training on maternal depression and children's mental health in response to disasters to mental health providers in Baton Rouge and in the hurricane affected areas including LFRC, Family Road, Office of Public Health, Mississippi National Guard, Office of Mental Health, Nurse Family Partnership and coordinated New Orleans children's mental health provider agencies including Institute of Mental Hygiene, Office of Mental Health, Children's Bureau, Family Services, Volunteers of America, Associated Catholic Charities and the LFRC and the crisis counseling and service organization, Louisiana Spirit. To improve emergency preparedness for the maternal and child population, MCH has collaborated with the Department of Health and Hospitals Office of Emergency Preparedness to develop a state plan. Coordination with the State Commission on Perinatal Care and the Louisiana Chapter of the American Academy of Pediatrics to develop this plan is underway, addressing sheltering of prenatal and postnatal women and their families, inpatient obstetric and neonatal care, and obstetric and pediatric manpower.//2007//

The Maternal and Child Health (MCH) Program has a long history of extensive coordination with public and private agencies and organizations serving pregnant women and children. MCH involvement with the Louisiana's Children's Cabinet Advisory Committee has facilitated the Cabinet's focus on prevention. Established by the legislature in 1998 as a policy office within the Office of the Governor, the Children's Cabinet has as its primary purpose the coordination of policy, planning, and budgeting that affects programs and services for children and their families and the elimination of duplication of services where appropriate. It is composed of the Secretaries of the Departments of Social Services (DSS), Health and Hospitals, Public Safety and Corrections, and Labor; the Superintendent of Education; the Commissioner of Administration; a member of the Louisiana Council of Juvenile and Family Court Judges, and a representative of the Office of the Governor, and a representative of the Children's Cabinet Advisory Board. The Advisory Board provides information and recommendations from the perspective of advocacy groups, service providers, and parents. Advisory Board members represent a wide variety of non-profit agencies, health and educational institutions, assistant secretaries from the Departments listed above, and juvenile court. The Children's Cabinet has recommended maternal and child health interventions among its top 5 priorities for funding, including expansion of the Nurse Family Partnership Program (NFP) (MCH's nurse home visiting program) and MCH administered adolescent school based health clinics. The Early Childhood Comprehensive System (ECCS) grant is administered as a joint venture between the Children's Cabinet and MCH/Office of Public Health (OPH). In the 2004 Legislative session H.C.R. No. 155 was passed asking for cooperation of State Agencies in the development of the strategic plan for the Early Comprehensive Systems

Building Initiative. H.C.R. No. 155 "urges and request the following agencies, departments, and their corresponding offices work together in the ECCS strategic planning process: Office of Family Support and Office of Community Services within the DSS; OPH including the Part C - Early Steps Program, Office of Mental Health, Office of Citizens with Developmental Disabilities, Office of Addictive Disorders, and the Bureau of Health Services Financing (Medicaid) within the Department of Health and Hospitals; State Department of Education (DOE) including the Pre-K and Early Childhood Education Programs section; Board of Elementary and Secondary Education; Division of Administration; and Office of Youth Development within the Department of Public Safety and Corrections." The Resolution also called for quarterly reports to the Children's Cabinet and a competed Strategic Plan by June 30, 2005.
/2010/An Early Childhood System Integration Budget was written into statute during the 2008 state legislative session, requiring the creation of a budget reporting the spending on children ages 0-5 years in the four early childhood system component areas of BrightStart initiative. This initiative provided infant mental health trainings for professionals in the OPH, the OCS, Part C-Early Steps, and the Division of Child Care and Early Childhood Education. BrightStart created the first association for parent educators in Louisiana, called LA Parenting Education Network and drafted a set of Core Competencies for Parent Educators in Louisiana, held two statewide Summits and two regional trainings, and sponsored conferences.//2010//

Early in the implementation of the NFP Program it became clear that the mental health needs of these first-time, poor, and often young, mothers were significant. MCH requested assistance from the state Office of Mental Health (OMH). The partnership resulted in the development of infant mental health consultation for these teams. A memorandum of agreement outlines how both agencies will coordinate services across the state. Following the successful implementation of this infant mental health intervention, the OMH received funding for an intervention to identify and mitigate the risks for young children ages 0-5 who are exposed to risk factors such as abuse, neglect, exposure to violence, parental mental illness, parental substance abuse, poverty, and developmental disabilities. The program promotes collaboration and partnership with all entities at the local (parish) level.

The MCH Program has supported an interagency agreement with the Child Protection Agency for the past 11 years to provide public health nursing assessments for children under investigation by the Office of Community Services (OCS) for suspected failure to thrive, malnutrition, or other medical neglect. /2009/The state OMH in the New Orleans region and MCH have memorandum of agreement to provide mental health staff to the MCH Perinatal Depression program. The state DSS, OFS began providing Temporary Assistance For Needy Families funding to MCH to expand the Nurse Family Partnership Program in October 2008.//2009//

The Fluoridation Program was created to promote, maintain, and monitor community water fluoridation to reduce the incidence of dental caries in all populations. The Fluoridation Program works with local government agencies to provide education and fund water systems that are initiating community water fluoridation. The Fluoridation Program works closely with the Louisiana Rural Water Association (LRWA) to educate water operators on the benefits and technical aspects of community water fluoridation. Members of the Fluoridation Advisory Board include a practicing dentist from each of the 9 Department of Health and Hospitals (DHH) regions, and representatives from the Maternal and Child Health Coalition, Louisiana Medical Society, Louisiana State University Health Sciences Center (LSU-HSC), LRWA, and a state licensed dental hygienist. At the 2004 Oral Health Summit, sponsored by the Oral Health Program, a wide range of attendees were present.

/2010/MCH Oral Health Program collaborated with the Louisiana Dental Association to provide information to policy makers on the benefits of optimal levels of fluoride in water systems in Louisiana. A legislative mandate passed during the 2008 state legislative session for fluoridation of water systems with more than 5,000 service connections. A full time Fluoridation Engineer was hired through funding from the Centers for Disease

Control. An Oral health screening was conducted in collaboration with 75 schools statewide to determine sealant and caries prevalence in Louisiana.//2010//

MCH has contracts with a New Orleans non-profit counseling agency to provide mental health services for children exposed to extreme violence including murder, families with a loss due to Sudden Infant Death Syndrome, and at-risk families with children age 0-5.

The Child Death Review Panel, established by the State Legislature in 1993, reviews all unexpected deaths in children under the age of 15. This panel includes representatives from MCH, OCS-Child Protection Agency, Coroners Association, Attorney General's Office, American Academy of Pediatrics, State Medical Society, Vital Registrar, State Police, Fire Marshall, the Legislature and the general public. The MCH Program currently staffs a full time position for the Child Death Review Panel.

The DSS, Child Care Assistance Program is a key partner with the MCH Program's Child Care Health Consultant (CCHC) initiative. The CCHC Program Director serves as a member of the ECCS Strategic Planning Committee, the Louisiana National Infant and Toddler Child Care Initiative, and the Bureau of Licensure's Task Force to write Standards for Quality Child Care. The CCHC Program Director also is chairperson of the CCHC Quality Improvement Committee and the Statewide Interagency Advisory Board for the CCHC Program. /2008/ A child-care quality rating system is being implemented in Louisiana.//2008// ***/2010/The 2007 legislature passed tax credits for parents, child care centers, and businesses that provide child care for their employees that meet higher ratings on the child-care quality rating system.//2010//***

The Medicaid Agency, the Bureau of Health Service Financing, and MCH coordinate in program development and data sharing. MCH is a Medicaid provider of EPSDT services, prenatal care, and case management. Local parish health units (PHU) determine eligibility for pregnant women to become Presumptively Eligible for Medicaid and assist pregnant women and children with the eligibility process for Medicaid and CHIP. PHUs continue to be the largest source of applications for Medicaid/CHIP. In large PHUs, Medicaid has out-stationed an eligibility worker to expedite applications for pregnant women, reducing the waiting time from as much as 45 days to 48 hours. MCH advocated for and assisted Medicaid in preparing the data and information to convince policy makers to expand Medicaid coverage for pregnant women from 133% of the federal poverty guidelines to 200% in January 2003. Starting in November 2003, this includes dental coverage for pregnant women with periodontal disease. /2008/Medicaid coverage for undocumented pregnant women was implemented May 2007.//2008// /2009/MCH collaborates with Medicaid for Targeted Case Management, Nurse Family Partnership Program.//2009//

MCH has a memorandum of agreement with the state Office of Addictive Disorders (OAD) to provide pregnancy testing and prenatal care referral for women served by OAD. MCH provides the test kits, training, and access to services of the PHU for pregnant women. Other collaboration includes assigning OAD substance abuse counselors to work with perinatal substance abuse programs in New Orleans and in Monroe. /2007/ A contract between MCH, OAD, and Ira Chasnoff, National Training Institute has been established to develop a statewide system addressing maternal substance abuse.//2007// /2009/The state Office of Mental Health has been added to the collaboration adding maternal depression to the screening and referral portion of SBIRT initiative. WIC is now involved to provide a wider population of pregnant women to be screened for these behavioral disorders.//2009// ***/2010/The state Office of Mental Health (OMH) wrote a successful grant for expansion of mental health services in Lake Charles for pregnant and postnatal women including those identified by the SBIRT initiative. A second grant was submitted through a collaboration between OMH and MCH/OPH to provide mental health services for pregnant and postnatal women in Shreveport.//2010//***

Local PHU staff funded by MCH provides pregnancy testing, prenatal care and education, preventive child health services, presumptive eligibility and home visiting services statewide. WIC services are provided at the same time patients receive MCH prenatal and EPSDT services. PHU

WIC patients who receive prenatal or child health care from private providers, receive health counseling, education, and referral from MCH funded staff. The state Title X Family Planning Program receives funding from MCH. Family Planning services are provided in PHUs and contract agencies statewide and are linked with prenatal services funded by MCH. Program directors of MCH, Family Planning, WIC, and other programs coordinate services and planning during regular OPH staff meetings. /2008/Late 2006, the Family Planning Waiver began in Louisiana.//2008// /2009/MCH is coordinating the evaluation for Louisiana's Family Planning Waiver.//2009//

New Orleans has an independent health department and MCH funds maternal and child health services. MCH provides funding for the MCH Medical Director, MCH Nurse Consultant and an MCH Epidemiologist for the New Orleans Health Department. Six social workers were funded by MCH to expand the New Orleans Healthy Start project area. MCH funds a large prenatal clinic in a low-income neighborhood with Louisiana State University (LSU) Medical School providing the clinical services and the City of New Orleans providing the facility. MCH provides funding for prenatal care and/or pediatric services in primary care centers in Orleans, St. Charles, and Caddo parishes. Prenatal clinics, outreach, case management, and home visiting services are funded by MCH in the four Healthy Start grant project areas. /2007/Due to the hurricane destruction in the New Orleans area, neighborhoods have been destroyed and many providers did not return. As a result, contracts have been discontinued or restructured to provide services in adjoining parishes.//2007// /2008/MCH now funds a Fetal Infant Mortality Review nurse through the New Orleans Health Department's Healthy Start Program.//2008//

A key provider of MCH services across the state is LSU-HSC. LSU-HSC administers the services of the 9 state operated hospital located in each region of the state. MCH contracts with LSU-HSC in 4 of the 9 regions to provide prenatal care, nurse home visiting, case management, pediatric services, Fetal-Infant Mortality Review (FIMR), needs assessment and strategic planning. These activities comprise the Infant Mortality Reduction Initiative (IMRI) functions. In the remaining regions, the IMRI is coordinated by public and private hospitals, universities and social service entities. LSU Dental School collaborates with MCH to provide the Oral Health Director, Dental Consultant, and Fluoridation Coordinator to administer the state Oral Health Program. /2009/ MCH Oral Health Program collaborates with the federally qualified health centers to address access problems.//2009//

/2010/The LSU-HSC provides obstetric and mental health expertise and consultation to the MCH Program. Internships for LSU-HSC School of Public Health students are provided in the MCH Program.//2010//

Louisiana is one of five states participating in the Action Learning Lab (ALL), Tobacco Prevention and Cessation for Women of Reproductive Age. MCH led the efforts for this collaboration along with the American College of Obstetricians and Gynecologists (ACOG) Louisiana, Planned Parenthood, Louisiana Public Health Institute (LPHI) and Medicaid. Information on smoking cessation and provider trainings was disseminated to over 200 ACOG providers. MCH contracts with LPHI to provide the evidence-based American Cancer Society's Make Yours A Fresh Start Family, a smoking cessation program for pregnant women. MCH participates in the State Infant Mortality (SIM) Collaborative. Five states are working to develop Tool Kits to address programs, policies, best practices and evidence based programs impacting infant mortality. The MCH Maternity Medical Director and Nurse Consultant collaborate with other groups on perinatal issues: Infectious Diseases, STD, HIV, Office of Addictive Disorders, OMH, School Based Health, American Cancer Society, March of Dimes, and faith-based initiatives.

MCH collaborates with the Louisiana Folic Acid Council to promote folic acid consumption to reduce the incidence of neural tube defects. MCH is represented on the Louisiana Council on Obesity Prevention and Management. The council's purpose is to study the issues relative to obesity in Louisiana, collect data on the subject, and develop recommendations for improving awareness regarding the health risks associated with obesity and suggesting modalities for

treatment. Its membership includes DHH, the State DOE, the Pennington Biomedical Research Center and others. /2007/The Folic Acid Council has been temporarily discontinued due to the relocation of the Council chair and coordinator.//2007//

Tulane University Health Sciences Center (TUHSC) collaborates with MCH to provide essential services. The SIDS Medical Director is a Pediatric Pulmonary Specialist in the TUHSC Department of Pediatrics. Evaluation, biostatistics, and health communication expertise is provided through contracts with the TUHSC School of Public Health and Tropical Medicine. Each semester at least 5 MPH students conduct their required internship in the MCH Program. /2009/ Tulane Department of Psychiatry provides faculty for infant mental health training and technical assistance for the Nurse Family Partnership Program. The Tulane University MCH Leadership Training grant is carried out in close collaboration with MCH state and local staff.//2009//

The MCH Director and the Maternity Program Medical Director serve on the State Commission on Perinatal Care and Infant Mortality, standardizing the framework for regionalization of perinatal services by determining the level of hospital services provided. These standards are used by the Hospital Licensing Section and for Medicaid reimbursement. The MCH epidemiologists present findings from birth and infant death and PRAMS data analysis at the Commission meetings to inform policy decisions.

The Adolescent School Health Initiative Program regularly convenes the Intergovernmental Coordinating Council to assist in implementation, oversight, and funding assistance for school-based health centers. The Council is composed of representatives from the State DOE, OMH, OAD, the Excellence in Health and Education Project (EHEP) at Southeastern Louisiana University, the state Medicaid Office, DSS and other health service entities.

Childrens Special Health Services (CSHS) is uniting with established partner organizations, private providers, parents and other stakeholders to implement a Long Range Plan to providing services for children with special health care needs (CSHCN) statewide and also to strategize for the future direction of the CSHS Program. Agencies and organizations that participated in this collaboration in 2001 and continue to participate include Children's Hospital, Tulane Hospital for Children, Shriner's Hospital, statewide Families Helping Families members, private physicians, OPH, Medical Center of Louisiana at New Orleans, state congressional staff, as well as parents stakeholders. As a result of this collaboration and teamwork, CSHS contracted with LSU-HSC in 2003 to conduct a Statewide Needs Assessment that will describe the current access to health and related systems of care for the provision of comprehensive and coordinated care of children birth through 21 years in Louisiana. CSHS has begun regional planning with local stakeholders, medical representatives, OPH staff, other agencies and parents to formulate plans for future CSHS services, as well services for all CSHCN in the community. /2008/ After hurricane Katrina, a redistribution of CHSCN families and physicians in the state accentuated pre-Katrina barriers to care, including lack of transportation and lack of accessible sub-specialists in rural areas. The CSHS long range plan addresses barriers to accessing healthcare for CSHCN by expanding care coordination and medical home activities and by addressing transition needs.//2008// ***/2010/CSHS is using its 2010 Needs Assessment to form a new stakeholder group of representatives from agencies and programs that serve the same population, including OCS, SBHC, OCDD (NOW Waiver, Early Steps, Respite), Families Helping Families, and DOE Part B. It is hoped that this will provide the structure for ongoing collaboration between programs.//2010//***

CSHS is also working in partnership with many agencies and organizations to address the need for primary health care services for all CSHCN in Louisiana. Since 2000, CSHS has collaborated with the Louisiana Chapter of the American Academy of Pediatrics to provide "Every Child Deserves a Medical Home" trainings. CSHS has taken leadership in planning meetings with local agencies and organizations including local hospitals, private providers, Medicaid, Social Security, Vocational Rehabilitation, State DOE, LSU Medical School, Tulane University Medical School and School of Public Health, ChildNet, Office of Citizens with Developmental Disabilities, Agenda for

Children, Families Helping Families, Family Voices, City of New Orleans Health Department, health care organizations and parents. The OPH has directed each of the 9 OPH regions to plan and implement a strategy to address the issue of adequacy of primary care providers to serve CSHCN statewide. CSHS will continue to work with each of the remaining regions of the state as they plan for Medical Home. /2008/ After providing 4 regional conferences for health providers on medical home, CSHS shifted to ensuring that all pediatric residents trained in Louisiana at both LSU and Tulane Schools of Medicine understand medical home and comprehensive, family centered coordinated care. CSHS supports 2 models, a teaching clinic for residents in collaboration with Children's Hospital, LSU and the AAP, and a private pediatrician. CSHS clinics and model medical homes have developed collaborations with local agencies, including local departments of education, schools, Office of Mental Health, hospitals, OCDD, sub-specialists, social security, Families Helping Families, health care organizations, and various parent support groups.//2008//

/2010/CSHS has hired a statewide care coordinator (CC) supervisor to develop collaborations with other agencies and programs and to develop training materials for CC's including referral information and forms for each region. To date CSHS has placed CC's in four practices. CC activities appear to continue in practices after funding for the CC is withdrawn.//2010//

CSHS is currently managing the EarlySteps program under Part C of Individuals with Disabilities Education Act. CSHS officially assumed responsibility for administering this early intervention program on July 1, 2003.

CSHS and EarlySteps are also collaborating to develop interagency agreements with several agencies. Negotiations are in progress with the State DOE, Office of Health Services Financing, Office of Citizens with Developmental Disabilities and Bureau of Health Services Financing (Medicaid) to ensure a coordinated system of early intervention services. /2008/ CSHS is transitioning Early Steps program under Part C of IDEA to Office for Citizens with Developmental Disabilities on July 1, 2007. CSHS will continue to be active with SICC and its agencies. CSHS' collaboration with OCDD will continue efforts to coordinate services for CSHCN, including early intervention services, waiver services and personal care services provided by OCDD. CSHS continues to use a joint application for CSHS, EarlySteps, Medicaid and OCDD services. This helps ensure coordination of services between agencies. CSHS is working with Medicaid to increase reimbursement for care coordination, both in private pediatric offices and in CSHS clinics.//2008// /2009/The CSHS Director is on the Advisory Board of the Healthcare Quality Forum (LHCQF), legislatively mandated to implement Medical Home (MH). CSHS presented its data on CC in the MH at a MH Summit by LHCQF attended by 115 invited policy makers. DHH will model its healthcare system after Florida's capitated system of Provider Service Networks (PSN's), with CC contracted out. CSHS will continue to assist MH's with CC and is exploring its interface with Medicaid, OCDD, DSS and PSN's in the new system.//2009// ***/2010/The CSHS Director continues on the Advisory Board of LHCQF and is also on both the the AAP and DHH healthcare reform workgroups for CSHCN.***

CSHS has been invited to pilot a data integration project with DSS and OCDD. Representatives from all programs that serve the CSHS population are meeting to establish a master patient database. This will greatly enhance the ability of CSHS to provide care coordination for CSHCN.//2010//

In addition, CSHS has been working in partnership with LSU School of Medicine to provide services for children of mothers who are substance abusers. CSHS funding is supporting the services of a Developmental Specialist who provides clinical services for identified children in clinics at University Hospital in New Orleans. In addition to assessments, this clinic provides information, referrals and follow-up to programs and agencies as determined by the needs of the child and family.

/2010/CSHS moved the Developmental Specialist to the LSU continuity clinic for pediatric residents after Katrina, when University Hospital was closed. She continues to teach developmental screening to residents in this model MH.//2010//

CSHS has also pooled resources with Children's Hospital to establish a model program dedicated to the specialized care of children with diabetes in Louisiana, with a focus on prevention of acute and chronic complications. This program provides the team services of a pediatric diabetologist, pediatric diabetes nurse educator, pediatric nutritionist, pediatric psychologist, exercise trainer and visiting pediatric diabetes liaison nurse. The goal of this program is to reduce emergency room visits, improve growth and development of the children, as well as decrease the average blood glucose level of the enrolled children. /2008/ CSHS will fund a nurse coordinator for pediatric rehabilitation clinics at Children's Hospital to provide care coordination services in the clinics.//2008//

CSHS, LSU Dental School and Children's Hospital have jointly provided funding for the Special Children's Dental Clinic at Children's Hospital. LSU Dental School staffs the clinic with pediatric dentists, dental students and dental support staff. CSHS provides funding for clinical services. This clinic services CSHCN from the 9 statewide CSHS clinics, as well as private clients.

CSHS is implementing the Birth Defects Monitoring Network. This name emphasizes partnering with other projects and agencies to ensure success of the program. The Advisory Board consists of 9 members including representatives from the Louisiana State Medical Society, Ochsner Foundation Medical Center, Tulane University Medical Center, LSU-HSC, March of Dimes, MCH Coalition, OPH, a parent representative and a consumer representative. At present, Louisiana has hired surveillance staff for the program in a partnership with LPHI. /2009/LBDMN also partners with Lake Charles Memorial Hospital for surveillance staff and Spina Bifida Association of GNO for its advisory board. LBDMN works closely with MCH for systems development.//2009// The Hearing, Speech and Vision Program (HSV) within CSHS works closely with all birthing hospitals in the state to ensure hearing screening for all newborns. CSHS also collaborates with private audiologists and the medical community for follow-up evaluations or for families with lack of insurance or no access to local community services. The State Advisory Council for Newborn Hearing Screening is appointed by the Governor and includes 14 stakeholders and advises the program on the EHDI system in the state. /2009/EHDI works with LA chapters of the Association of the Deaf, Commission for the Deaf, Hospital Association, AAP, AAFP, Speech/Language Hearing Association, American Speech/Language Hearing Association, American Academy of Audiology, Speech Pathologists and Audiologists in LA Schools, and Board of Examiners for Speech Pathology and Audiology.//2009//

The CSHS Program Manager participates in the State Planning Council for Developmental Disabilities in Louisiana. Other members of this council include the Advocacy Center, LSU-HSC Center for Excellence in Developmental Disabilities, self advocates, parents, State DOE, OMH, Office for Citizens with Developmental Disabilities, Louisiana Rehabilitation Institute, Governor's Office on Disability Affairs, Governor's Office on Elderly Affairs and others. This ongoing collaboration addresses issues related to all aspects of life for persons with disabilities. /2009/The CSHS Director is on the Developmental Disabilities Council.//2009//
/2007/In the aftermath of the disasters, collaboration with community partners provided much needed assistance for the CSHS program. Agencies such as Families Helping Families, the Southeast Area Health Education Authority, Easter Seals, and Children's Hospital provided temporary office space and resources for displaced CSHS staff. In addition, many agencies such as Families Helping Families visited Special Needs Shelters providing resources to families with CSHCN displaced by the disasters. The national Family Voices office also provided financial assistance directly to some affected families.//2007//

F. Health Systems Capacity Indicators

Introduction
Health Systems Capacity Indicators are used as a monitoring/assessment tool. They are used to measure the state's effectiveness in maintaining or improving the overall health of the state's population of pregnant women, women of child bearing age, infants, children and children with special health care needs. State MCH efforts have been successful in improving early and adequate prenatal care. Examination of the data for disparities is vital in order to tailor efforts to reach out to populations and areas in greatest need, in order to make further progress. There are concerns post-Hurricanes about the capacity of the state's health service infrastructure to provide adequate services and the HSCI enables such monitoring.

The goal of the State System Development Initiative (SSDI) grant is to enhance the data capacity of Louisiana's Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) Programs. Improving existing and establishing new data linkages and surveillance systems enhance data capacity. Current linkages between the birth files, infant death files, Medicaid eligibility files, women, infant, and child program (WIC) eligibility files, and newborn screening data will continue to allow in depth analyses by MCH and CSHCN Programs, which identify priority needs for programs and interventions. Data is used as an indicator for developing new strategies and efforts to address emerging population needs.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	74.4	60.3	57.1	55.3	55.3
Numerator	2388	1817	1722	1650	1650
Denominator	320790	301375	301375	298157	298157
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data is preliminary and based upon 2007 data.

Notes - 2007
Data is based upon 2005 Louisiana Hospital Inpatient Discharge Data (LAHIDD).Data is provisional, based on 2005. Since 2002, the primary data source of analysis and reporting for this indicator is the Louisiana Hospital Inpatient Discharge Data (LAHIDD). LAHIDD is compiled by the Health Statistics Department of the Louisiana Office of Public Health, and EMS/Injury Research and Prevention Program analyzes the data needed for this indicator.
Since participation in reporting hospital inpatient discharge data is not mandatory in Louisiana, then differences in the number, size, and type of hospitals reporting annually will affect our data reported. The variability limits year-to-year comparison analyses. Also, since the CDC has changed the 2004 Census population data for Louisiana from 4,515,770 to 4,506,685, then the 2004 statistics reported are based on the new population data.

Notes - 2006
Data is based upon 2006 Louisiana Hospital Inpatient Discharge Data (LAHIDD).Data is final. Since 2002, the primary data source of analysis and reporting for this indicator is the Louisiana Hospital Inpatient Discharge Data (LAHIDD). LAHIDD is compiled by the Health Statistics Department of the Louisiana Office of Public Health, and EMS/Injury Research and Prevention

Program analyzes the data needed for this indicator.
Since participation in reporting hospital inpatient discharge data is not mandatory in Louisiana, then differences in the number, size, and type of hospitals reporting annually will affect our data reported. The variability limits year-to-year comparison analyses. Also, since the CDC has changed the 2004 Census population data for Louisiana from 4,515,770 to 4,506,685, then the 2004 statistics reported are based on the new population data.

Narrative:
/2010/ Final data shows a decreased rate of children hospitalized for asthma in 2007 at 55.3 per 10,000 children under 5 years of age compared to a rate of 57.1 per 10,000 in 2006 and 60.3 per 100,000 in 2005. //2010//

/2009/ Based on final 2005 Louisiana data, the rate of children under 5 years of age hospitalized for asthma in 2005 is 60.3 per 10,000 children less than age 5 years. Hospital Discharge Data for 2006 and 2007 are not yet available. //2009//
In 2004, the rate of children hospitalized for asthma is 74.4 per 10,000 children less than five years of age. This rate is higher than the rates in 2001 (67.9 per 10,000), 2002, (61.4 per 100,000), and 2003 (52 per 10,000). Hospital discharge data for 2005 and 2006 are not yet available for comparison.

Some factors influencing this indicator are the use of best practices for outpatient management of childhood asthma; (increased) access to medications and medical care; and the education of parents/caregivers on how to reduce exposure to asthma triggers.
/2010/ The Louisiana Asthma Management and Prevention Program (LAMP) and the Asthma Surveillance Collaborative use data regarding asthma control and management from Louisiana Medicaid, Office of Public Health's Environmental Epidemiology and Toxicology Section, Office of Vital Statistics, Department of Environmental Quality, Louisiana Hospital Inpatient Discharge Database (LAHIDD) and emergency room data regarding asthma triggers and asthma related emergency room visits for statewide asthma burden and surveillance reporting, program planning, and policy development on asthma control and management. //2010//
/2009/ Louisiana uses the Behavior Risk Factor Surveillance System (LABRFSS) and the Youth Tobacco for data on childhood asthma prevalence data are used by DHH Chronic Disease Program and Louisiana Medicaid's LaCHIP continues its performance monitoring of the use of appropriate asthma medications as one of its core quality measures. //2009//

The state uses its Behavior Risk Factor Surveillance System (LA BRFSS) to gather annual data on asthma prevalence, and, as one of its core performance measures, Louisiana Medicaid Program tracks the use of appropriate medications for children with asthma. Information from the Louisiana Medicaid performance monitoring on asthma showed that the use of appropriate medications in children with asthma increased from 60.79% in 2003 to 66.27% in 2004.

/2010/ Louisiana Medicaid recipients diagnosed with asthma have access to the Asthma HELP Program, a free telephone-based pharmaceutical care program designed to improve the health of asthmatics by providing asthma-related education from licensed Louisiana pharmacists who are certified by the National Asthma Educators Certification Board as asthma educators. Educators provide mailed printed education materials, asthma action plans, and guideline summaries along with monthly telephone counseling. A priority of the Louisiana Asthma Management and Prevention Program is to establish asthma friendly communities, including schools and child care centers, through a systems approach to implementing effective educational outreach efforts as well as social and environmental policy development. //2010// Louisiana is committed to asthma management in children. The MCH Program supports the state's efforts to reduce childhood asthma through education and outreach efforts to parents, healthcare providers, and in school-base health centers. One of Louisiana CommunityCARE's quality projects is "Achieving Better Care for Asthma". The goals of

this statewide project are to promote healthy behaviors in our Medicaid population resulting in improved health outcomes; to improve medical home management by providing education, office management tools, and utilization data to providers; and to develop patient self-care through education. Also, the MCH Program supports Medicaid and LaCHIP's efforts to enroll eligible children into the respective program to increase children's access to healthcare.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	88.7	87.5	89.8	90.2	89.9
Numerator	40591	40441	40505	43931	43757
Denominator	45770	46225	45119	48707	48699
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
From Louisiana Medicaid Management Information Systems, HCFA 416, for dates of service 10/01/2007 - 09/30/2008. Since Louisiana's SCHIP program is through Medicaid expansion, the numerator and denominator Include children enrolled in LaCHIP.

Notes - 2007
From Louisiana Medicaid Management Information Systems, HCFA 416, for dates of service 10/01/2006 - 09/30/2007. Since Louisiana's SCHIP program is through Medicaid expansion, the numerator and denominator Include children enrolled in LaCHIP.

Notes - 2006
From Louisiana Medicaid Management Information Systems, HCFA 416, for dates of service 10/01/2005 - 09/30/2006. Since Louisiana's SCHIP program is through Medicaid expansion, the numerator and denominator Include children enrolled in LaCHIP.

Narrative:
/2010/ Fewer Medicaid enrollees, or 89.9%, under age 1year received at least one periodic screen in 2008 compared to 90.2% in 2007. //2010// /2009/ The percent Medicaid enrollees under age 1 year who received at least one periodic screen increased to 90.2% in 2007. //2009// There was no significant change in the percent of Medicaid enrollees less than one year of age who received at least one initial periodic screen. The rate increased from 88.7% in 2004 to 88.6% in 2006. However, from 2001 to 2006, there was an overall increase from 86.9% to 88.6%.This indicator reflects the capacity of Louisiana's healthcare system to provide services, which include provider enrollment; opportunities to access preventive healthcare services with a primary care physician; and patient utilization of accessible services.

Medicaid and LaCHIP recipients in Louisiana are enrolled in the Department of Health and Hospitals' (DHH) CommunityCARE Program, which is a comprehensive health delivery system that links recipients to a primary care physician, creating a "medical home". The participating physicians provide enrolled children with preventive care, including periodic screens, outpatient

and hospital inpatient care, health education, and referrals to specialists.

The MCH Program will continue to support delivery of preventive health services, such as health screenings, immunizations, and parental education, to low income infants and children in the state's public health clinics, school base health centers, and contract clinics; screen infant and children seen in the public health clinics for Medicaid eligibility; provide technical assistance to the Medicaid program on issues related to access to services for children; and promote the Medical Home concept, through Louisiana's Early Childhood Comprehensive Systems Initiative and collaboratively with the Louisiana Chapter of the American Academy of Pediatrics.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	86.4	86.4	53.6	89.3	91.3
Numerator	515	459	260	509	496
Denominator	596	531	485	570	543
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data is provided by the Medicaid Office.

Notes - 2007
Data is provided by the Medicaid Office.

Notes - 2006
Data is provided by the Medicaid Office.

Narrative:
/2010/ In 2008, 91.3% of LaCHIP enrollees under age one year received at least one periodic screen, an increase from 2007 (89.2%). //2010//
/2009/ The percentage of LaCHIP enrollees under age one year who received at least one periodic screen in 2007 was 89.2%, which is higher than the rate of 53.6% in 2006 and 86.4% in years 2005 and 2004. //2009//

The percentage of LaCHIP enrollees whose age was less than one year who received at least one periodic screen for 2006 was 53.6%. Decreased access to services due to the loss of healthcare providers and the displacement of citizens resulting from Hurricane Katrina may explain this decrease. The percentage was unchanged for 2004 and 2005 at 86.4%.

This indicator reflects the capacity of Louisiana's healthcare system to provide services, which include provider enrollment; opportunities to access preventive healthcare services with a primary care physician; and patient utilization of accessible services. Louisiana has continued its aggressive outreach efforts by the La. Covering Kids Coalition since 2003, to enroll eligible children into the LaCHIP and Medicaid Programs. By July 2005, more than 45,000 children were enrolled into LaCHIP, which increased their access to providers and preventive health screens.

Enrollment efforts continued immediately post-Hurricane Katrina to enrolled eligible evacuees, including those displaced from Louisiana.

LaCHIP recipients are enrolled in the DHH CommunityCARE Program, which is a comprehensive health delivery system that links recipients to a primary care physician, creating a "medical home". The participating physicians should provide enrolled children with preventive care, including periodic screens, outpatient and hospital inpatient care, health education, and referrals to specialists.

The MCH Program will continue to: support delivery of preventive health services, such as health screenings, immunizations, and parental education in the state's public health clinics, school base health centers, and contract clinics; screen infants and children seen in the public health clinics for LaCHIP and Medicaid eligibility; provide technical assistance to the Medicaid program on issues related to access to services for children; and promote the Medical Home concept, through the Louisiana's Early Childhood Comprehensive Systems Initiative and with the Louisiana Chapter of the American Academy of Pediatrics.

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

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	90.3	89.7	90.0	90.0	90.0
Numerator	58460	53901	56593	58881	58881
Denominator	64769	60109	62870	65449	65449
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Narrative:
The 2005 indicator was 89.9%. This was a drop from the 2004 level of 90.3%. Prenatal care access and utilization serves several important roles in monitoring the maternity population. First, it may serve as an indicator of overall prenatal services. This includes availability, provider willingness to accept Medicaid, and transportation to care issues. The second important issue is patient utilization of services and awareness of benefits of care. This is a marker for patient education activities and their results. While it might be assumed that improved care will result in lower infant mortality rates, there does not appear to be a direct correlation.

/2009/ The final 2005 data was 89.7% and the preliminary 2006 data is 90.0%. The hurricanes of 2005 resulted in marked disruption of prenatal care access, especially in southern Louisiana. This disruption of access and in-migration of immigrant (primarily Hispanic) populations have resulted in new challenges for early and adequate prenatal care. The MCH program has been working diligently with partners throughout the state to assure access. //2009//
/2010/ Final 2006 data is 90.0%. Preliminary 2007 rate is 90.0%. //2010//

New data linkages are developed with Louisiana Hospital Inpatient Discharge Data (LaHIDD) and with the Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS). Efforts are

established to access to the Louisiana Birth Defects Survey conducted by CSHCN and Caring Community Youth Survey conducted by the Office for Addictive Disorders, and increase data analysis and dissemination of information from PRAMS and its linked data. Prenatal visits are one of the data collected and analyzed. /2009/ PRAMS collection and analysis was disrupted for a year following the 2005 hurricanes but has now resumed. //2009//

Prenatal care rates in Louisiana have been improving, but no associated drop in mortality rates have been seen. The current decrease in rate is concerning and one being discussed and addressed by program activities. The majority of births in Louisiana are to Medicaid mothers, Louisiana physicians typically will accept Medicaid and these private providers see most patients in the state. Thus, availability of care is present in most areas. The MCH program works within the public health unit system to provide prenatal care in areas where private and other public providers are not available. The Partners for Healthy Babies media campaign targets prenatal care as one of its primary messages to promote improvement in this area. The statewide Fetal and Infant Mortality Reduction Initiative (IMRI) targets prenatal care as one of its areas of improvement. /2009/I n the continuing aftermath of the 2005 hurricanes, prenatal care access continues to be a challenge for some, especially minority and immigrant populations. The MCH program continues providing care through public health units in regions with provider shortages and works with partners to secure access as possible. Work with the March of Dimes has resulted in mobile prenatal vans and Centering Pregnancy groups. //2009//

/2010/ MCH continues to provide prenatal care and case management and to work with March of Dimes, Centering Pregnancy and other partners in insure access. MCH works closely with Medicaid to assure early coverage of pregnant women. Partners for Healthy Babies public information campaign continues to be an effective outreach method for early prenatal care in Louisiana. //2010//

The goal of the State System Development Initiative (SSDI) grant is to enhance the data capacity of Louisiana's Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) Programs. Improving existing and establishing new data linkages and surveillance systems will enhance data capacity. Current linkages between the birth files, infant death files, Medicaid eligibility files, women, infant, and child program (WIC) eligibility files, and newborn screening data will continue to allow in depth analyses by MCH and CSHCN Programs, which identify priority needs for programs and interventions.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	92.3	92.3	83.2	85.5	89.9
Numerator	642442	666584	636648	645924	663982
Denominator	696077	721919	764825	755539	738184
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008

For 2008, data was obtained from the Louisiana Department of Health and Hospitals Medicaid Annual Reports for Federal Fiscal Year 2007/2008. The numerator is the (unduplicated) number of all Medicaid children (Title XIX and XXI) under age 19 years who received at least one processed claim during the period involved, whether or not he/she was enrolled on the date the claim was paid but was enrolled at the time the service for the claim was provided. The denominator is the number of all children who applied and have been approved to receive services, regardless of whether he/she received services and/or any claims have been filed on his/her behalf. Therefore, any post-annual report data of all Medicaid children's enrollment, recipients of service(s), and/or total costs of received services received for a specific state fiscal year, which is obtained after the date of the data used for the Medicaid report, will differ from the data in the report because retroactive eligibility will be included in the new figures.

Notes - 2007
For 2006 and 2007, data was obtained from the Louisiana Department of Health and Hospitals Medicaid Annual Reports for State Fiscal Year 2005/2006 and 2006/2007. The numerator is the (unduplicated) number of all Medicaid children (Title XIX and XXI) under age 19 years who received at least one processed claim during the period involved, whether or not he/she was enrolled on the date the claim was paid but was enrolled at the time the service for the claim was provided. The denominator is the number of all children who applied and have been approved to receive services, regardless of whether he/she received services and/or any claims have been filed on his/her behalf. Therefore, any post-annual report data of all Medicaid children's enrollment, recipients of service(s), and/or total costs of received services received for a specific state fiscal year, which is obtained after the date of the data used for the Medicaid report, will differ from the data in the report because retroactive eligibility will be included in the new figures.

Notes - 2006
For 2006 and 2007, data was obtained from the Louisiana Department of Health and Hospitals Medicaid Annual Reports for State Fiscal Year 2005/2006 and 2006/2007. The numerator is the (unduplicated) number of all Medicaid children (Title XIX and XXI) under age 19 years who received at least one processed claim during the period involved, whether or not he/she was enrolled on the date the claim was paid but was enrolled at the time the service for the claim was provided. The denominator is the number of all children who applied and have been approved to receive services, regardless of whether he/she received services and/or any claims have been filed on his/her behalf. Therefore, any post-annual report data of all Medicaid children's enrollment, recipients of service(s), and/or total costs of received services received for a specific state fiscal year, which is obtained after the date of the data used for the Medicaid report, will differ from the data in the report because retroactive eligibility will be included in the new figures.

Narrative:
/2010/ The percentages of potentially Medicaid-eligible children who received a paid service by Medicaid increased to 89.9% in 2008 from 85.5% in 2007. //2010// /2009/ The percentages of potentially Medicaid-eligible children who received a paid service by Medicaid are 83.2% in 2006 and 85.5% in 2007, which are both less than 92.3% in 2005. //2009//
The percent of potentially Medicaid-eligible children who have received a paid service by Medicaid in 2005 was 92.3%, which is unchanged from 2004. There was an overall increase in the percent of potentially Medicaid-eligible children who have received a service paid by Medicaid from 70.7% in 2001 to 92.3% in 2005. Data is not yet available for 2006. This indicator reflects the following: enrollment of eligibles; Louisiana's healthcare system's capacity to provide services, including healthcare provider enrollment; accessibility to preventive healthcare services with a primary care physician; and patient utilization of accessible services.

/2010/ A promising practice to improve healthcare provider service delivery to Medicaid/LaCHIP eligible children is incentive bonus payments for specific services rendered. Since its implementation in 2006, Louisiana's statewide opt-in CommunityCare Immunization Pay-for-Performance Initiative continues to provide incentive bonus

payments to participating Louisiana Medicaid Primary Care Case Management (PCCM) enrolled providers to increase the number of 24-month-old Medicaid/CHIP-eligible children who are up-to-date with childhood vaccines. Data for the first year of this initiative (July 2006 - June 2007) indicated that immunization rates improved in 62 percent of provider practices receiving incentive payments, with an average increase of 9.76 percent in the percentage of 24-month-old children in these practices considered up-to-date with childhood immunizations. //2010// Medicaid recipients in Louisiana are enrolled in the Department of Health and Hospitals' CommunityCARE Program, a comprehensive health delivery system that links recipients to a primary care physician, creating a "medical home". The participating physicians provide enrolled children with preventive care, including periodic screens, outpatient and hospital inpatient care, health education, and referrals to specialists. Positive strides were made to increase the adequacy of primary care for Medicaid enrollees, primarily by extending eligibility criteria for health insurance to children and increasing enrollment of eligibles into the Medicaid Program. However, health insurance alone cannot reduce the inequities in healthcare access. Therefore, beyond expanding health insurance coverage for children, further efforts are also needed to increase patient utilization of services and healthcare provider participation in the Medicaid Program.

The MCH Program continues to support delivery of preventive health services, such as health screenings, immunizations, and parental education in state public health clinics, school base health centers, and contract clinics; screen infants and children seen in the public health clinics for LaCHIP and Medicaid eligibility; provide technical assistance to the Medicaid program on issues related to access to services for children; and promote the Medical Home concept, through the Louisiana's Early Childhood Comprehensive Systems Initiative and with the Louisiana Chapter, American Academy of Pediatrics.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	41.5	42.0	40.2	40.4	44.5
Numerator	59417	62777	58224	62241	66807
Denominator	143106	149564	144751	153948	150115
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
From Louisiana Medicaid Management Information Systems, HCFA 416, for dates of service 10/01/2007 - 09/30/2008.

Notes - 2007
From Louisiana Medicaid Management Information Systems, HCFA 416, for dates of service 10/01/2006 - 09/30/2007.

Notes - 2006
From Louisiana Medicaid Management Information Systems, HCFA 416 , for dates of service 10/01/2005 - 09/30/2006.

Narrative:
The Louisiana Medicaid Management System (2005 -- 2006) reports that 37% of 6 through 9 year olds have received any dental services during the year. This data reflects a decrease in the percentage of children receiving services from the previous year's data. Louisiana has over 2000 practicing dentists, however, only 392 dentists are actively participating ($10,000 or more in Medicaid claims). /2009/ The Louisiana Medicaid Management System (2006 -- 2007) reports that 27% of 6 through 9 year olds have received any dental services during the year. Louisiana has over 2000 practicing dentists, however, only 410 dentists are actively participating ($1000 or more in Medicaid claims) as Medicaid providers, according to the 2007 American Dental Association Annual Survey. //2009//

In our effort to increase dental health care utilization, the Oral Health Program's school-based dental sealant program is expanding to include both rural and urban schools where access to care is a challenge and dental health needs are great. The sealant program expanded to new parishes including Evangeline, Catahoula, Avoyelles, and East Baton Rouge and continued in Allen, Caddo, East Feliciana and Desoto parishes. Current program data reveals that 889 children have been screened and 2413 dental sealants have been placed (not all schools reported). The Health Enrichment Network, an organization for health care advocacy, partnered with MCH to provide volunteer dentists to do screenings. The organization also donated dental supplies. MCH partnered with Health Care Centers in Schools (Coordinated School Health Services) and the Louisiana Dental Association to participate in Give Kids a Smile Day, which is a community outreach project sponsored by the American Dental Association. Two East Baton Rouge parish schools and 1 school in Acadiana Parish participated. Over 150 students received oral health education, dental screenings, and dental sealants. /2009/ The sealant program expanded in Rapides Parish School-based Health Centers. Sealant program activities were coordinated by the Oral Health Program's community partners in central Louisiana. Program efforts continued in Allen, Avoyelles, Catahoula, Concordia, Evangeline, and East Baton Rouge parishes. Current program data reveals that 2400 children have been screened and 1800 dental sealants have been placed (data includes parishes reported as of 06/5/08). Four East Baton Rouge parish schools participated. Over 200 students received oral health education, dental screenings, and dental sealants. //2009//

In addition to providing the dental sealant program, the OHP staff will continue to work with community health centers, School-based Health Centers and private practitioners to ensure that the children secure a ‘dental home'.

/2010/ The Louisiana Medicaid Management System (2007--2008) reports that 44% of 6 through 9 year olds have received any dental services during the year. Louisiana has over 2000 practicing dentists, however, only 365 dentists have paid Medicaid or SCHIP claims of $10,000 or more, according to the 2008 Association for State and Territorial Dental Directors State Synopsis. This measure reflects active participation in the Dental Medicaid Program.

Access to care is being addressed in Louisiana through partnering with community health centers, and private practitioners to provide dental sealants in schools. The Oral Health Program has recruited a dental sealant program coordinator through resources provided by a cooperative agreement with the Centers for Disease Control and Prevention. The coordinator will assist in building the program's capacity to provide dental sealants to school-aged children.

In 2008, the oral health program has conducted the basic screening survey of the 3rd grade children to determine oral health needs of Louisiana's children. This was the first representative sample survey conducted in the state. In this initiative, 3,049 children were screened among 75 schools. Preliminary results reveal that only 33.2% of 3rd grade

children have at least one dental sealant on one of their permanent molar teeth. Final results of this survey will assist in targeting dental sealant program activities, in an effort to reach areas where the greatest oral health disparities exist.

Children are continuing to benefit from dental sealant program activities in Louisiana. Dental providers under contract with the Oral Health program provide sealants to 2nd and 6th grade children. Schools are eligible to participate if 50% of the students are on free or reduced lunch. Give Kids A Smile Day, a community outreach initiative sponsored by the American Dental Association, included oral health education, dental screenings, and dental sealants for 402 elementary school children. This event is a collaborative effort of the Louisiana Dental Association, LSU School of Dentistry, and Health Care Centers in Schools.

During the 2008 school year, the sealant program expanded to Orleans, Lafayette, Plaquemines, LaSalle, Rapides, and Madison parishes. The program continues in Allen, Avoyelles, Caddo, Catahoula, Concordia, East Feliciana, and East Baton Rouge Parishes. During this school year, 2981 children participated in the sealant program. In two of the new parishes, 333 children were screened and 202 children received dental sealants. In total, second and sixth grade children received 5503 dental sealants. //2010//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	4.6	8.4	5.6	4.3	3.7
Numerator	1228	2058	1400	1101	1055
Denominator	26671	24448	25036	25541	28385
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source for 2008 numerator is Medicaid. The Denominator is from the Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100 percent data. Table: "Number of children under age 16 receiving federally administered SSI payments, by state or other area, December 2008."

Notes - 2007
Source for 2007 numerator is Medicaid. The Denominator is from the Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100 percent data. Table: "Number of children under age 16 receiving federally administered SSI payments, by state or other area, December 2007."

Notes - 2006
Source for 2006 numerator is Medicaid. The Denominator is from the Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100

percent data. Table: "Number of children under age 16 receiving federally administered SSI payments, by state or other area, December 2006."

Narrative:
This capacity indicator is based on the capacity of the CSHS program in providing direct care to children. Because the eligibility of the program is restricted financially and medically, not all children with SSI may qualify medically for CSHS. In addition, many are able to access Medicaid services in their community. One influencing factor on this indicator is the availability of Medicaid providers in individual communities. When services are available, fewer children need to access CSHS services.

The reporting of this indicator is also influenced by data collection. Because of the way Medicaid structures their eligibility cards, it is not clear which children are SSI recipients. Data has been obtained from Medicaid which is an overestimate of the population. /2009/ Correction: This data includes only children with SSI disability, as reported by the SSI Disability Determinations office. It is not an over estimation as previously thought. //2009//

With the development of care coordination activities in CSHS, more children will receive these services. SSI will be able to refer for care coordination just as other sources. Regional CSHS offices currently have working relationships with their Medicaid and SSI offices. Limited eligibility will remain a factor in improving this indicator.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2007	matching data files	12.7	8	11.2

Narrative:
Medicaid is the federal and state health care funded program primarily to serve to increase access and provide care for otherwise unfunded citizens. This implies that the Medicaid population may have higher risks, such as increased poverty, poorer access to care, less education opportunities, and higher utilization of substances as compared to the non-Medicaid population who would be assumed to have commercial insurance. This does not account for populations of undocumented immigrants who typically have no coverage, and may have risks similar or higher than the Medicaid population. By comparison of the two groups, indicators of areas to target for intervention result. Reflective of these increased risks, the low birth weight rate for the Medicaid population is significantly higher than the non-Medicaid population (2005- 13.4% vs. 8.0% respectively). The overall low birth weight rate for 2005 was 11.5% as compared to 11.0% for 2004. /2009/ The final 2005 overall percent of low birth weight was 11.5%, with the Medicaid population rate of 13.4% and the non-Medicaid rate of 8.2%. Preliminary 2006 data shows the overall rate of 11.5%, Medicaid rate of 12.9% and non-Medicaid rate of 8.6%. Following the hurricanes of 2005, significant population shifts and additional stressors were seen in Louisiana families. It is felt that these events could lead to increased rates of low birth weight births. Additionally, a significant number of immigrant families have entered the state. The state Medicaid program did begin prenatal care coverage of undocumented individuals through the

LaCHIP program. //2009//

/2010/ Final 2006 data is 11.4% low birth weight overall, with rate of 12.9% in Medicaid and 8.3% in non-Medicaid populations. There was a .5% reduction in the low birth weight rate among the Medicaid population comparing 2004 to 2006 data. //2010//

Low birth weight can provide valuable information as a general indicator of the state's maternal health status and prenatal care provision. While a surrogate marker for prematurity, it can also identify infants who have intrauterine growth restriction. By analyzing low birth weight infants, by regions and specific population groups such as payer type, it can help direct resources to those areas in most need. By following this figure over time, a general measure of risks and results of interventions are obtained. Specific interventions include the IMRI, smoking cessation program, dental services program, substance abuse and depression screening programs. New data linkages are developed with Louisiana Hospital Inpatient Discharge Data (La HIDD) and with the Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS). Efforts are established to access to the Louisiana Birth Defects Survey conducted by CSHCN and Caring Community Youth Survey conducted by the Office for Addictive Disorders, and increase data analysis and dissemination of information from PRAMS and its linked data. /2009/ The SBIRT program screening for alcohol use, tobacco use, substance abuse, depression and domestic violence in pregnancy is active in 4 of 9 regions of the state. Program implementation in 2 other regions will occur by mid-2008 and all regions are expected to be screening by 2009. This program targets screening in both the public and private sectors. Plans are being developed to implement screening in WIC clinics also. A family planning waiver, Take Charge, is providing increased access to services for Medicaid eligible women. //2009//

/2010/ Take Charge family planning waiver has been found to be underutilized due to limitations in scope of coverage. Folic acid is provided in state family planning clinics. An expanded focus on preconceptional and interconceptional health services is occurring, especially in regard to prevention of adverse pregnancy outcomes. The SBIRT program is statewide, and being implemented in WIC clinics in all regions. //2010//

The goal of the State System Development Initiative (SSDI) grant is to enhance the data capacity of Louisiana's Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) Programs. Improving existing and establishing new data linkages and surveillance systems will enhance data capacity. Current linkages between the birth files, infant death files, Medicaid eligibility files, women, infant, and child program (WIC) eligibility files, and newborn screening data will continue to allow in depth analyses by MCH and CSHCN Programs, which identify priority needs for programs and interventions.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2007	matching data files	10.7	5	8.9

Narrative:
The 2005 preliminary infant death rate of the Medicaid population was 11.9 compared to 6.6 for the non-Medicaid population. The infant death rate for all groups dropped to 10.0 in 2005 as

compared to 10.4 in 2004.

/2010/ Final 2006 data is 10.0 deaths overall, 11.6 for Medicaid and 6.7 for the non-Medicaid population. Preliminary 2007 data is 8.9 overall, 10.7 for Medicaid and 5.0 for non-Medicaid populations. //2010//

Medicaid is the federal and state health care funded program primarily to serve to increase access and provide care for otherwise unfunded citizens. This implies that the Medicaid population may have higher risks, such as increased poverty, poorer access to care, less education opportunities, and higher utilization of substances as compared to the non-Medicaid population who would be assumed to have commercial insurance. This does not account for populations of undocumented immigrants who have no coverage, and may have risks similar or higher than the Medicaid population. By comparison of the 2 groups, indicators of areas to target for intervention result. Infant mortality serves as a broad marker of health status and health care utilization for women and children. Many factors contribute to infant mortality, but preterm births, especially those less than 1500 grams, contribute heavily to the measure. While it is a broad marker, it is one that is commonly recognized and utilized by the general public. It provides valuable comparison of a state over time, and by trending, can serve as a marker for intervention success. It is important in evaluation of specific groups, as in the disparity present in African American and white births. Comparison between regions, states, and other countries of this marker are common. The infant death rate in Louisiana has generally been increasing over the last decade. Multiple interventions have begun, including the IMRI project, FIMR in each region, collaboration with other state agencies (Medicaid, Mental Health, Addictive Disorders), and smoking/addictive disorder screening and treatment. Active involvement with Louisiana ACOG, the private Louisiana MCH Coalition, and the state Perinatal Commission is ongoing. /2009/ The final 2005 data for infant death rate was 10.1 overall, with the Medicaid population rate of 12.1 and non-Medicaid rate of 6.8. The preliminary data for 2006 reveals an overall rate of 9.7, with a Medicaid rate of 10.8 and non-Medicaid rate of 7.6. The improvement in Medicaid rate may be due to several identified factors. First, the IMRI project and regional FIMR groups have placed increased regional focus on infant mortality, preterm births, and racial disparities. Multiple interventions have begun to address these issues. Additionally, following the 2005 hurricanes there has been a decrease in African American births, primarily due to population shifts. Issues concerning access to care, and increased stressors, may still have some adverse impacts on the infant mortality rate. MCH is working to identify and alleviate these adverse factors. A family planning waiver, Take Charge, is providing increased access to services for Medicaid eligible women. //2009//

The goal of the State System Development Initiative (SSDI) grant is to enhance the data capacity of Louisiana's Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) Programs. Improving existing and establishing new data linkages and surveillance systems will enhance data capacity. Current linkages between the birth files, infant death files, Medicaid eligibility files, women, infant, and child program (WIC) eligibility files, and newborn screening data will continue to allow in depth analyses by MCH and CSHCN Programs, which identify priority needs for programs and interventions. New data linkages will be developed with Louisiana Hospital Inpatient Discharge Data (La HIDD) and with the Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS). Efforts are established to access to the Louisiana Birth Defects Survey conducted by CSHCN and Caring Community Youth Survey conducted by the Office for Addictive Disorders, and increase data analysis and dissemination of information from PRAMS and its linked data.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05	YEAR	DATA SOURCE	POPULATION

Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State			**MEDICAID**	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	matching data files	82.5	96.5	86.9

Narrative:
The Medicaid population rate was 82.5 compared to 95.8 among the non-Medicaid population. /2009/ The Medicaid population rate was 83.1 compared to 94.9 among the non-Medicaid population. //2009//
/2010/ Preliminary 2007 data indicates that the Medicaid population rate was 82.5 compared to 96.5 among the non-Medicaid population. //2010//
MCH program funds direct prenatal services to indigent pregnant women especially in areas where there are access to care problems. The statewide MCH Partners for Healthy Babies Social Marketing campaign promotes early prenatal care through all of its activities, including multimedia and other communication strategies. Fetal & Infant Mortality Review Initiatives (FIMR) have been established in all regions of the state. ***/2010/ FIMR are established in 8 of the 9 regions of the state. Partners for Healthy Babies continues to promote early prenatal care and has included a special focus on supporting public relations efforts of Fetal & Infant Mortality Review coordinators to engage local media to highlight relevant issues. //2010//*** The program (staff and coalition structure) is charged with assessing service delivery gaps including prenatal care. The Nurse Family Partnership, nurse home visiting program provides case management services for first time mothers statewide, assuring early and adequate care for its enrollees.

The Fetal and Infant Mortality Reduction (FIMR) programs, through the Community Action Teams, are becoming Regional Forums, serving as umbrella organizations within the community for MCH issues. Regional FIMRs are expanding focus on diversity and cultural competence in strategic planning for the Community Action Teams. Parishes in the lowest quartile for first trimester entry into prenatal care are targeted by Regional IMRI Community Action Teams for the development of additional prenatal initiatives. OPH has partnered with the March of Dimes to implement regional CenteringPregnancy Programs. One initiative targets Latina clients; others are in areas where there is inadequate access to prenatal care. Needs Assessment for Native American tribal groups is ongoing in collaboration with the Bureau of Minority Affairs. Collaboration with Medicaid is expanding. Plans to expand and update the Partners for Healthy Babies (PHB) website are underway. /2009/ The Partners for Healthy Babies (PHB) website and helpline are being coordinated with local FIMR resources. //2009// In addition PHB is training and supporting the regional FIMR Coordinators in public relations efforts/activities.

State MCH efforts have been successful in improving early and adequate prenatal care. It is vital to examine the data for disparities in order to tailor efforts to reach out to populations and areas in greatest need, in order to make further progress. Concerns post-Hurricane Katrina are in terms of capacity of state's health service infrastructure to provide prenatal services and this is being monitored.

Using our SSDI Coordinator, the MCH program has gone to great lengths to research sources of data. The SSDI Coordinator has obtained agreements and data sets external to the MCH program but internal to the Department of Health Hospitals, such as Health Statistics/Vital Records and Medicaid. These data sets include those that measure women receiving prenatal care beginning in the first trimester.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	matching data files	89.2	91.6	90

Narrative:
The rate for the Medicaid population was 88.5% compared to 92% for the non-Medicaid population. /2009/ The rate for the Medicaid population was 88.5% compared to 92% for the non-Medicaid population. //2009//
/2010/ The rate for the Medicaid population was 89.1% compared to 91.9% for the non-Medicaid population. //2010//
MCH program funds direct prenatal services to indigent pregnant women especially in areas where there are access to care problems. To assure adequate prenatal care in the Medicaid population, the MCH program collaborates with 4 Healthy Start programs covering 5 regions of the state. ***/2010/ To assure adequate prenatal care in the Medicaid population, the MCH program collaborates with 4 Healthy Start programs covering 5 regions of the state. //2010//*** The statewide MCH Partners for Healthy Babies Social Marketing campaign promotes early prenatal care through all of its activities, including multimedia and other communication strategies. ***/2010/ PHB messages are designed to resonate with target audiences that have limited access to resources, including the Medicaid population. //2010//*** Fetal & Infant Mortality Review Initiatives (FIMR) have been established in all regions of the state. ***/2010/ FIMR are established in 8 of the 9 regions of the state. //2010//*** The program (staff and coalition structure) is charged with assessing service delivery gaps including prenatal care. The Nurse Family Partnership, nurse home visiting program provides case management services for first time mothers statewide, assuring early and adequate care for its enrollees.

The Fetal and Infant Mortality Reduction Initiative (FIMR) exists in each region of the state. Regional FIMRs are expanding focus on diversity and cultural competence in strategic planning for the Community Action Teams. Parishes in the lowest quartile for first trimester entry into prenatal care will be targeted by Regional IMRI Community Action Teams for the development of additional prenatal initiatives. OPH has partnered with the March of Dimes to implement regional CenteringPregnancy Programs, one of which targets our Latina clients. Needs Assessment for Native American tribal groups is ongoing in collaboration with the Bureau of Minority Affairs. Collaboration with Medicaid is expanding. ***/2010/ FIMR Groups in 2 regions collaborate with African American faith-based coalitions. //2010//*** Plans to expand and update the Partners for Healthy Babies (PHB) website are underway. In addition PHB will train and support the regional FIMR Coordinators in public relations efforts/activities.

State MCH efforts have been successful in improving early and adequate prenatal care. It is vital to examine the data for disparities in order to tailor efforts to reach out to populations and areas in greatest need, in order to make further progress. Concerns post-Katrina/Rita, are in terms of

capacity of state's health service infrastructure to provide prenatal services and this is being monitored carefully.

Using our SSDI Coordinator, the MCH program has gone to great lengths to research sources of data. The SSDI Coordinator has obtained agreements and data sets external to the MCH program but internal to the Department of Health Hospitals, such as Health Statistics/Vital Records and Medicaid. These data sets include those that measure women receiving adequate prenatal care.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	200

Notes - 2010
Since April of 2008, families with incomes between 200 and 250 percent of FPL will be able to obtain health coverage at an affordable monthly premium and with co-payments through the new LaCHIP Affordable Plan.
For all children ages 0 through 19 years, the percent of poverty level for eligibility in Louisiana Medicaid and LaCHIP is up to 200% at no cost.

Narrative:
/2010/ The percent of poverty level for eligibility of infants (0 to 1 year) in the State's Medicaid Program and LaCHIP Program remains at up to 200% of FPL. Eligibility for LaCHIP Affordable Plan also remains the same, which is a family with income between 200-250 percent of FPL. Each year the U.S. Department of Health and Human Services adjusts the federal poverty guidelines to determine financial eligibility for certain programs such as no-cost or low-cost health insurance. As a result of the U.S. Department of Health and Human Services' adjustment to federal poverty guidelines for program eligibility of certain programs, such as no-cost or low-cost health insurance programs, the monthly income eligibility thresholds increased as of April 1, 2009 for a family of four from $3,534 to $3,675 for LaCHIP and from $4,417 to $4,594 for the LaCHIP Affordable Plan. //2010//

/2009/ For infants (0 to 1 year), the percent of poverty level for eligibility in the State's Medicaid Program is up to 200%, and the percent of poverty level for the LaCHIP Medicaid expansion program is up to 200%. Since April of 2008, families with incomes between 200 and 250 percent of FPL will be able to obtain health coverage at an affordable monthly premium and with co-payments through the new LaCHIP Affordable Plan. //2009//

For infants, the percent of poverty level for eligibility in the State's Medicaid Program is 133%. The percent for the LaCHIP Program is now 300%, which expands health insurance eligibility requirements. Health insurance expansion is necessary to improve children's access to healthcare, which may improve the health status of low-income children.

Poverty levels can be a broad measure of the health status and welfare of infants and children.

Eligibility rules help the state and MCH Program assess needs of children based on the estimated number of children eligible to participate in Medicaid and LaCHIP programs but who remain uninsured.

The MCH Program will continue to support activities to mitigate the adverse affects of poverty on an infant and child's physical, cognitive, emotional, and behavioral development by driving policy making efforts at the state level, especially through active involvement in healthcare reform efforts and through the ECCS Initiative and the Governor's Children's Cabinet; supporting direct preventive health services at the public health units; and addressing our current MCH priority needs.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 14) (Age range to)	2008	 200 200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2008	 200

Notes - 2010
Since April of 2008, families with incomes between 200 and 250 percent of FPL will be able to obtain health coverage at an affordable monthly premium and with co-payments through the new LaCHIP Affordable Plan.
For all children ages 0 through 19 years, the percent of poverty level for eligibility in Louisiana Medicaid and LaCHIP is up to 200% at no cost.

Narrative:
/2010/ The percent of poverty level for eligibility of infants (0 to 1 year) in the State's Medicaid Program and LaCHIP Program remains at up to 200% of FPL. Eligibility for LaCHIP Affordable Plan also remains the same, which is a family with income between 200-250 percent of FPL. Each year the U.S. Department of Health and Human Services adjusts the federal poverty guidelines to determine financial eligibility for certain programs such as no-cost or low-cost health insurance. As a result of the U.S. Department of Health and Human Services' adjustment to federal poverty guidelines for program eligibility of certain programs, such as no-cost or low-cost health insurance programs, the monthly income eligibility thresholds increased as of April 1, 2009 for a family of four from $3,534 to $3,675 for LaCHIP and from $4,417 to $4,594 for the LaCHIP Affordable Plan. //2010//

/2009/ For all children ages 0 through 19 years, the percent of poverty level for eligibility in Louisiana Medicaid and LaCHIP is up to 200% at no cost. Since April of 2008, families with incomes between 200 and 250 percent of FPL will be able to obtain health coverage at an affordable monthly premium and with co-payments through the new LaCHIP Affordable Plan.

//2009//
For children, the percent of poverty level for eligibility in the Medicaid Programs for all ages is 133% for 1-5 years of age and 100% for 6-14 years. The LaCHIP program expands health insurance eligibility requirements for all ages to 300 percent of the poverty level. Health insurance expansion is necessary to improve children's access to healthcare, which may improve the health status of low-income children.

Poverty levels can be a broad measure of the health status and welfare of infants and children. The state and MCH Program can assess needs of children based on the estimated number of eligibles who participate in Medicaid and evaluate the estimated number of eligibles who qualify for participation in either program but remain uninsured.

The MCH Program will continue to support activities to mitigate the adverse affects of poverty on an infant and child's physical, cognitive, emotional, and behavioral development by driving policy making efforts at the state level, especially through active involvement in healthcare reform efforts and through the ECCS Initiative and the Governor's Children's Cabinet; supporting direct preventive health services at the public health units; and addressing our current MCH priority needs.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women		

Notes - 2010
Pregnant women are covered under the state's LaMOMS program. This program is a standard Medicaid program and is not covered by SCHIP funds.

Narrative:
The ability to maintain and/or improve eligibility levels are influenced by the state budget.

Expansion of prenatal care coverage through the SCHIP (Title XXI) program (Effective May 1, 2007) is a recent strategy implemented to expand children's health insurance by providing coverage eligibility for non-citizen pregnant women who are not otherwise eligible for Medicaid. The coverage is for prenatal care for this population.

Expansion of family planning through the Family Planning Waiver is a recent strategy for program expansion to residents. Ongoing discussion Medicaid and the State Budget officials to improve eligibility levels continue. /2009/ The Louisiana Medicaid Program now provides applications online. Applications are now available in Spanish and Vietnamese. //2009//

/2010/ As part of the Louisiana family planning waiver Take Charge which targets post-partum and reproductive age women below 200 percent of the federal poverty level, OPH hired full-time workers to coordinate outreach for the program in each of the state regions, and integrate with LaMOMS outreach for pregnant women
The data serves as a comparative tool to other states and the associated outcomes.

//2010//

The Louisiana State Systems Development Initiative (SSDI) program focuses on obtaining linked data, surveys, and registries. MCH epidemiologists will conduct studies and evaluations that will provide relevant information to program staff and policy makers in order to develop interventions that will help the state to meet national and state performance targets. SSDI program analysis and results will be disseminated at the state and local levels in the form of: 1) presentations to the State Perinatal Commission, the MCH Coalition, and internal and external meetings and conferences (e.g., MCH Epidemiology conference), 2) publications, such as the Louisiana State Medical Society Journal, Baby Talk Newsletter, and The Louisiana Morbidity Report, and 3) data and information on the state intranet and internet sites.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	1	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:
The MCH Program employs its Epidemiology, Assessment and Evaluation (EAE) unit to provide relevant MCH data support in monitoring HSCIs. The EAE Core Group includes a CDC assignee

MCH epidemiology team leader, a CSTE fellow, two SSDI staff, and two PRAMS staff, including a PRAMS coordinator and an assistant data manager. The Title V-MCH Director supervises the EAE unit.

The MCH/CSHCN epidemiology programs work with program coordinators, providers, and other stakeholders to share information obtained from the analysis of surveillance system data, linked data sets, and other MCH relevant surveys, and to seek program input on the policy implications of the findings. The MCH EAE unit works closely with internal partners at the Department of Health and Hospitals (DHH) to establish and improve linkages between vital records surveillance files and MCH related databases. The results are MCH-related surveys and registries and improved access to information to monitor health.

Louisiana has a State Systems Development Initiative in place to support this measure, HSCI 09A. SSDI staff and the EAE Unit provide the foundation, tools and structure to assure the MCH program access to policy and program relevant information.

Disparities in low birth weight and infant mortality continue to be major problems in Louisiana. The Louisiana SSDI program focuses on increasing the data/epidemiologic capacity of Louisiana's MCH and CSHCN programs to address the problems mentioned above. The main goals of the project are to: (1) improve the data linkages, analyses, and dissemination utilizing birth records linked with infant death records, Medicaid eligibility files, WIC eligibility files, newborn screening data, Pregnancy Risk Assessment Monitoring System (PRAMS) data, Louisiana hospital inpatient discharge data, and birth defects surveillance data; and (2) establish to access to and analyze data of Caring Community Youth Survey (CCYS).

From the linked data, surveys, and registries, MCH epidemiologists conduct studies and evaluations that provide relevant information to program staff and policy makers in order to develop interventions that will help the state to meet national and state performance targets. The SSDI program is responsible for maintaining all MCH related data obtained through these various programs and assuring that the MCH program has access to the most recent data available for each data source.

Access to the CCYS data was just granted in June 2007 and data will be made available to MCH from this point forward. The new availability of these bi-annually collected data provides new opportunities to gain better insight into the behavior of Louisiana children in the 6th, 8th, 10th, and 12th grades.

SSDI program and EAE unit analyses and results are disseminated at the state and local levels in the form of: 1) presentations to the State Perinatal Commission, the MCH Coalition, and internal and external meetings and conferences (e.g., MCH EPI conference), 2) publications, such as peer reviewed journals, the Louisiana State Medical Society Journal, Baby Talk Newsletter, and The Louisiana Morbidity Report, and 3) data and information on the state intranet and internet sites.

/2009/ Staffing changes in 2008 included the graduation of the CSTE fellow in August, 2007 and resignation of the PRAMS coordinator and SSDI data manager in January, 2008. Although Louisiana was approved to host a new CSTE fellow, no match was made. A new PRAMS coordinator begins in June, and the SSDI position should be filled by August, 2008. The EAE unit will host a 2008 Summer intern through the Graduate Student Intern Program to work on MCH program evaluation.

Critical data collection/management responsibilities of these positions have remained covered through temporary redirection of remaining staff priorities and supplemental capacity from temporary contract staff and graduate students. Full analytic capacity will resume when new PRAMS and SSDI staff are in place.

Vital records 2005 data were unavailable until May, 2008, delaying analytic and translation activities for 2005, however new analyses of prior data continues. The EAE unit participated in a CDC-sponsored PRAMS course, resulting in a report on Louisiana preterm birth. Updated data linkages remain on schedule through SSDI. New analyses from linked vital records-hospital discharge data are nearly complete. CSHS birth defects surveillance completed its first full year of data collection; SSDI staff linked the data to birth records. Two abstracts based on CCYS data analyses were submitted to a conference. When the 2005 MCH indicator analyses are complete, new dissemination activities of all results will be scheduled with key stakeholders. //2009//

/2010/ A new PRAMS coordinator and data manager were hired. The SSDI data manager will not be replaced as the coordinator assumed all SSDI roles. Two individuals start in August to handle data aspects of the 2010 Title V needs assessment, including a full-time epidemiologist and a 12-week intern through the Graduate Student Intern Program.

Final 2005, 2006, and preliminary 2007 vital records and 2006 PRAMS data were received. SSDI data linkages remain on schedule. A CDC-sponsored course using PRAMS data for Title V needs assessment preparations is nearing completion; infant car seat usage, bed-sharing, and preconception care questions were analyzed. A 2000-05 databook of MCH data analyses will be published in July. //2010//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	2	No

Notes - 2010

Narrative:
Because the response rate of the Louisiana YRBS over the last several years has been inadequate, MCH will continue using tobacco use data obtained in the Communities that Care Youth Survey (CCYS). This survey is conducted by the Office of Addictive Disorders/DHH every two years and provides parish specific data on a number of adolescent risk behaviors, including tobacco use. According to the 2006 Communities that Care Youth Survey the percent of adolescents in grades 8 through 12 who reported using a tobacco product in the past month was 20.5%, down from 23.7% in 2004. Nationally, 23% of students reported current tobacco use in 2005. ***/2010/ According to the 2008 Communities that Care Youth Survey the percent of adolescents in grades 8 through 12 who reported using a tobacco product in the past month increased to 21.1% from 20.5% in 2006. //2010//***

As a public health measure to address tobacco use, the Adolescent School Health Program includes tobacco use as a core sentinel condition in their continuous quality improvement (CQI) program. Each SBHC is required to undergo a rigorous on-site CQI review. During the review, charts are audited randomly and evaluated on whether the provider asks the student about tobacco use and provides appropriate prevention and/or cessation counseling. /2009/ During 2007-08, 7 SBHC sites underwent review. //2009// In addition, many of the SBHC staff provide tobacco prevention programs at their schools. In addition, OPH has a Tobacco Control Program that has many initiatives underway to decrease tobacco use, including efforts to change environmental policies. The Tobacco Program is not funded with MCH dollars. ***/2010/ During 2007-08, 7 SBHC sites underwent CQI review. In 2009, 11 sites will have a CQI review. //2010//***

This Health Systems Capacity Indicator serves as a monitoring tool that will help Louisiana focus

its resources on continued efforts to bring down the percent of adolescents who use tobacco products. By reducing the proportion of adolescents and young adults who use tobacco products, Louisiana can prevent the resultant morbidity and mortality of this risk behavior.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Louisiana, like most of the Southeastern states, differs from the rest of the Nation in terms of its demographic profile and socioeconomic status. African-American births comprise 41% of total births black compared with 15% nationally. Because of this, the higher low and very low birth weight rates of black infants have a disproportionate effect on our infant mortality rate. Louisiana has one of the Nation's highest overall poverty rates and ranks 49th for child poverty. It ranks 50th for the rate of families headed by a single parent. It is a predominantly rural state with a low per capita income and also low literacy levels. These factors coupled with budget shortages experienced by the State present challenges to the Title V Program in achieving the goals of decreasing mortality and morbidity in the MCH population and assuring access to needed services. /2007/New challenges resulting from the hurricanes' impact on the state's infrastructures will impact the MCH Program's ability to deliver Title V services. //2007// /2009/ Louisiana Title V Program still faces such challenges as a high percentage of African American births (40% compared to 15% nationally) which affects infant mortality rates; second highest rates in the nation for infant mortality, low birth weight babies, child poverty, and children in single-parent families (ranked 49th, 2008 Kids Count); and access to care. //2009//

/2007/ Program activities and assigned resources are now based on the following set of priorities, which were derived from the 2005 statewide MCH Needs Assessment: 1) Decrease infant mortality and morbidity in collaboration with regional coalitions 2) Decrease intentional and unintentional injuries in the MCH populations; 3) Address barriers, including Medicaid provider availability and lack of transportation, to assure access to quality health care for the MCH populations; 4) Address the mental health needs of the MCH populations; 5) Address the substance abuse related needs of the MCH populations through prevention and early intervention, screening, and referral; 6) Promote comprehensive systems of care and seamless transition to adult services for the CSHCN; 7) Promote pre-and inter-conception health care including family planning and folic acid education; 8) Address the oral health needs of the MCH populations; 9) Address healthy nutrition, proper prenatal weight gain, breastfeeding, and physical activity; 10) Obtain and utilize reliable evidence to: a) identify preventable causes of maternal, child and adolescent mortality and morbidity; b) develop preventive public health campaigns targeting high risk populations; and c) perform process and outcome evaluation.

/2010/ Data from 2008 show improvements in 3rd graders with sealants, licensed child care centers with CCHC contact, and CSHS patients with case management follow-ups. Data for other measures are pending. //2010//

/2009/ Final 2007 data showed improvements in licensed daycare centers with health consultant contact (SPM#10); children with special health care needs age 0-18 yrs. whose families have adequate insurance (NPM#4) and whose families report organized community-based service systems (NPM#5). No improvements were in CSHS patients with follow-up case management visits from nurse, social worker, nutritionist (SPM#4). //2009//

/2008/ Of the few performance measures with finalized 2006 data, an improvement was seen from 2005 to 2006 in the percent of CSHS patients with case management (follow-up visits) from a nurse, social worker, or nutritionist (SPM #4). An improvement was not seen in the percent of licensed daycare centers with a health consultant contact (SPM #10), which is primarily due to the loss of 426 child care centers due to Hurricanes Katrina and Rita and a loss of 61 child care health consultants.//2008// /2009/ Final 2006 data showed improvements in all children/adolescents enrolled in LA. public schools with access to SBHC services (SPM #1); infants receiving WIC in Public Health Units, screened with LA. Risk Assessment -Infant version (SPM #6); children with special health care needs 0-18 yrs. whose families partner in decision making/satisfied with services received (NPM#2); and youth with special health care needs who received services necessary to transition to adult life (NPM#6). No improvements were in

newborns screened for hearing before discharge (NPM#12); children with no health insurance (NPM#13); and 19-35 mo. olds with full schedule of age appropriate MMR, DTP, H. Flu, and Hep. B) immunizations (NPM#7). The rate of abused/neglected children under 18 (SPM#3) was unchanged. //2009// ***/2010/ Final 2006 data showed improvements in SIDS rate, timely follow-up to screen positive newborns, child deaths from motor vehicle crashes, 3rd trimester women smokers, and suicide deaths of youths 15-19 yrs. //2010//***

Of the few performance measures with finalized 2005 data, improvements were seen from 2004 to 2005 in NPM#1, follow-ups of positive newborn screens (increased to 100%); SPM#4, percent of CSHS patients with case management; and SPM#10, percent of licensed daycare centers with a health consultant contact. Improvements were not seen in SPM#1, percent of all children and adolescents enrolled in public schools with access to school-based health centers, and SPM#2, percent of women who received family planning services. One major contributing factor to the decreases in these measures is Hurricane Katrina, which resulted in the loss of SBHCs and the Women's Clinic in New Orleans. Also, statewide gaps in family planning services resulted from temporary suspension of services in the state's public health unit and/or delays in resuming services because of staff reassignment to emergency response duties. /2008/ Additional performance measures now have finalized 2005 data. Though improvement was not seen in NPM#16, the rate of suicide deaths aged 15 through 19, improvements were seen from 2004 to 2005 in NPM#10, rate of deaths to children under 15 years from motor vehicle crashes; NPM#12, percentage of newborns screened for hearing before hospital discharge; and SPM#10, percent of licensed day care centers with a health consultant contact.//2008//

/2009/ Final 2005 data showed improvements in deaths to children 14 yrs. and younger from motor vehicle crashes (NPM#10) and infants born to pregnant women with prenatal care beginning in the first trimester (NPM#18). No improvements were in SIDS infant deaths (SPM#8) and 19-35 mo. olds with full schedule of age appropriate MMR, DTP, H. Flu, and Hep. B immunizations (NPM#7). //2009//

However, from 2001 to 2004, there were improvements in the following performance measures: NPM#1, follow-ups of positive newborn screens; NPM#7, completely immunized children through age; NPM#8, teen birth rate; NPM#11, moms breastfeeding at discharge (2001-2003) NPM#12, newborns hearing screens; NPM#13, uninsured children; NPM#18, infants born to women with 1st trimester prenatal care; SPM#1, percent of all children and adolescents enrolled in public schools with access to school-based health centers; SPM#2, percent of women in need of and received family planning services; SPM#4, percent of CSHS patients with case management; SPM#7, percent of women who use alcohol during pregnancy (data through 2003), SPM#10, percent of licensed day care centers with a health consultant contact.

Performance measures which have not improved from 2001-2004 are: NPM#10, MVA fatalities of children under 15 years (increased); NPM#16, suicides among youths 15-19 (increased); NPM#17, very low birth weight infants delivered at facilities (increased); SPM#3, rate of children under18 abused or neglected (increased); SPM#5, percent of children (2-5) on WIC > 95th percentile weight for height (increased); SPM#8, rate of infant deaths due to Sudden Infant Death Syndrome (increased through 2003). There was no additional data to change in the National Performance Measures related to CSHS (NPM #2 - 6) or the percent of third grade children who receive protective sealants (NPM #9).//2007//

We feel confident that the approaches we have initiated to address the Priority Needs from the 2005 Needs Assessment and the operational plan we have developed to address the priority needs developed in the current needs assessment will have the positive outcomes we seek and ultimately will improve the the National Outcome Measures.

B. State Priorities

Priority Need 1: Decrease infant mortality and morbidity in collaboration with regional coalitions comprised of public and private health and social service providers.

Related Performance Measures (PM): National Performance Measures (NPM) 8, 15, 17, 18 and State Performance Measures (SPM) 7, 8 and 9

MCH funds community-based outreach, case management and home visiting programs in areas with limited access. This includes funding for family planning. In addition, MCH administers public information and media campaigns to reduce infant mortality promoting early prenatal care and healthy behaviors, and SIDS risk reduction. Communication is population-based and includes multi-media presentation and direct presentations (speeches, health fairs). MCH assists parish and regional MCH and public health leaders to address infant mortality through data analysis, technical assistance and funding of interventions. MCH funds Infant Mortality Reduction coordinators in each of the 9 regions to assure the infrastructure and capacity is in place to address this problem. In order to gather more detailed information on perinatal deaths, OPH has initiated the development of Fetal-Infant Mortality Reviews (FIMR) in all regions. The MCH Director and the Maternal Health Medical Director serve on the state Perinatal Commission which issues the state perinatal guidelines.

To reduce mortality due to congenital anomalies and birth defects, the Louisiana Birth Defects Monitoring Network (LBDMN) performs surveillance in the major birthing areas. The program also collaborates with the March of Dimes in prevention activities. /2008/The program increased active surveillance from 40 to 48% of births.//2008// /2009/ The program developed a resource guide for parents of infants in the birth defects registry to increase access to treatment and early intervention. Surveillance increased to approximately 57% of births. //2009// ***/2010/ LBDMN now covers over 70% of births. //2010//***

Priority Need 2: Decrease intentional and unintentional injuries in the maternal, child, adolescent, and children with special health care needs populations.

Related PMs: NPM 10, 16; SPM 3, 6

The MCH funds the SAFE KIDS program, a comprehensive injury prevention program that organizes local chapters, distributes newsletters and pamphlets, conducts special events, and participates in health fairs. Interventions address car, gun and fire safety, childproofing homes, bicycle helmet use, and sports injury prevention. MCH has established Regional MCH Injury Prevention Coordinators who work to decrease unintentional injuries in children in each of the 9 regions. MCH funds suicide awareness and prevention for school personnel and has collaborated with the Office of Mental Health on a grant to expand these trainings. The (NFP) Family Partnership and Best Start programs address primary prevention of family violence. The use of the Louisiana Risk Assessment in WIC clinics has increased the screening for domestic violence. The Prevent Abuse and Neglect through Dental Awareness program distributes materials on recognizing and reporting signs of child abuse and neglect to all dentists and hygienists. The Child Death Review Panel reviews all unexpected deaths in children under the age of 15. The MCH Program currently staffs a full time position for the Child Death Review Panel. The network of 160 Child Care Health Consultants provide health and safety training for child care providers.

CSHS provided leadership and funding for a special project to address prevention of secondary disabilities in CSHCN from birth to age 5 and has collaborated in a national grant to train parents of CSHCN to promote healthy activities and nutrition in this population. CSHS conducted a survey of families with CSHCN prior to Hurricane Katrina in a joint project with Bioterrorism Program. Families were provided information on making plans for evacuation and special considerations for CSHCN. Another survey will be performed in conjunction with CDC grant with Federation for Families for after-action information and problems encountered. /2008/ The AAP Emergency Form is used in CSHS clinics to help prepare families of CSHCN for evacuation.//2008// /2009/ Training for coroners, death scene investigators, injury prevention health educators, and other

health professionals attended an MCH sponsored conference on Death Scene Investigation, Child Death Review and Injury //2009//Prevention. ***/2010/ Child Safety Coordinators participated in more than 516 child passenger safety events, which reached more than 5,100 people statewide, and about 1,448 seats/child restraints were checked at check-up events and fitting stations. //2010//***

Priority Need 3: Assure access to quality health care for the maternal, child, adolescent, and children with special health care needs populations, addressing barriers including Medicaid provider availability and lack of transportation.

Related PMs: NPM 1, 3, 4, 5, 6, 7, 13; SPM 1, 2, 4

The CSHS Program will implement a care coordination model. It will include medical home coordination as a component of the plan of care and promotion of health strategies, including primary, secondary and tertiary prevention of disabilities. Parent participation in the program assures that the CSHS Program is family-centered and advocacy-focused. CSHS has had parent participation for over 14 years. Parent Liaisons attend CSHS clinics to offer emotional support and resources to families of CSHCN. Parent input into program policy and procedures occurs with 3 statewide parent coordinators who have collaborated with staff in the development of the Care Coordination model, continuous Quality Improvement, Universal Newborn Hearing Screening Systems, and the Medical Home project. /2008/ CSHS has piloted the Care Coordination program in Region I in the aftermath of Katrina.//2008// /2009/ CSHS is conducting a second care coordination pilot, with plans for expansion. CSHS collaborated with Families Helping Families to provide transportation for families in Region VI (Alexandria) to medical appointments outside of the region. //2009// ***/2010/ CSHS continues to provide sub-specialty care in provider shortage areas. Care coordination in CSHS clinics continues in Regions I and IV. CSHS has also provided care coordinators (CC's) for four model medical homes. One of these is now NCQA certified as a Level 1 Medical Home. LSU and Tulane pediatric residents are trained in medical home and community resources. CSHS staff are active in healthcare reform efforts of DHH to ensure that CSHCN have access to care in the new system. CSHS is piloting a data integration project with programs in DSS and OCDD to create a master patient index to assist with care coordination for patients.//2010//*** The Part C program, Early Steps, also provides Family Service coordination for eligible children from birth to age 3. CSHS will incorporate support for wrap-around services to assist families overcome barriers to care such as transportation. Funds shifted from direct services will be used to provide these enabling services. In addition, families will be trained and encouraged to be better consumers of services so that quality health care will be easily accessed. /2008/Early Steps was moved to the Office for Citizens with Developmental Disabilities July 1, 2007.//2008//

MCH funds prenatal, family planning and preventive/primary care in areas with limited access to such services. Adolescent School Based Clinics (ASBC) continue to reach this underserved population and additional funding from the Kellogg Foundation and the state will add clinics in hurricane-ravaged New Orleans. Additional newborn screening tests have been added to the battery of genetic and metabolic testing. MCH funds immunization services statewide. MCH works closely with Medicaid and the Robert Wood Johnson funded Covering Kids and Families outreach programs, resulting in significant decreases in uninsured pregnant women and children. /2008/ Newborn screening tests have been added to be in line with national standards. A Family Planning Waiver has been implemented in Louisiana. DHH received state funding to continue the work of the Robert Wood Johnson grant which ended. Undocumented pregnant women can receive Medicaid coverage effective May 2007.//2008//

Priority Need 4: Address the mental health needs of the maternal, child, adolescent, and children with special health care needs populations, through prevention and early intervention, screening, referral, and where appropriate, treatment.

Related PMs: NPM 3, 5, 6; SPM 1, 3, 4, 6

/2008/ MCH received a Perinatal Depression grant allowing the hiring of mental health staff serving women in the New Orleans region.//2008// MCH funds the Nurse Family Partnership, a psycho-social intervention for first time mothers of low socioeconomic status, in all regions of the State. Mental health services are provided in all ASBCs. MCH collaborates with the Office of Mental Health (OMH) to provide mental health support and services to the Program. MCH and CSHS collaborate with the OMH Early Childhood Supports and Services (ECSS) program that provides mental health services to children from birth to age 5. MCH developed the Louisiana Risk Assessment (LRA) tool to screen families for mental health risk factors and uses this for referral to ECSS, Best Start and other interventions.

MCH has developed a new parenting newsletter. The series emphasizes developing healthy infant caregiver relationships, healthy social and emotional development, parent and parenting issues, and mental health concerns. Public health nurses assist child protection workers in investigating suspected cases of medical neglect, malnutrition and failure to thrive, through an interagency agreement with Office of Community Services. A 30 hour Infant Mental Health (IMF) Educational Series was developed. The series emphasizes attachment theory and current knowledge of infant social and emotional development. This IMH training is provided to public health staff, including CSHS staff. /2008/ Eight CSHS nurses are currently receiving mental health training to aid in their identification of mental health concerns in young children.//2008// ***/2010/ Adolescent School Health Program provided direct behavioral health counseling and referral to Louisiana's youth in 60 school based health center sites. Behavioral health concerns remained among the top 2 most common reasons for seeking care. //2010//***

CSHS is developing parent training modules to address issues experienced by families of CSHCN in lower socio-economic populations. CSHS has begun to see an increased need for mental health services for families affected by recent disasters. Limited state resources to address these needs are being recognized, however funding has not been made available for services.

Priority Need 5: Address the substance abuse related needs of the maternal and adolescent population, through prevention and early intervention, screening, and referral. Assure early identification and referral of substance abuse, domestic violence and child abuse and neglect.

Related PMs: NPM 15; SPM 6, 7, 9

A risk assessment is conducted on patients receiving comprehensive prenatal care in the parish health units, and includes questions about substance abuse and domestic violence. Referrals are made to local substance abuse treatment facilities and battered women shelters. The LRA tool focusing on psychosocial risk factors, specifically substance use, domestic violence, financial/social service needs and mental health has been disseminated for use along with training for brief intervention. The MCH child health record is used to identify infants and children at risk for child abuse and neglect by looking at factors, such as parental substance use. Contracts with the state Office of Addictive Disorders provides pregnancy testing for women in treatment for substance abuse, counselors to provide services in an MCH funded prenatal clinic in Monroe, and for the development of a statewide system of services for the perinatal population. MCH targets smoking cessation services for perinatal populations through a contract with the Louisiana Public Health Institute to work with prenatal providers and to conduct a media campaign. CSHS, through Early Steps, has entered into an agreement with the Office of Community Services to provide for a mandatory referral of all children, birth to age 3, with substantiated abuse or neglect findings to the Part C System. /2008/ The state Office of Addictive Disorders, MCH, Medicaid, Office of Mental Health and the National Training Institute have implemented a comprehensive intervention for substance abusing pregnant and postpartum women in 4 areas of the state.//2008//

Priority Need 6: Promote comprehensive systems of care and seamless transition to adult services for the Children with Special Health Care Needs population by providing care

coordination.

Related PMs: NPM 2, 3, 4, 5, 6; SPM 4

CSHS provides subspecialty health care and care coordination services in 9 regional subspecialty clinics. The CSHS Medical Home project specifically targets access and utilization of primary care by families of CSHCN. /2008/ CSHS funds 2 care coordinators in model medical homes. Recent Medical Home Index Surveys and Family Satisfaction Surveys document the effectiveness of the care coordinators.//2008// /2009/ These results were presented at a state Medical Home Summit. CSHS is working with Medicaid to include care coordination into plans for a redesigned healthcare system based on medical home. CSHS will continue to place care coordinators in key Medical Homes. //2009//

The CSHS Program has taken a leadership role in the Medical Home Project, assuring that all children have a medical home. The Community Care Program provides physician primary care case management for Medicaid clients. All children in CSHS medical clinics are screened for primary health care coverage, and families are referred to primary care providers when the child has none. CSHS is working to enhance opportunities for increased access to care for CSHCN that have resulted in the aftermath of recent disasters. Pediatric health care providers who accept Medicaid have expanded services to meet needs of shifting population base.

CSHS has implemented a transition project that includes all 15 and 16 year old children seen in clinics. Staff and Parent Liaisons discuss transition issues with families and refer for additional resources. /2008/ The transition project was expanded to include children 14-17 years of age.//2008// ***/2010/ CSHS has placed CC's in 4 pediatric clinics. Transition activities continue in all CSHS clinics. CSHS has worked with Medicaid to obtain coverage for YSHCN as they age out of CSHS. A new in-depth web-based care coordination system focusing on youth in transition has been piloted in Regions I and VI. //2010//***

Priority Need 7: Promote pre-conceptional and inter-conceptional health care including family planning and folic acid education.

Related PMs: NPM 8; SPM 2

MCH provides funding for the operation of the Family Planning program and provided leadership and technical assistance for the development of the Family Planning Medicaid Waiver that was recently approved. The NFP program has a strong focus on the inter-conceptional health of its clients, addressing physical health issues including postpartum care and family planning; mental health issues including depression and domestic violence; and social health issues including educational and vocational attainment. /2009/ MCH sponsored a conference on pre and inter-conceptional health with 130 health professionals attending. MCH Bureau provided technical assistance funding for Michael Lu, M.D., a noted expert, as the featured speaker. MCH will provide funding for folic acid to be distributed to OPH Family Planning patients beginning July 1, 2008. MCH is conducting the evaluation for the Family Planning Medicaid Waiver program. //2009// ***/2010/ MCH funded folic acid for distribution in the Family Planning Program reaching over 9,000 from July to December 2008 compared to 500 women in 2007, prior to this initiative. //2010//***

Priority Need 8: Address the oral health needs of the maternal, child, adolescent, and children with special health care needs populations

Related PMs: NPM 9

CSHS funds a Dental Clinic for CSHCN in the New Orleans area. Services are provided by LSU School of Dentistry and are designed to be readily accessible to this population, known to have barriers to accessing regular dental care. This project also enhances training for dental students

in providing care to CSHCN. CSHS provides assistance for non-Medicaid eligible children to receive routine dental services through the private sector. The Oral Health Program (OHP), in conjunction with the Fluoridation Advisory Board of Louisiana, works with non-fluoridated communities. The OHP provides funding and technical assistance for the fluoridation projects. The OHP assesses the oral health needs of children and adolescents. School-based sealant initiatives are being implemented in 6 parishes. In addition, a sealant initiative is being implemented in the trailer communities and schools serving hurricane evacuees. The OHP promotes the Medicaid covered dental services for pregnant women with periodontal disease to pregnant women, prenatal providers, and dentists. /2008/ The Oral Health Program was awarded an infrastructure grant from HRSA.//2008// /2009/ Two additional staff were hired in the Oral Health Program focusing on fluoridation and school-based sealant expansion, which expanded fluoridation services to another community and sealant services to 9 parishes. //2009// ***/2010/ The Oral Health Program dental sealant program in 39 schools screened 2,410 students and 2,001 sealants. In the 2008 legislative session, a fluoridation mandate bill passed. The Oral Health Program was awarded a CDC Oral Disease Prevention Cooperative Agreement grant. //2010//***

Priority Need 9: Improve the health of the maternal, child, adolescent, and children with special health care needs populations, addressing healthy nutrition, proper prenatal weight gain, breastfeeding, and physical activity.

Related PMs: NPM 11, 14

Parish health units provide all pregnant women with extensive counseling and education on healthy nutrition, breastfeeding and proper weight gain. Families of children receiving WIC services receive counseling and educational materials. MCH has initiated a breastfeeding promotion program entitled The Gift. This intervention targets delivery hospitals and seeks to certify the hospitals as a "breastfeeding-friendly" once a list of requirements are met. Breastfeeding coordinators in each parish health unit and peer educators promote breastfeeding among the WIC population.

CSHS is participating in a CDC grant with Tufts University and the Federation of Families to prevent additional disabilities in CSHCN. Families have participated in focus groups to determine issues with the most relevance to this population and nutrition and exercise is a focus. /2008/ A nutritionist was hired, enabling CSHS regional nutritionists to have central office direction in meeting the unique nutritional needs of CSHCN.//2008//

Priority Need 10: Obtain and utilize reliable evidence to: a) identify preventable causes of maternal, child and adolescent mortality and morbidity; b) develop preventive public health campaigns targeting high risk populations; and c) perform process and outcome evaluation

Related PMs: The program supports all of the Performance Measures through this priority need but most specifically NPM 8, 10, 11, 15, 16, 18; SPM 7, 8, 9, 10

MCH has been successful at linking birth records with Medicaid, WIC, newborn screening, and PRAMS data to assess maternal, infant, and child mortality, morbidity, and contributing risk factors. Data from Louisiana's hospital discharge data base and birth defects registry adds to the information MCH uses to determine which interventions, geographic areas, or sub-populations need are priorities. The MCH Epidemiology, Assessment, and Evaluation Section conducts multi-level analyses, disseminates MCH data to national, state, and local stakeholders, and informs decision-making among the MCH management team and other public health staff including state Medicaid, WIC, Family Planning, Sexually Transmitted Diseases, Lead Poisoning Prevention, Oral Health, and Newborn Screening programs. MCH funded Injury Prevention Coordinators in each region utilize injury data to determine priorities for intervention. The SIDS and Partners for Healthy Babies media campaigns use state level quantitative data along with focus groups and

sentinel site surveys to develop messages and evaluate impact of the campaigns. Distribution of region-specific data at the annual meeting of the 9 Regional Infant Mortality Reduction Initiatives allows local leaders to understand the health status and trends of their maternal and child population and conduct needs assessments and strategic planning.

The Birth Defects Monitoring Network performs surveillance in the major birthing areas of the state. When data collection reaches reportable levels, prevention activities will be targeted to those high risk areas. This program recently collaborated with the Infectious Epidemiology section and the Region VI OPH office in an investigation of anencephaly cases in a community. Scientific methods were used to investigate this possible cluster and results were reported to the Regional Office and the community. /2009/ The Birth Defects Monitoring Network is collaborating with MCH epidemiology to determine if the possible cause of increased gastroschisis cases in Region IV. //2009//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	95	95	99	99	99
Annual Indicator	94.2	96.0	99.1	97.9	98.8
Numerator	114	120	116	137	159
Denominator	121	125	117	140	161
Data Source					Louisiana Genetics Database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
Data is for calendar year.

Notes - 2007
Data is for calendar year.

Notes - 2006
Data is for calendar year.

a. Last Year's Accomplishments
Population Based Services
In 2008, initial newborns screens were conducted on 64, 429 infants in Louisiana. Based on a newborn population estimates of 65, 000 for 2008, this represents a screening rate of 98%.

Table 1 in the Attachments indicates the number of infants detected with the diseases included in the newborn screening battery from 2004 through 2008. Of all the infants screened in 2008, 162 infants had a confirmed diagnosis of a genetic disease. Year to year, sickle cell disease and congenital hypothyroidism are the two most often diagnosed heritable conditions. The role of tandem mass spectrometry has increased the state's ability to screen for numerous metabolic disorders. The table reflects the success of the newborn screening expansion and the state's ability to play a vital role in preventing some of the debilitating effects of some of these genetic conditions

The Genetics Section ensures that greater than 95% of newborns are screened for all the diseases on the official battery by providing education to medical providers on the legislation and rule mandating screening, and by only allowing Office of Public Health (OPH) approved laboratories to perform the tests on newborns. The project of matching newborn screening records with birth records was conducted in 2006 with 2004 data and in 2007 using 2005 data.

The Louisiana Newborn Screening Rule (Louisiana Administrative Code 48:v.6303.08) was amended to provide more clarity to providers on the timing of collection of newborn screening and to provide guidance on collection of screens post transfusion. The new rule became effective January 20, 2008.

Direct Services
Genetics Program continued to contract with medical geneticists to conduct regional genetics clinics at ten sites reaching over 500 families, ensuring early detection and initiation into specialized care.

Enabling Services
Contracts were continued with Sickle Cell Foundations in 7 regions to provide patient assistance to families affected by sickle cell disease.

Infrastructure Building Services
The return of newborn screening to the state laboratory after Hurricane Katrina on November 12, 2007 has reduced the time between collection of a newborn screen and the release of results. This has allowed Genetics to contact providers sooner regarding abnormal results. Follow-up coverage after hours and on week-ends is also critical to the infrastructure of the program.

The Louisiana Newborn Screening Advisory Committee (LANSAC) continued to meet on the adoption of the American College of Medical Genetics' core panel and newborn screening policy issues, such as policy 24 vs. 48 hour cut off for repeating the screen and the policy of rescreening post blood transfusion. Also, the ad hoc Metabolic Group continued to meet to address the high rate of suspect positive results identified through tandem mass spectrometry.
An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conduct universal newborn screening and follow-up for 29 conditions.			X	
2. Conduct training sessions at hospitals to reduce unsatisfactory screening specimens.				X
3. Conduct regional genetics clinics at 10 sites staffed by a medical geneticist.	X			
4. Provide clinic-based wrap-around services by contracted sickle cell foundation staff.		X		
5. Educate adolescent PKU girls and high risk maternity staff on fetal effects of maternal PKU.		X		X

6. Provide an educational program for sickle cell patients and families.		X		
7. Provide an educational program for medical providers on metabolic diseases detected through tandem mass spectrometry.				X
8. Develop protocols for NICU staff for timing of rescreening.				X
9. Enhance program website as medical providers use it as the source for current information on NBS.				X
10.				

b. Current Activities

Direct Services and Enabling Services

Genetics Program continues to conduct regional genetics clinics for evaluation and counseling. Since the expansion of the newborn screening panel, these clinics have become important for referral of metabolic patients. Contracts are continued for regional sickle cell foundations.

Population-Based Services

The core panel recommended by the American College of Medical Genetics was adopted. The last of the diseases to be added to the panel was cystic fibrosis on July 1, 2007.

Infrastructure Building Services

With the addition of Cystic Fibrosis to the panel, a Cystic Fibrosis Advisory Committee was convened to monitor issue surrounding cystic fibrosis testing, follow-up, management and care for infants diagnosed with this condition.

The Louisiana Sickle Cell Medical Council will continue to meet to develop a plan for transitional and adult care, and to address improvements in the current regional pediatric sickle cell system.

c. Plan for the Coming Year

Objective: Increase to 96% 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.

Direct and Enabling Services

The Genetics Section will ensure the provision of specialized medical and nutritional management for 100% of affected infants identified through newborn screening pursuant to the adoption of tandem mass spectrometry. Genetics will continue to contract with medical schools to cover patients identified through the expanded metabolic screening.

Population-Based Services

The Genetics Section will review and evaluate the outcome of the adoption of the ACMG core panel.

Infrastructure Building Services

The Genetics Section will convene the Newborn Screening Advisory Committee to review the data from over a year of testing the expanded panel and addressing emerging issues in newborn screening. Increasing the availability of screening result data of patients for authorized medical providers will be evaluated and considered, such as inclusion of newborn screening specific data fields on the Louisiana Immunization Network for Kids System (LINKS). Consideration will continue for consolidating the newborn hearing infrastructure with that of the newborn heel stick system. Website enhancements will be made over the next year to include a parent section and a page on fetal effects of maternal PKU.

Improving the knowledge level of medical providers on the following newborn screening topics will be addressed through professional education: expanded screening and confirmatory testing of newborns with positive metabolic results, screening protocols for transfused infants and infants on Total Parenteral Nutrition, blood specimen collection, fetal effects of maternal PKU, and transitional care for sickle cell patients.

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)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	60	60	60	62	65
Annual Indicator	55.2	55.2	55.2	62.2	62.2
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	65	65	65	70	70

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
The CSHCN Survey for 2005/2006 shows 62.2% of families of CSHCN in Louisiana partner in decision--making at all levels and are satisfied with the services they received. This is an increase from the last CSHCN Survey of 57.5% and it is above the national average for this measure. In 2002 Louisiana was below the national average.

Direct and Enabling Services
Staff in CSHS regional clinics worked to encourage families of CSHCN to become active partners in decision making for their children. CSHS employed Parent Liaisons (PLs) in various capacities

to work with families of CSHCN statewide. Eleven PLs worked in the 9 CSHS regional clinics. PLs and other staff in CSHS linked families to resources, provided one-on-one support and encouraged families in advocating for their children with other providers. PLs kept up to date on state and community resources though ongoing follow-up with agencies/organizations and updates to regional resource binders. When needed, PLs in CSHS linked families to the PLs at Families Helping Families who assisted them in IEP planning and development.

Population Based Services
PLs worked with the regional Family to Family Health Information Centers (F2F HICs) to gather updated resource information for families. The F2F HICs in Louisiana are located in the regional Families Helping Families (FHF) offices. This information was shared with families in CSHS clinics. When indicated, PLs referred families to F2F HICS for additional information. PLs conducted community based trainings based on needs/requests from families of CSHCN served in CSHS and their communities. PLs worked in health fairs statewide, providing resource information and linkages for families of CSHCN. The CSHS website was updated to include linkages to national, state and regional resources, as well as to provide educational information for families. The CSHS newsletter, Families Matters, was published quarterly. This newsletter was provided to families receiving CSHS services and was posted on the CSHS website. Family Matters contained articles on issues related to CSHCN and a calendar of upcoming events. New CSHS brochures were developed at a low literacy reading level, to reach families with limited reading ability. PLs distributed these brochures to physician practices and at health fairs, as well as at other training/meeting opportunities. The brochure was also posted on the CSHS website.

Infrastructure Building
CSHS employed a Statewide Parent Consultant and Statewide Parent Training Coordinator, as well as 11 regional PL staff. CSHS strived to employ an ethnically diverse PL staff to address needs of the families in each region. PL staff was selected on knowledge of issues of concern in their area and their ability to work with families to address these concerns, such as transportation issues and the availability of specialty physicians and services. CSHS staff included PLs in policy making decisions at both the state and local levels, ensuring a parent perspective. The Statewide Parent Consultant and Parent Trainer provided regional PLs with educational updates on various subjects so that they would be able to assist families at a local level. PLs statewide served on numerous boards and committees, providing insight to assist policy and services that impacted the lives of CSHCN and their families. A Family Resource Guide was developed for families of infants identified though the Louisiana Birth Defects Monitoring Network (LBDMN) to inform families of programs and services for CSHCN.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide funding for CSHS staff and Parent Liaisons in all CSHS offices.	X	X	X	X
2. Employ parents of CSHCN of different ethnicities and knowledge of local issues.	X	X	X	X
3. Provide direct support services to all families attending CSHS clinics.	X	X		
4. Update regional resource manuals.	X	X		
5. Publish Family Matters newsletter quarterly.			X	
6. Mail Family Resource Guide to families of infants identified through birth defect surveillance.			X	
7. Provide quarterly trainings for PL staff.			X	
8. Provide support to families of CSHCN through local trainings, workshops and health fairs.	X	X	X	

9. Work with F2F HICs to coordinate services and update CSHS website to reflect current resource information and opportunities.			X	
10. Include parents in policy decision making at all levels.				X

b. Current Activities

Direct and Enabling Services

PLs work in all 9 CSHS regional clinics, with an emphasis on empowering families to partner in decision making for their CSHCN. PLs link families to community resources and other sources that provide support or services.

Population Based Services

CSHS works collaboratively with the regional F2F HICs and other FHF staff to coordinate information and services for families. PLs provide trainings for families of CSHCN and work in health fairs to give families current information and resources. The CSHS website is updated to reflect new linkages and current information for families. The Family Matters newsletter is published quarterly and disseminated to families in CSHS clinics and posted to the CSHS website. LBDMN began mailing the Family Resource Guide to families of infants identified through birth defect surveillance. A comment card was included with each Guide.

Infrastructure Building Services

CSHS employs a Statewide Parent Consultant, Parent Trainer and PLs in every region of the state. Quarterly trainings for PLs continue.

c. Plan for the Coming Year

Objective: To increase to 65% of children with special health care needs age 0-18 whose families partner in decision making at all levels and are satisfied with the services they receive.

Direct and Enabling Services

PLs will work closely with other agencies serving CSHCN to enhance coordination of information and services. CSHS will employ PLs for all CSHS regional clinics to assist in addressing the needs of CSHCN and their families. The CSHS website will be updated, providing families with information vital to keep them informed of resources and opportunities. CSHS will publish the Family Matters newsletter quarterly.

Population Based Services

The Statewide Parent Consultant and Parent Coordinator will provide quarterly trainings for all regional PL staff to assist them in working with families locally. Regional PLs will offer support and information in workshops and support group meetings to families with CSHCN.

Infrastructure Building

CSHS will employ Statewide Parent Consultants and regional PLs to provide parent perspective in CSHS policy at the local and state levels. The Parent Coordinator and Parent Consultant will develop a report for the CSHS Director and Program Manager on issues of concern identified by regional PLs, as well as information gathered in working with regional PL staff. This report will seek to advise administrative staff on policy to enhance services to families served by CSHS, as well as to better assist regional PL staff.

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)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**

Annual Performance Objective	50	50	50	55	55
Annual Indicator	48.8	48.8	48.8	49.6	49.6
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	55	55	55	55	55

Notes - 2008
The data reported in 2008 are pre-populated with the data from 2007 for this performance measure.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
Direct and Enabling Services
CSHS sub-specialty clinics continued in all 9 regions of the state. Teams consisting of physician, nurse, social worker, social service counselor, audiologist, and parent liaison provided care coordination, parent support, and teen transition services, which were expanded from YSHCN ages 14-17 years to ages 14-18 years. 99% of children coming to the clinics were linked with a primary care physician (PCP). PCPs received a consultation letter after every visit. The population exodus from the state following Katrina slowed in 2008 and the number of CSHS patients in rural areas remained high. The number of CSHS patients in New Orleans decreased due to sufficient sub-specialty Medicaid providers as well as indigent care programs, including Children's Hospital's CHAPS program and a LSU Shreveport Medical School program. Patients coming to CSHS in these areas were either uninsured or needed the care coordination (CC), transition services, and parent support provided in CSHS clinics and not yet found in their "medical homes" (MH). Number of children seen in CSHS clinics decreased from 4645 in 2007 to 4421 in 2008. The number of visits increased from 17,874 to 19,025 reflecting increased complexity of children seen. CSHS hired a nutritionist and a social worker for central office.

Population Based Services
Web-based CC software for the new expanded CC program focusing on transition in CSHS clinics was completed in May 2008. The first pilot of the software began in Region I (Orleans) in July. The CSHS nurse consultant, social worker, and epidemiologist provided intense hands on training during clinics to implement the new process. Staff was instructed to complete a Family Needs Assessment on two adolescents per clinic, which formed the basis for a Care Plan. Goals

identified are tracked using the software until all goals are met. Care coordinators placed in pediatric practices use a CC system designed for use in a MH. Care coordinators continued in 2 Model MHs: a large rural practice in Bogaloosa and a LSU public hospital pediatric clinic in Baton Rouge. The care coordinator at Tigercare, the LSU continuity clinic for LSU pediatric residents, moved out of state. New CSHS brochures for families as well as physician handouts explaining CSHS services and how to refer to CSHS were designed, printed, distributed to regions, and added to the CSHS website. Parent liaisons took these two brochures to pediatric practices in their regions.

Infrastructure Building Services
Dr. Berry, the CSHS Director, continued to be on the Advisory Board for the Healthcare Quality Forum (HCQF) MH Committee for the state, which is a legislated stakeholder group to advise the administration on health care reform. Data demonstrating effectiveness of CC at Tigercare in improving family satisfaction and improving "medical home-ness" using the MH Index and the MH Family Index pre and post CC were presented to the HCQF MH Committee in February and to the state MH summit for 115 policy makers on May 23, 2008. CSHS was invited to participate in a DHH workgroup to address the needs of CSHCN as the administration develops its healthcare reform policies based on MH concepts. The proposed reform model involves a conversion from fee for service to Care Coordination Networks (CCN), which would function like HMO's. The group decided that reimbursement for CSHCN should remain fee for service. The administration then asked the state AAP chapter to design a plan for integrating CSHCN into CCNs. Dr. Berry, FAAP, served on this committee. Future meetings were suspended pending approval of the Medicaid Waiver by CMS. CSHS met with Medicaid to identify coverage for cystic fibrosis (CF) clients in transition aging out of CSHS. Sources of coverage were identified for all CSHS CF clients over age 21. Barriers to enrollment were identified and addressed. A new CSHS policy was implemented in July 2008 to discharge youth with CF at age 21 with other coverage and to limit CSHS coverage to clinic visits and four classes of lifesaving medications. All Tulane and LSU residents completing their developmental rotations (directed by the CSHS Director) were trained in MH. By incorporating MH into resident training and putting a care coordinator in Pediatric Residency Continuity Clinics CSHS hopes to inspire new pediatricians to incorporate MH principles into their future practices.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide subspecialty care in shortage areas.	X			
2. Link CSHCN in CSHS clinics to medical homes.		X		
3. Support transition services for adolescents.		X		
4. Identify health coverage for transitioning CF patients.		X		
5. Provide population based care coordination in CSHS clinics.		X	X	
6. Provide care coordinators to pediatric offices.		X	X	
7. Participate in DSS Data Integration project to improve care coordination for CSHCN.			X	X
8. Provide evidence for care coordination effectiveness to encourage Medicaid reimbursement; participation in state HCQF Medical Home Advisory Group.				X
9. Incorporate medical home model into LSU pediatric resident training.				X
10. Serve on AAP CSHCN healthcare reform committee.				X

b. Current Activities
Direct and Enabling Services
A retreat was held with regional staff to begin revision of the CSHS clinic manual. The CSHS application was shortened and changed to mail-in. Subspecialty clinics in each region address

provider shortages. CSHCN are linked to MHs, who receive copies of care plans and sub-specialty consultation letters.

Population Based Services
CSHS participates in a project to integrate DHH and DSS data. The project will create a master patient data base to link data from the two agencies. This will assist CC by indicating which programs a child is enrolled in and which programs he may be eligible for. The CC pilot focusing on transition continues in region I although slowed by regional staff turnover. A second pilot began in Region VI in May 2009. The CSHS central office social worker left in December; a new social worker as hired April 2009. A RN Care Coordinator Supervisor was hired in April to expand CC in pediatric offices. Tigercare CC has persisted even though the care coordinator left a year ago.

Infrastructure Building
Several MH are now NCQA certified due to a federal Primary Care Access and Stabilization Grant (PCASG) which links NCQA criteria to increased grant funding, including Tigercare. Dr. Berry and the Statewide Care Coordinator Supervisor are on the Advisory Board for the LHCQF MH committee. A Medicaid Waiver was submitted to CMS in December, and the CSHCN CCN workgroup is on hold pending federal approval of the restructuring plan.

c. Plan for the Coming Year
Objective: To increase the % CSHCN in LA with a MH to 55%. (National CSHCN Survey 2010).

Direct and Enabling Services
In the 2006 CSHCN survey, LA had higher % CSHCN receiving primary care from a doctor's office (85.9% LA vs 80.9% other states), fewer problems obtaining referrals (83.4% vs 78.4%), and higher % receiving care coordination (77.2% vs 73.0%). which is improved from the 2001 survey. Only % YSHCN receiving transition services remained below the national average. Therefore CSHS will continue to expand its CC in CSHS clinics focusing on transition. CSHS sub-specialty clinics will continue to provide access to care in rural regions. Clinics with low numbers of patients will be closed. CSHS will continue to link CSHCN with a MH and to send consultant letters with transition plans, when applicable, after each CSHS clinic. CSHS will continue to rewrite its clinic manual, and post revised sections on the CSHS website for staff.

Population Based Services
CSHS will continue to work with the administration on the DSS-DHH data integration project to create a master patient data base to facilitate CC. The CSHS Needs Assessment will include a survey of pediatricians to determine current MH CC activities and to identify areas of need. CC in pediatric offices will be expanded to include two to three new practices. Preference will be giving to teaching clinics to influence pediatricians in training. Training materials will be developed including regional referral information and referral forms. Clinics that receive a care coordinator will be encouraged to apply to be NCQA certified. CSHS will test the feasibility of training practices to do CC with by funding a short term a care coordinator, since referrals at Tigercare continued to be made after the care coordinator left. CC pilots in CSHS clinics focusing on transition will continue in Regions I and VI, and expand to Region IV and at least one other region. If necessary, CSHS will contract a new social worker for regions that have insufficient staff to incorporate CC. Regions will be trained in new simplified eligibility procedures and in processing the new CSHS mail in application.

Infrastructure Building Services
Reaching the 2010 goal for MH will be dependent on healthcare reform policies in LA. CSHS will continue to work with the administration and the AAP to ensure that the needs of CSHCN are considered in LA's health care reform, such as linking Medicaid reimbursement to meeting NCQA criteria, minimizing PCP changes in assigning CSHCN to CCNs, and ensuring that CC is

reimbursed adequately. Dr. Berry and the statewide CC supervisor will continue to be active on the Advisory Board for the LHCQF MH committee. CSHS will expand CC in both CSHS clinics and pediatric offices to increase access to CC and transition services and to enable MHs to provide these services.

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)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	57	55	55	57	70
Annual Indicator	51.9	51.9	51.9	65.5	65.5
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	70	70	70	75	75

Notes - 2008
The data reported in 2008 are pre-populated with the data from 2007 for this performance measure.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
The CSHCN Survey shows a 13.6% increase from 51.9% for the initial 2001 survey to 65.5% for the 2005/06 survey. Louisiana was below the national average for this indicator in 2001 and in 2005/06 was above the national average.

Direct Services
CSHS staff evaluated insurance coverage for all CYSHCN attending clinics in each of the nine OPH administrative regions. Staff worked with families to apply for insurance coverage and determined eligibility as needed. 88.7% of CSHS clients had Medicaid, 8.9% had private insurance and 2.6% were covered by CSHS as the payer of last resort.

Enabling Services

Parent Liaison and social service staff were available to answer questions and assist families with applying for appropriate insurance coverage, as needed. Families were counseled on their particular insurance eligibility options, including private insurance, various Medicaid plans such as SSI Disability and Medicaid Purchase Plan, and programs such as Children's Healthcare Assistance Plan (CHAP) at Children's Hospital in New Orleans which assists families with limited resources to obtain services at Children's Hospital. Medicaid mail-in applications were provided in CSHS clinic waiting areas. Parent Liaison and social service staff were available to answer questions and assist families with applying for appropriate insurance coverage as needed. Resource binders containing health insurance coverage information were available for use by staff and families. Families were informed of the new mail-in Medicaid application.

Population-Based Services
CSHS Social Work Consultant disseminated information and trained staff and stakeholders on changes in CSHS Cystic Fibrosis Over Age 21 Policy. Social services staff notified adult clients that CSHS coverage over age 21 would be limited to four classes of pharmaceuticals and clinic visits. Clinic staff assisted clients affected by the policy change to find more comprehensive coverage options, such as Medicaid Purchase Plan, SSI Disability, Medicare and private insurance. Clients remained eligible for limited CSHS services until they were enrolled in a more comprehensive health insurance plan.

Infrastructure Building Services
CSHS administrative staff met with Medicaid staff to discuss options for adult clients with Cystic Fibrosis. Medicaid assigned CSHS a Medicaid contact person to assist with SSI Disability and Medicaid Purchase Plan applications to reduce denial rates. The SSI Disability representative made recommendations for changes in application completion protocols to improve initial acceptance rates. CSHS established a primary contact in the billing office at Tulane University Hospital to troubleshoot any billing issues involving clients with Cystic Fibrosis seen at this CSHS supported clinic, where CSHS clients were being incorrectly billed for services. CSHs worked with all providers to expedite paperwork and ensure sufficient and continuous health care coverage for clients.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with Medicaid and State Insurance programs to assure coverage.			X	X
2. Inform families of available services and programs.		X		
3. Provide informational materials to families in the clinical setting.		X		
4. Work directly with families to link to services.	X			
5. Expand Care Coordination Services.	X	X		
6. Track and advocate for LA CSHCN with regards to the Health Care Redesign initiative.			X	X
7. Work with AAP to engage pediatricians in Medicaid healthcare reform policies.				X
8.				
9.				
10.				

b. Current Activities
Direct Services
CSHS staff continues to screen families and update insurance information annually for all clients during clinic visits. CSHS staff continue to provide care coordination in CSHS clinics linking families to resources that provide health insurance coverage.

Enabling Services
Parent liaisons provide CSHS brochures, health insurance informational brochures, and other resource information to families of CSHCN at health fairs and other community events. Medicaid mail-in applications continue to be available in all CSHS clinic waiting areas and from social service and parent liaison staff. CSHS staff assist families with determining and applying for their specific coverage options, and to work with the CSHS Medicaid contact person to decrease denial rates.

Population-Based Services
CSHS clinic staff work to increase awareness of State/Federal programs that serve CSHCN to ensure that all necessary services are adequately covered. CSHS Social Work Consultant disseminates information to regional staff and trains staff and community stakeholders on new programs and changes in policy for current programs. The CSHS website is updated, as needed, with insurance resource information.

Infrastructure Building Services
CSHS participates on the healthcare reform CSHCN workgroup to reorganize Medicaid based on Care Coordination Networks, the equivalent of HMOs. CSHS continues to work to maximize the number of children linked to Medicaid primary care providers.

c. Plan for the Coming Year
Objective: 70% of families of CSHCN ages 0-18 will report that they have public or private insurance that is adequate to meet their needs. (CSHCN survey 2010)

Direct Services
Parent liaisons will continue to link CSHS clients and their families with agencies that provide appropriate insurance coverage. They will continue to make sure CSHCN are linked to a Medical Home that accepts their particular insurance plan.

Enabling Services
CSHS will continue to provide mail-in Medicaid applications in all CSHS clinics as well as resource information on other insurance coverage sources. Staff will be available to assist with completion of forms and to answer any questions, as needed. Having appropriate comprehensive insurance will also be included as a care plan goal in the new care coordination program in for youth in transition currently being piloted in CSHS clinics.

Population Based Services
Parent liaisons will work to increase awareness among clients of state/federal insurance coverage programs. Social service staff will continue to evaluate client needs and make referrals. CSHS Social Work Consultant will disseminate information and train staff and community stakeholders on new programs and policy changes. The CSHS website will provide the most current insurance resource information available.

Infrastructure Building Services
CSHS will continue its participation on the healthcare reform CSHCN workgroup to be sure that new Medicaid reimbursement policies adequately cover the needs of CSHCN and are linked to providers meeting Medical Home criteria. CSHS will also continue to work with the AAP to be sure policies developed will be accepted by pediatricians, to maximize the number of primary care providers available to CSHCN. CSHS will continue to work to maximize the number of children linked to Medicaid participating primary care physicians.

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)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	70	70	70	75	90
Annual Indicator	68.8	68.8	89.3	89.3	89.3
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	90	90	92	92

Notes - 2008
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
CSHCN Survey data for 2005/2006 indicate that 89.3% of families of CSHCN in Louisiana report that community-based service systems are organized so they could easily be used. This was an increase from the 2001/02 NS-CSHCN (68.8%). Additionally, Louisiana exceeds the current national average of 89.1%.

Direct and Enabling Services
CSHS staff, including parent liaisons (PLs), across the state provided direct consultation to families to facilitate linkage to community-based resources. CSHS provided direct medical services in 9 regional clinics where such services were otherwise not accessible.

Population Based Services
The CSHS statewide parent consultant and parent trainer conducted quarterly trainings to all PLs on developing skills to enable families of CSHCN to be continuously linked to/informed about community-based resources. The Hearing Speech and Vision Program (HSV) provided follow-up and referral to community-based services for infants identified though Early Universal Newborn Hearing Screening and Intervention (UNHSI). A physician guide and patients' brochure was

developed and disseminated. A Family Resource Guide was developed for families of infants identified though the Louisiana Birth Defects Monitoring Network (LBDMN) that provides information about programs and services for CSHCN. Staff in CSHS Central Office responded to website inquires about available services for CSHCN.

Infrastructure Building Services
CSHS administrative staff provided technical assistance to regional staff in the care coordination (CC) pilot region. Enhancing staff assessment capacity, knowledge of service systems, and documentation and communication of care between providers within programs and across programs through the CC web based database was the focus of the CC pilot. Staff and client surveys showed satisfaction with CC. The CSHS website was continuously updated with links and statewide events.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide funding for CSHS staff and Parent Liaisons in all CSHS offices.	X	X		
2. Update regional resource manuals.	X	X	X	
3. Provide workshops and educational programs through PLs to families with CYSHCN.	X	X	X	
4. Collaborate with community agencies and providers to facilitate access of services.		X	X	X
5. Continue piloting and expansion of Care Coordination.	X	X	X	
6. Continue to update and enhance CSHS program website.		X	X	
7. Collaborate with state agencies to integrate data.		X	X	X
8. Provide educational information to identified families of CYSHCN.		X	X	
9.				
10.				

b. Current Activities
Direct and Enabling Services
CSHS works with families in all 9 regional CSHS clinics to assist in linkages to community-based services. The PLs continuously update regional resource manuals. CSHS parent consultants provide quarterly trainings to all PLs to enhance their knowledge/skills to enable families to be linked/informed about community-based services.

Population Based Services
CSHS provides educational programs for families that include activities to address linkages to community-based services. CSHS posts the quarterly newsletter to the CSHS website. LBDMN began mailing the Family Resource Guide to families of children identified through birth defect surveillance. A comment card was included with each Guide. HSV will provide follow-up for infants identified through UNHSI.

Infrastructure Building Services
CC was expanded to another region. CSHS works with agencies across the state to share information and organize systems for ease of use by families. CSHS proactively sought to be the first program to pilot data integration between programs within the Department of Health and Hospitals (DHH) and Department of Social Services (DSS). This will create a master patient data base to link data that will assist families through linkages to other programs in which the child may be eligible. CSHS continues to employ parent consultants to facilitate training programs for families and PLs statewide. CSHS website is continuously updated and designed to meet designated audience needs.

c. Plan for the Coming Year
Objective: 90% of families of children with special health care needs age 0 to 18 will report that community-based service systems are organized so they can use them easily. This new objective is based on the progress the 2005/2006 CSHCN survey data reflects.

Direct and Enabling Services
The CC project will expand to 2 additional regions of the state. The PLs will continue to update regional resource manuals. Current clinical protocol with nurses, social workers, and PLs will continue to facilitate linkages. Parent consultants will continue to train all PLs on effective means to link families to needed services.

Population Based Services
CSHS will meet with other public health agencies and programs that serve CSHCN to identify ways to collaborate and streamline services. CSHS will provide educational programs for families on community-based services. CSHS will post the quarterly newsletter to the CSHS website. LBDMN will mail the Family Resource Guide to families of infants identified through birth defect surveillance.

Infrastructure Building Services
Collaboration will continue with DHH and DSS in the development of the data integration project to develop a master patient index which will assist with care coordination. A data portal linking information of CYSHCN within and across agencies will be developed. Staff will be trained on the database to document referrals and track linkages to referrals to ensure families' needs were addressed. A care coordinator will be hired in the New Orleans area to work with families of CSHCN who receive health care services in private clinics to assist in linkages to needed resources. CSHS will continue to employ parent consultants to facilitate training programs for families and PLs statewide. The CSHS website will be continuously updated and further enhanced to meet designated audience needs.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	10	6	6	10	44
Annual Indicator	5.8	5.8	5.8	40.9	40.9
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**

Annual Performance Objective	44	44	44	44	44

Notes - 2008
The data reported in 2008 are pre-populated with the data from 2007 for this performance measure.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
The 2005/2006 CSHCN Survey showed 40.9% of YSHCN in Louisiana received services necessary to make transition to all aspects of life.

Direct and Enabling Services
CSHS staff completed transition surveys for YSHCN ages 12 - 17 in direct CSHS clinical settings in all regions of the state and provided service coordination for identified needs. One region (New Orleans area) participated in a pilot care coordination (CC) program for YSHCN ages 14 to 20 and focused on transition services. In the CC program, service coordination was provided for all identified needs and a written care plan was developed for YSHCN identified with more extensive needs. Family/YSHCN priority was emphasized in the development of the plan. The CC program care plan utilized web-based software. CSHS employed Parent Liaisons (PLs) in all nine regions of the state. These PLs worked with families/YSHCN in the clinical setting, including activities to assist with transition.

Population Based Services
The CSHS website was updated to reflect changes in contact information for state agencies that serve CYSHCN. Website updates included mental health resources (particularly post-hurricane additional services), links to national and state disability organizations, educational resources, transition resources, as well as articles to assist families and YSHCN in planning for transition. Regional staff was informed as resource information was added to the website. PLs in CSHS participated in local health fairs and trainings to promote transition related resources and provide guidance.

Infrastructure Building Services
CSHS worked statewide and regionally with other agencies that serve YSHCN, such as Louisiana Rehabilitation Services (LRS), Office of Citizens with Developmental Disabilities (OCDD) and Department of Education (DOE) to facilitate services for YSHCN during transition. CSHS administrative staff worked closely with the pilot CC project and began the process of initiating the CC project into another region. Staff also collaborated with Families Helping Families Health Information Centers (F2F HICs) to coordinate transition services. This parent-based organization works with any YSHCN/family that requests services, including those served in CSHS clinics. The Statewide CSHS PL Consultant and Parent Trainer conducted quarterly trainings for all PLs in the nine regional CSHS clinics. All trainings included updates on resources and activities for YSHCN, as well as how to assist in the transition process.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screen all adolescents and young adults in CSHS clinics for transition needs.	X	X		
2. Provide support services to families/YSHCN on transition issues in CSHS clinics.	X	X		
3. Expand care coordination program to another region of the state.	X	X		
4. Update CSHS website on resources/activities related to transition.			X	
5. Provide quarterly training to Parent Liaisons in all regions on transition issues.		X		
6. Collaborate with other state agencies to coordinate transition services for YSHCN.	X	X		X
7. Collaborate with other DHH agencies and DSS on data integration project.				X
8.				
9.				
10.				

b. Current Activities

Direct and Enabling Services

CSHS staff continued to survey YSHCN in CSHS clinics and provided services for identified needs. The CC program was expanded to another region of the state (Central Louisiana). CSHS continued to provide PL support services to families/YSHCN in all 9 regions.

Population Based Services

CSHS continues to update its website to add new information and resources on transition services. PL staff continues to participate in health fairs and trainings focused on transition.

Infrastructure Building Services

CSHS is working with a liaison from the Medicaid Office to facilitate applications for YSHCN in CSHS clinics to apply for Medicaid programs as they transition out of LaCHIP. This has been particularly successful in the Medicaid Purchase Plan application process. In addition, staff in Central Office met with some subspecialists to promote Medicaid Purchase Plan with YSHCN seen in private clinics. CSHS began collaboration with other agencies in the Department of Health and Hospitals (DHH) and the Department of Social Services (DSS) to integrate data. This will assist agencies to identify and link YSHCN to eligible programs within these departments. Some of the agencies in these departments include LRS and OCDD. Parent Consultants continue to conduct quarterly trainings for PL staff, including transition issues.

c. Plan for the Coming Year

Objective: 44% of YSHCN report receiving services necessary to make transitions to all aspects of life, including adult health care, work, and independence.

Direct and Enabling Services

CSHS staff will survey all YSHCN in direct CSHS clinics statewide on transition needs and provide services as needed. The CC project will be expanded to two additional regions. PLs will continue to work with families/YSHCN in transition support in all nine regions.

Population Based services

The CSHS website will be updated as needed. PLs will continue to educate and support families/YSHCN on transition through participation in health fairs and trainings in all nine regions.

Infrastructure Building Services
CSHS will participate in multi-agency collaborations targeted at comprehensive, coordinated transition services for YSHCN. Collaboration will continue with DHH and DSS in the development of the data integration project. The CSHS Parent Consultants will conduct quarterly trainings for PLs, which will emphasize issues related to transition and the CC process. The process for CC of transition age youth will be evaluated and improved with regard to staff and family feedback.

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.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	72	74	80	84	82
Annual Indicator	74.9	74.9	72.3	77	77
Numerator					
Denominator					
Data Source					The National Immunization Survey (NIS)
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	82	85	87	90	90

Notes - 2008
2008 data if provisional and based upon 2007 data.

Notes - 2007
The National Immunization Survey (NIS) is sponsored by the National Immunization Program (NIP) and conducted jointly by NIP and the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention. The survey is a list-assisted random-digit-dialing telephone survey followed by a mailed survey to children's immunization providers. Estimates of vaccine coverage are produced for the nation and for each of 78 Immunization Action Plan (IAP) areas, consisting of the 50 states, the District of Columbia, and 27 large urban areas. Final 2007 data from the NIS survey for Louisiana indicates 77 + 6.1% of children within the ages of 19-35 months are at the appropriate immunization level for age for the vaccine series 4:3:1:3:3:1 which now includes 1 dose of Varicella vaccine in the series.

Notes - 2006
The National Immunization Survey (NIS) is sponsored by the National Immunization Program (NIP) and conducted jointly by NIP and the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention. The survey is a list-assisted random-digit-dialing telephone survey followed by a mailed survey to children's immunization providers. Estimates of vaccine coverage are produced for the nation and for each of 78 Immunization Action Plan (IAP) areas, consisting of the 50 states, the District of Columbia, and 27 large urban areas. Final 2006 data from the NIS survey for Louisiana indicates 72.3 + 6.9% of children within the ages of 19 – 35

months are at the appropriate immunization level for age for the vaccine series 4:3:1:3:3:1 which now includes 1 dose of Varicella vaccine in the series.

a. Last Year's Accomplishments

Direct and Population Based Services

The CDC National Immunization Survey has indicated that Louisiana's national ranking of immunization coverage rate from Year 2006 to Year 2007 improved from 44th to 28th among states; while this is an improvement from the previous year, Louisiana's vaccine coverage level still remains lower than the national level with a rate of 77%. The Immunization Program continues to strive to meet the primary goal toward achieving the 2010 Health Objectives of 90% immunization coverage rate among children through age two.

It should be noted that a major change that occurred in Louisiana with regard to immunizations was the dramatic shift in service delivery from the public to private sector in the early 1990s. LA-OPH Immunization Program has had the challenge of raising immunization levels through a collaborative effort that demands local involvement and the commitment of other programs, private vaccine providers (VCF) and school-based agencies. To this end, the Program has directed many of its efforts to build community coalitions, educate medical providers about the importance of immunizations; implement, maintain, and, enhance the Louisiana LINKS Immunization Registry; and raise public awareness through the Shots For Tots campaign to encourage parents to get their children two years old and younger vaccinated on an age-appropriate schedule. Childhood vaccines are distributed to all VFC-eligible children with an estimate of over 1 million doses distributed to both private and public health care providers statewide.

In April 2008, National Infant Immunization Week was held to promote the benefits of immunizations and to focus on the importance of immunizing infants by age one. The Louisiana Shots for Tots Coalition purchased 175 banners that read "Love them, Protect them, Vaccinate them!" and was placed across the state at both public and private immunization facilities. The coalition of public/private entities worked cooperatively to educate parents/providers in order to ensure the highest level of immunizations possible. In this effort, all parish health units waived the normal $10 administrative fee and accepted all walk-in clients.

Infrastructure Building Services

Enhancement of the LINKS registry continues by populating the registry with data-merges of batched immunization data from institutional-based systems such as Medicaid, Ochsner health system sites and other hospital-based management systems. The registry allows for comprehensive vaccine record-keeping system of all children who receive immunizations statewide.

The LINKS registry also continues to expand in the enrollment of VFC providers as a result of collaboration with the Medicaid Program's incentive pay-for-performance immunization initiative. This initiative involves participation with the LINKS registry by VFC providers with the goal of achieving age-appropriate immunizations as per American Committee of Immunization Practices (ACIP) schedule. During July 2006-June 2007, 264 providers received incentive payment where 62% of these providers had an average increase of 9.76% in the percent of up-to-date 24 month old vaccine recipients; in comparison, during July 2007 -- June 2008, 317 providers received incentive payments of which 57% had an increase in the percent of up-to-date 24 month old vaccine recipients with an average increase of 14.37%.

The number of Vaccines for Children (VFC)/Assessment, Feedback, Incentives, & Exchange (AFIX) onsite visits has increased to conduct immunization quality assessment practices and provide feedback to VFC providers. The VFC program enhances the Immunization Program's ability to assess and improve immunization delivery practices at the provider's level to assure that VFC eligible children are receiving quality services.

Reminder/recall immunization drills were conducted for age groups 0 -- 6 years of age and 11-13 years of age where postcard reminder notices were mailed utilizing the LINKS system data in collaboration with Wyeth Pharmaceuticals via TeleVox to inform parents of the need to update their children's immunizations. Due to the national shortage of Haemophilus influenzae type B vaccine (HIB), the booster dose has been deferred. As soon as the HIB vaccine production is sufficient, the LINKS system will conduct a recall for whom vaccine was deferred to advise them to return to their health care provider for vaccine update.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Supply vaccines to enrolled providers through the Vaccines for Children (VFC) program.			X	
2. Expand VFC provider enrollment.			X	X
3. Expand on-site VFC/AFIX (Assessment Feedback Information Exchange) active provider sites.				X
4. Expand the Louisiana Immunization Network for Kids Statewide (LINKS) by integrating data systems and partnering with other providers to enhance vaccination coverage.				X
5. Enhance efforts to provide immunizations in public health units monitored by CASA state surveillance reviews.	X		X	X
6. Coordinate with Medicaid Program with pay-for-performance incentives to improve immunization practices.		X		X
7. Annual Shots for Tots Conference.				X
8. Conduct immunization reminder/recall notifications monthly.		X		
9.				
10.				

b. Current Activities

The 16th annual Shots for Tots (SFT) Conference was held in November 2008. The conference provided information to all health care providers in the delivery of comprehensive immunization services for all age groups, explored innovative strategies for improving immunization coverage, and provided the latest scientific information on newly developed vaccines. The SFT Coalition was honored to have First Lady Jindal as the SFT campaign spokesperson for which poster pictures were placed in all Wal-Mart stores statewide. First Lady Jindal collaborated with the SFT Coalition's initiative with the Hallmark birth card mailout emphasizing immunizations in the birth certificate packets sent to new mothers.

National Infant Immunization Week (NIIW) was conducted between April 25th and May 1st , 2009. All walk-ins and scheduled appointments for immunizations were available statewide at all public health units at no cost.

July 2008, a new law for LINKS participation was enacted according to Section 1. R.S. 17:170(D) whereby public or private schools which operates an existing student-specific electronic data system shall electronically transmit immunization compliance reports relative to first time enterers entering schools, kindergartens, colleges, proprietary or vocational schools, and day care centers for the first time to the Department of Health and Hospitals, Office of Public Health.

c. Plan for the Coming Year

Objective: To improve the current statewide vaccination coverage rate by 5% among children 19 -- 35 months of age for year 2009-2010 with completion of the 4:3:1:3:3:1 series for Louisiana to achieve the 2010 National Performance Objective.

Activity Objectives: Conduct tracking and follow-up to each 2 year old child to ensure age-appropriate immunizations, ensure each 2 year old is enrolled in immunization registry by conducting provider practice site audits, and educate the communities about importance of vaccination by coordinating with local health departments, private care providers and other community based organizations to improve immunization rates.

The projected plan will be to continue VFC-AFIX community-based trainings that will incorporate best practices from all components of the immunization program including customer service, vaccine management and assessment, appropriate delivery of immunizations, use of the LINKS registry and routine provision of educational information to VFC providers.

The National Infant Immunization Week will be held in Year 2010 for which the Program will offer continual support for local and state community coalition initiatives and activities as well as increase immunization awareness throughout the state in collaboration with internal and external partners.

The Program will maintain ongoing collaboration with the Medicaid pay-for-performance (P4P) initiative to expand provider enrollment and improve immunization service delivery at primary care sites and contribute to the success of the pay-for-performance initiative. The Program will also support Medicaid in the expansion of the P4P toward adolescent and adult immunizations as well as newly developed vaccines incorporated in the ACIP immunization schedule.

During FY09 and FY10, the Immunization Program will work with the School Nurses and Administrators of the Public, Charter, Parochial and Private schools to assure high immunization rates in the face of new regulations. The Immunization Program staff will work with the Health Standards Administration to provide data needed to enforce immunization compliance for licensed child development centers and Head Start centers and assure staff at these facilities are informed of the new regulations.

Other potential institutional data base system exchange integration with LINKS is being planned with public and private school database systems statewide. In addition, a feasibility study will be conducted with regards to METRON, which is the same system used by physicians for billing purposes, for which third-party insurance billing for services rendered at public health immunization clinics would be possible.

Reminder/recall notifications will continue on a quarterly basis to inform parents of the need to update their children's immunizations throughout the year utilizing the LINKS database in collaboration with Wyeth Pharmaceuticals via TeleVox.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	31	30	29	25	25
Annual Indicator	29.2	26.6	30.0	30.6	30.6
Numerator	2955	2670	2824	2861	2861
Denominator	101048	100211	94142	93471	93471
Data Source					Louisiana Vital Records and Statistics
Check this box if you cannot report					

the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	24.5	24	24	24	24

Notes - 2008
Data for 2008 is provisional and based upon 2007 data.

Notes - 2007
Data for 2007 is provisional.

Notes - 2006
The 2006 data is final

a. Last Year's Accomplishments
Direct Services
In 2007, the total number of live births for female teenagers aged 15 through 17 was 2,691 with a total number of women all ages was 65,656. The 2007 rate of birth (per 1,000) for female teenagers aged 15 through 17 years was 30.6 versus 29.9 in 2006 and 26.6 in 2005. In 2008, 4,819 teenagers aged 15 through 17 utilized family planning services, of which 4,635 users were females.

The FPP provided reproductive health care services to teens statewide in 69 state-administered facilities and 6 contract sites; and prioritized adolescent scheduling in family planning clinics. An education and outreach needs assessment was conducted in family planning clinics to identify barriers to services. The results were used to develop a plan that assist staff in specifically targeting the adolescent community, direct services where needed most, and help structure outreach activities.

Enabling Services
The FPP continued to develop and strengthen community-based organizations working with adolescents, developed and maintained collaborative efforts with community-based organizations to specifically target the adolescent community, and coordinated and facilitated the issuance of educational materials to adolescents.

Infrastructure Building Services
A Health Education and Outreach Plan was developed for all clinic staff in an effort to better serve adolescents in the community and attract adolescents to clinics. The FPP promoted folic acid to all women of childbearing age to help prevent neural tube defects. All female clients of childbearing age were given a one year supply of the folic acid supplement along with educational materials. A public service announcement was also created to inform the hard to reach population, specifically teens, of the importance of taking folic acid before becoming pregnant.

The FPP collaborated with the Center for Health Training on training events relating to family involvement in young clients' reproductive health. In addition, Mystery Caller Assessments were conducted to identify barriers to services for family planning clients, including adolescents.

Population Based Services
Culturally and language appropriate educational materials were distributed to adolescents in the

community and in family planning clinics. Educational materials addressed abstinence, sexual coercion, making responsible choices about sex, STD and HIV/AIDS.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide comprehensive reproductive health care services to adolescents.	X			
2. Present and distribute education materials to teens and professionals.		X	X	
3. Provide technical assistance on teen pregnancy prevention mass media campaigns.			X	X
4. Provide training manual to clinic nurses for education on adolescent reproductive health issues.				X
5. Conduct Mystery Caller Study to assess adolescent need.				X
6. Promote clinical trainings to create a teen-friendly environment and increase teen utilization.				X
7.				
8.				
9.				
10.				

b. Current Activities

Direct and Enabling Services

Adolescents receive reproductive health care services statewide and their scheduling is a priority in family planning clinics. The FPP continues to establish and maintain collaborative relationships with organizations working with teens, such as schools, community and faith-based groups as well as service providers.

Infrastructure Building Services

Currently, the statewide Health Education and Outreach Plan is being implemented. It provides structure for outreach activities conducted to adolescents. The FPP will continue promoting folic acid supplements and education to ensure that all women of childbearing age intake adequate folic acid before pregnancy to help prevent birth defects.

The FPP continues to encourage family participation in minors' reproductive health. The program collaborates with the Center for Health Training on training events relating to family involvement in young clients' reproductive health. Activities include initiating a quality assurance study on documentation of parental involvement counseling, and developing counseling protocol for minor and parent family planning visit.

Population Based Services

Pamphlets and brochures, such as Thinking about Contraception, HPV Testing, and Vaginal Infections were purchased to inform teens about pregnancy prevention and overall health. Educational materials are also available is Spanish for teens with Limited English Proficiency.

c. Plan for the Coming Year

Objective: Decrease birth rate to 29 (per 1000) for teenagers aged 15 through 17 years.

Direct and Enabling Services

The FPP will continue to provide reproductive health care services to teens statewide and prioritize adolescent scheduling in family planning clinics. Collaborative teen pregnancy prevention efforts will be continued and strengthened with community based organizations

working with adolescents. The FPP will continue to improve strategies for conducting effective education and outreach to teens.

Infrastructure Building Services
The Health Education and Outreach Plan will be updated regularly to reflect the results from the annual education and outreach needs assessment. As an initiative to help reduce birth defect rates in Louisiana, the FPP will continue to offer a one year supply of folic acid vitamins along with education materials to all female clients capable of becoming pregnant. An evaluation of the folic acid initiative will be conducted. The Mystery Caller Quality Assurance Study will be conducted again to identify waiting time for a family planning clinic visit and assess the needs of adolescents. The FPP, with consultation from the Center for Health Training, will continue training programs and technical assistance on attracting adolescents to clinics and parental involvement.

Population Based Services
Following approval from a review committee, additional educational materials will be distributed to teens, organizations working with teens, and at community events. The FPP will enhance efforts for identifying, recruiting and retaining teen members on the State Advisory Board.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	20	20	20	20	23
Annual Indicator	18.0	18.0	18.0	18.0	33.2
Numerator	157	157	157	157	16223
Denominator	871	871	871	871	48894
Data Source					Basic Screening Survey 2008
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	40	40	40	40	40

Notes - 2008
The real values for the numerator (N) and denominator (D) are 899 and 2634 and the weighted values of N and D have been used to calculate annual indicator. The State Oral Health Program has preliminary results of the Basic Screening Survey. According to these results, 33.2% of Louisiana 3rd grade children have dental sealants on at least one of their permanent molar teeth. There are 41.9% percent of children with untreated caries and 65.7% of children with caries experience.

Notes - 2007
The State Oral Health Program has begun collecting sealant prevalence data on 3rd graders statewide, every 5 years. This data is used to tabulate the sealant prevalence rate for FY2006

because the Oral Health Program is confident that this data more accurately reflects the sealant status of this population than the data previously collected more than 5 years ago.

Notes - 2006
The State Oral Health Program has begun collecting sealant prevalence data on 3rd graders statewide, every 5 years. This data is used to tabulate the sealant prevalence rate for FY2006 because the Oral Health Program is confident that this data more accurately reflects the sealant status of this population than the data previously collected more than 5 years ago.

a. Last Year's Accomplishments
Direct Services
The MCH Oral Health Program continued to expand the dental sealant program for 1st, 2nd, and 6th grade children in an effort to increase the number of children with dental sealants. Nine parishes participated in the program last year, including Grant, East Baton Rouge, Evangeline, Concordia, Catahoula, Allen, Avoyelles, East and West Feliciana Parishes. In the 39 schools that participated, a total of 2410 students received oral health screening, and 2001 students in participating schools received dental sealants.

Enabling Services
MCH Oral Health Program staff continued to partner with Medicaid outreach efforts to ensure that eligible pregnant women received needed dental services. The Oral Health Program staff and the Medicaid program administrative staff attended the New Orleans Dental Conference and Louisiana Dental Association Annual Meeting to promote provider enrollment in the dental Medicaid program. Program material was disseminated and the oral health program staff offered information to update providers on Medicaid policy changes and administrative issues regarding the dental services program for pregnant women.

Population Based Services
The Fluoridation Program continued to address efforts to increase the proportion of the population benefiting from optimally fluoridated water. In the 2008 Regular Session, the state passed Act 761, a fluoridation mandate bill, sponsored by the Louisiana Dental Association (LDA). In response to the mandate, the Oral Health Program and the LDA formed a task force to move implementation efforts forward. The task group has met on a regular basis to strategically work with identified communities to initiate fluoridation. The program continues to work with the town of Walker to initiate fluoridation.

Infrastructure Services
The Oral Health Program applied for and was awarded a CDC State-Based Oral Disease Prevention Cooperative Agreement, providing funding for up to five years to increase program capacity through infrastructure building. The grant funds new staff including a Fluoridation Engineer, a Dental Sealant Program Coordinator/Health Education Coordinator, and an Epidemiologist/Evaluator.

During the 2007-08 school year, the Bright Smiles for Bright Futures Oral Health Screening Survey was conducted to determine the oral health status of school-aged children. School nurses and OHP staff screened 3rd grade students statewide. Seventy-five schools were randomly selected to be included in a representative sample of the 3rd grade student population. The survey included an assessment of the children's oral health status and determination of the presence of dental sealants on permanent 1st molars. A total of 2,651 children participated in the screening.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Expansion of the dental sealant program into three new	X		X	

parishes.				
2. Development sustainability plan for a dental sealant program model for statewide application in Louisiana.	X			X
3. Partnered with LDA, LSU School of Dentistry and other partners to provide dental sealants on Give Kids a Smile Day.			X	X
4. Sealant program participants receive oral hygiene instruction and oral health aids to promote improvement of oral health.	X	X		
5. Plan to determine the retention rates of sealants in program in a sample of participants.	X		X	
6. Identifying funding sources for the expansion of the sealant program.			X	X
7. Conduct an oral health assessment of the third grade school children in Louisiana.			X	
8.				
9.				
10.				

b. Current Activities

Direct Services

The Oral Health Program (OHP) is administering the school-based dental sealant program in cooperation with public and private partnerships, including community health centers and dental providers in private practice, expanding to three new parishes.

Enabling Services

OPH partners with Medicaid to ensure that eligible pregnant women received dental services. The staff participates in dental health professionals, school-nurses, and pediatric dentists conferences to recruit providers for the dental sealant program and dental services program for pregnant women. The staff also attends meetings with non-dental health professionals, presenting information on dental screenings, evidenced --based practices, and anticipatory guidance on oral health for infants, children, and pregnant women.

Population Based Services

Currently 42.7% of LA's population receives fluoridated water; this will increase to 43.1% in August, 2009. The OHP and the OPH Engineering Section conducted presentations on the benefits of water fluoridation to water operators at the LA Rural Water Association Conference. The OHP is working to bring Louisiana in compliance with the CDC fluoridation recommendations and updating the procedures manual for local operators

Infrastructure Services

The OHP has developed a surveillance plan for data collection and analysis.

c. Plan for the Coming Year

Direct Services

The Oral Health Program will work toward increasing the number of children who receive protective dental sealants through a statewide school-based sealant program.

Enabling Services

In order to promote the Pregnant Women's program, MCH will work toward increasing the number of dental providers treating Medicaid children and Medicaid eligible pregnant women. MCH will provide continuing education and program information to dental health providers in the state in forums such as dental society meetings and annual state conferences.

Population Based Services

The Fluoridation program will implement an ongoing training program for water operators to

ensure safe and consistent delivery of the optimal levels of the fluoride ion and promote the benefits of community water fluoridation.

The OHP will work to increase the number of Louisiana residents who receive the protective benefit of community water fluoridation and to increase our community education efforts through local, grass-roots efforts in communities affected by the fluoridation mandate. It is anticipated that the Town of Walker will initiate fluoridation in October of 2009. Plans also include providing additional financial and technical support to systems to continue fluoridation.

Infrastructure Services
Through the additional staffing provided by the CDC Cooperative Agreement, the Oral Health Program should be able to enhance its capacity to develop and expand the School-based Dental Sealant Program and Community Water Fluoridation efforts. The Oral Health Program (OHP) has applied for a HRSA Work Force Development Grant. If funding is granted, the program will contract with dentists and dental hygienists in all of the nine DHH Administrative Regions to deliver a school-based dental sealant program in schools with 50% or more of the children on free or reduced lunch. A sustainability plan is being developed to include Medicaid billing and a detailed evaluation plan to ensure the cost-effective operation of the sealant program.

OHP staff will begin to develop a state wide Oral Health Coalition composed of program partners and stakeholders to begin the work of creating a state plan. We will use our surveillance plan to produce a Burden of Oral Disease document which will drive program decisions and policy issues.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	6.7	6.7	6.7	4	4
Annual Indicator	7.0	5.2	4.8	5.7	5.7
Numerator	67	49	43	51	51
Denominator	963046	946320	897508	888587	888587
Data Source					Louisiana Vital Records and Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	4	4	4	4	4

Notes - 2008
2008 data is provisional and based upon the 2007 data.

Notes - 2007
2007 data is provisional.

Notes - 2006
2006 data is provisional.

a. Last Year's Accomplishments
Preliminary data shows that in 2007, 51 children aged 0-14 years were killed in motor vehicle crashes at a rate of 5.7 deaths/100,000 children. Though this rate is lower than Healthy People 2010's goal of 9.0 deaths by motor vehicle crashes/100,000 population, it is higher than Louisiana's 2006 final rate of 4.8 deaths/100,000 children. In 2006, 43 children aged 0-14 years were killed in motor vehicle crashes. Final rates for 2004 and 2005 are 7.0, and 5.1 deaths/100,000 children, respectively. Data for 2008 is not yet available for reporting.

The Maternal and Child Health (MCH) Program worked towards reducing child vehicular deaths. MCH funded Louisiana's 9 Regional Child Safety Coordinators (formerly known as MCH Injury Prevention (MCH IP) Coordinators, who are also National Child Passenger Safety Certified Technicians and the Safe Kids Louisiana Program.

Population-Based Services
The MCH Program continued to support the Regional MCH IP (Child Safety) Coordinators' participation in car seat/child restraint check-up events, in collaboration with Safe Kids Louisiana, the Louisiana Passenger Safety Task Force, and Louisiana Highway Safety Commission. In 2008, the MCH Child Safety Coordinators participated in more than 516 child passenger safety events, which reached more than 5,100 people statewide, and about 1,448 seats/child restraints were checked at check-up events and fitting stations. In 2007, more than 3,100 people participated statewide in more than 84 local child passenger safety events, and 1,544 seats/child restraints were checked at check-up events and at fitting stations.

Infrastructure Building Services
The MCH Child Safety coordinators and Safe Kids coordinators continued to offer technical assistance and culturally appropriate educational outreach in child safety/injury prevention, including child passenger safety and pedestrian safety, to health providers, educators, childcare providers, faith-based and community leaders, and the general public through seminars, workshops, health fairs, the media (radio and television), printed materials (brochures, newsletters, pamphlets), and presentations. In 2008, more than 34,000 children and adults were reached with culturally appropriate child safety/injury prevention educational information.

The State and the local Child Death Review Panels (CDRP) continued to review all unexpected deaths of children under the age of 15 years resulting from motor vehicle crashes and other unintentional, unexpected causes. In 2008, at least 121 unexpected infant and child deaths were reviewed at the state and local levels. MCH continued to manage Louisiana Child Death Review and the state panel, and the MCH Child Safety Coordinators continued to serve as the local CDRP Coordinators.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. LA SAFE KIDS and MCH Child Safety (IP) coordinators will conduct/assist with monthly car seat check-up events, in collaboration with the Louisiana Passenger Safety Task Force and Louisiana Highway Safety Commission.			X	
2. MCH Child Safety (IP) coordinators to distribute car seats and booster seats, if available, to needy children.			X	
3. MCH to provide technical assistance and collaborate with the OPH EMS/ Injury Research & Prevention Section on childhood				X

injury and motor vehicle occupant injury prevention activities.				
4. Support the outreach efforts of Louisiana SAFE KIDS and the nine regional MCH Child Safety (IP) coordinators to provide safety/injury prevention education and resources.				X
5. . LA SAFE KIDS and MCH Child Safety (IP) coordinators will collaborate with epidemiology colleagues to report injury data to implement effective child motor vehicle occupant and other injury prevention interventions.				X
6. Child Death Review Panels will review all unexpected deaths of children under the age of 15 years resulting from motor vehicle crashes and other causes.				X
7.				
8.				
9.				
10.				

b. Current Activities

Population Based Services

The MCH Child Safety Coordinators, as certified Child Passenger Safety Technicians, have continued car/booster seat distribution and car seat/child restraint check-up events/fitting station participation in collaboration with Safe Kids Louisiana, Louisiana Passenger Safety Task Force, and Louisiana Highway Safety Commission. Several coordinators have received training on child restraints for children with special healthcare needs. Since October 2008, at least 524 car seats/restraints have been checked.

Infrastructure Building Services

The State and Local Child Death Review Panels (CDRP) have continued to review unexpected deaths of children 14 years and under resulting from motor vehicle crashes and other causes. MCH has a new State CDRP Coordinator to oversee the operations of child death review, and the MCH Child Safety Coordinators are also the local CDRP coordinators. Since October 2008, more than 48 infant/child death cases have been reviewed.

MCH Child Safety Coordinators, in collaboration with Safe Kids Louisiana, EMS for Children, and Injury Research Prevention Program, have continued to offer technical assistance and culturally appropriate, community-based child safety/injury prevention educational outreach, including child passenger safety and pedestrian safety, through health fairs, seminars, workshops, media, and printed materials (English/Spanish). Since October 2008, over 15,022 people have been reached in over 468 events statewide.

c. Plan for the Coming Year

Objective: To decrease to 4 per 100,000 children the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes.

Population-Based Services

The MCH Child Safety Coordinators will continue to distribute car seats and booster seats to children in need and will continue to participate in car seat/child restraint check-up events and fitting stations, in collaboration with Safe Kids Louisiana, Louisiana Passenger Safety Task Force, and Louisiana Highway Safety Commission.

Infrastructure Building Services

In order to reach our objective, the MCH program will continue to support the MCH Child Safety Coordinators and Safe Kids Louisiana to provide technical assistance, injury prevention educational outreach, and motor vehicle occupant injury prevention activities, which are community-based and culturally appropriate for the target at-risk populations. The educational

materials are also available in Spanish for the growing Hispanic population with limited proficiency of the English language in Louisiana.

The State and Local/Regional Child Death Review Panels will continue to review all unexpected deaths of children under the age of 15 years resulting from motor vehicle crashes and other causes. MCH and the Louisiana Child Death Review will implement the CDC web-based case reporting system of infant and child death review findings for both the State and Local CDRPs. The MCH Program will continue to support childhood injury prevention interventions, developed from which result from State and Local CDRPs, in collaboration with the Safe Kids, OPH EMS for Children and Injury Research & Prevention Program.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			10.4	15.6	15.8
Annual Indicator	15.2	15.2	15.2	21.9	21.9
Numerator	9253	9253	9253	66	66
Denominator	60873	60873	60873	302	302
Data Source					National Immunization Survey (NIS)
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	25	26	27	28	29

Notes - 2008
This year's data is provisional and based upon 2005 National Immunization Survey (NIS) data. LaPRAMS 2006 data indicated that 17.02% of mothers breastfed their infants at 6 months of age, however, LaPRAMS has not reached 70% response rate since Hurricane Katrina in 2005 and therefore data is unreliable. Furthermore, infants are between 2 and 6 months at the time of the survey, which may lend bias to the question of breastfeeding at six months.

Notes - 2007
Data is provisional and based upon 2005 NIS data.

Notes - 2006
Data is provisional and based upon 2004 PRAMS Data.

a. Last Year's Accomplishments
Enabling Services
WIC sites continue to create clinic environments that endorse breastfeeding as the preferred method of infant feeding. Sites addressed large disparities seen among the different racial and ethnic groups by providing updated and culturally appropriate breastfeeding educational videos,

handouts and posters. Structured breastfeeding classes were offered to participants. The breastfeeding peer counseling program is an on-going effort to support and increase breastfeeding initiation and duration rates. WIC continues to provide manual, electric and personal electric breast pumps to participants as needed.

Population Based

Breastfeeding awareness information and support continues at the community level, including hospitals, faith-based organizations, physicians' offices, other health care providers and community events. Local businesses were recruited to become breastfeeding friendly employers as a major community breastfeeding projects.

A hospital-based breastfeeding incentive program, entitled The Gift, continued. The Gift program supports and encourages Louisiana birthing facilities to implement breastfeeding-friendly policies and practices. Birthing facilities that meet The Gift's "Ten Steps to a Healthy, Breastfed Baby" receive the designation of "Gift Certified. There are approximately 62 maternity hospitals and 1 birthing center in Louisiana. From October 1, 2007 to September 30, 2008 two birthing facilities were "Gift Certified" bringing the total to eight certified facilities.

A website for The Gift was developed to increase awareness of the program and related events/resources. A statewide email list was created to disseminate information regarding statewide breastfeeding activities and general breastfeeding information. There are three regional breastfeeding coalitions: Central Louisiana Breastfeeding Coalition, Greater New Orleans Breastfeeding Awareness Coalition, and the newly formed Acadiana Breastfeeding Coalition. With participation of local breastfeeding support groups, the Louisiana WIC Program, the Maternal Child Health Coalition and the American Academy of Pediatrics breastfeeding representatives, the Louisiana Breastfeeding Coalition (LBC) was formed. The work of the LBC will be guided by a 12-member Steering Committee. The primary purpose of the LBC is to make breastfeeding the norm for all babies in Louisiana. The Coalition will protect, promote and support breastfeeding through a variety of means including: improved public policy, professional education, use of the media, information sharing among lactation consultants, and development of regional/local coalitions. The LBC held its Inaugural Meeting on September 17, 2008. Information about the LBC and a listing of upcoming meetings can be found on The Gift website at www.thegiftla.org. Regional Breastfeeding Coalitions continue to be established statewide and will continue until all nine regions have established coalitions.

Infrastructure Building Services

The statewide resource guide was updated with information on WIC Clinic Breastfeeding Coordinators, local La Leche League groups and leaders, hospitals and individuals statewide offering breastfeeding services. Links on the Office of Public Health Nutrition Services Website includes breastfeeding policies and procedures, and new breastfeeding educational DVDs. An evidence-based, breastfeeding training program, offering 6 continuing education hours, for hospital staff and community breastfeeding health care workers (i.e. La Leche League Leaders, WIC Breastfeeding Peer Counselors) was developed and offered in each region at no cost. The trainings included: evidence-based breastfeeding support as it relates to The Gift, advantages of breastfeeding, risks of not breastfeeding, anatomy and physiology of breastfeeding, correct positioning and latch, prevention and management of common problems, maintaining a woman's milk supply if breastfeeding is interrupted, local and national breastfeeding resources. Meetings were held with hospital administrators and staff and presentations were given at FIMR Community Action Team meetings to increase knowledge of breastfeeding and participation in The Gift. Routine follow-up, including a mid-certification survey, was conducted with Gift Certified facilities.

A "Louisiana Breastfeeding Fact Sheet" was developed to increase awareness of breastfeeding outcomes in Louisiana among legislators, health care providers and public health professionals.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provision of manual, hospital grade and portable electric breast pumps.		X		
2. Collection and analysis of WIC breastfeeding initiation and duration at 6 months of age rates.				X
3. Revision of breastfeeding policies and procedures including on-line breastfeeding training for all clinic staff and monitoring of positive clinic environment that endorses breastfeeding.				X
4. Provision of prenatal breastfeeding promotion bags to support breastfeeding initiation and duration rates.				X
5. Provision of trainings to promote new WIC foods for breastfeeding dyads to clinic staff and community partners.		X	X	X
6. Delivery of breastfeeding trainings with continuing education units for hospital staff and community breastfeeding health care workers (i.e. La Leche League Leaders, WIC Breastfeeding Peer Counselors) statewide by The Gift program.				X
7. Provision of breastfeeding classes and breastfeeding peer counselors for prenatal, postpartum and breastfeeding participants to encourage and support breastfeeding initiation and duration.		X		X
8. Provision of new breastfeeding support and education materials on new WIC foods for breastfeeding clients.				X
9. Provision of support and assistance to birthing hospital administrators and staff to enroll their hospital in The Gift program.			X	
10. Establishment of breastfeeding worksite promotion and support.			X	

b. Current Activities

Enabling Services

All WIC staff and community partners are being trained on the new WIC foods, effective October 1, 2009, which promotes breastfeeding as the preferred method of infant feeding. Prenatal participants began receiving breastfeeding support tote bags with breastfeeding educational materials at certification for program participation.

Population Based Services

Breastfeeding awareness information and support continued at the community level, including military bases, faith-based organizations, daycare and head start programs, physicians, other health care providers and community events. WIC completed a media program focusing on the breastfeeding peer counseling program and has distributed focus group DVDs to clinics and community partners. Community support continued with provision of supportive breastfeeding items to local businesses choosing to become breastfeeding friendly employers. There are 9 "Gift Certified" hospitals and 4 applications in process. Meetings with hospital administrators and staff to enroll their hospital in The Gift program continue to be held and program materials distributed.

Infrastructure Building Services

The statewide resource guide was updated and will be updated on a continual basis to reflect changes in closures and new openings. By June 30, 2008, 18 breastfeeding trainings at 6-contact hours each will be held throughout the state.

c. Plan for the Coming Year

Objective: Increase to 29.0 percentage the proportion of mothers who breastfeed their infants at 6 months of age by 2013.

This year's data is provisional and based upon 2005 National Immunization Survey (NIS) data. LaPRAMS 2006 data indicated that 17.02% of mothers breastfed their infants at 6 months of age, however, LaPRAMS has not reached 70% response rate since Hurricane Katrina in 2005 and therefore data may be unreliable. Furthermore, infants are between 2 and 6 months at the time of the survey, which may lend bias to the question of breastfeeding at six months.

Enabling Services
WIC will continue to utilize the breastfeeding peer counselor program to provide encouragement and support to participants prenatally as well as the breastfeeding moms. Clinics will continue to provide breastfeeding education and support through classes, distribution of prenatal breastfeeding promotion bags, updates on the new WIC foods and breast pump assistance.

Population Based Services
WIC will continue to focus on providing breastfeeding support to a maximum of 15 worksites in the state that promote and support their breastfeeding moms. Meetings with hospital administrators and staff to enroll their hospital in The Gift program will continue to be held and program materials distributed. The Gift website continues to be updated and maintained on a regular basis. To increase the number of Gift Certified facilities a 1-contact hour (continuing education unit) program on Gift Certification will be applied for through the Louisiana State Nurses Association as requested by hospital administrators and staff. This program will assist hospitals in implementing evidence-based policies and practice, increase support for The Gift and create continuity in The Gift application process. Statewide and Regional Breastfeeding Coalition mobilization and efforts to increase statewide support for breastfeeding will continue.

Infrastructure Building Services
Staff and community partners will be updated on new breastfeeding policies, new WIC food packages supportive of and encouraging breastfeeding, and new breastfeeding education materials. The Gift Program Coordinator will submit a proclamation and press release for World Breastfeeding Week (WBW) 2009 and WBW 2010. A "Tool Kit" CD to assist hospitals in achieving Gift Certification will be developed and utilized by birthing facilities seeking Gift certification and re-certification. A tracking and monitoring system for The Gift program will be implemented on the website to allow for easier reporting. Three 6-contact hour breastfeeding trainings will be conducted until additional funding and resources for the training program are obtained. Monitoring, follow-up surveys, and routine communication with Gift Certified facilities will be continued and documented. The Gift Program Coordinator will obtain assurances required regarding lactation support, staff education and training, and how infant formula is handled.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	93	95	98	98	98
Annual Indicator	95.9	96.3	95.9	96.6	96.8
Numerator	61984	41228	52801	61440	62571
Denominator	64636	42825	55084	63630	64661
Data Source					Early Hearing Detection and Intervention

					Database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	98	98	99	99	99

Notes - 2008
Data is still provisional.

Notes - 2007
Data is based on entire year.

Notes - 2006
Data is based on entire year, but not all occurrent birhts are represented due to problems with the EBC server failure following Hurricanes Katrina and Rita.

a. Last Year's Accomplishments
The goal of this program is to meet the American Association of Pediatrics' (AAP) 1-3-6 guidelines for screening, identification and intervention. The program sought to reduce the morbidity, developmental and educational delays associated with hearing loss.
During 2007, the program screened 97.43% of newborns for hearing loss (63,211 out of 64,880 births). This 2.02% increase from 2006 can be attributed to the increase in hospital reporting and communications between Universal Newborn Hearing Screening and Intervention (UNHSI) and hospital staff. This data represent approximately 98.82% of occurrent births. Data from 2006 represented only 89% of occurrent births. The percentage of infants screened is affected by the reporting of infant transfers and deaths, which must be reported manually by the transfer hospital. The percentage of infants lost to follow-up or lost to documentation (ltfu/ltd) during 2007 was 35%, an improvement from 51% during 2006. However, data is incomplete for 2006 due to infrastructure failures following Hurricane Katrina.

Direct Services
Newborn hearing screening services are mandated by law and provided by all 60 birthing hospitals. Follow-up testing for those who did not pass the screening was provided by both the public and private sector. Follow-up data is reported directly to Hearing, Speech and Vision (HSV) via the Follow-Up Services Report. Direct services were provided by HSV audiologists, providing services for children who lack insurance or access to services. They provided 370 hearing and speech screenings for infants and toddlers; 742 audiological evaluations to CSHS eligible children; 220 hearing aids to CSHS eligible children. These services reflect a slight decrease from the prior year, due in part to the temporary closure of a Region V facility following two 2 major hurricanes.

Enabling Services
HSV distributed 40,000 informational brochures to hospitals and other stakeholders for parents about newborn hearing screening and follow-up for children referred, in both English and Spanish. HSV provided in-services and written information to Primary Care Physicians (PCPs), who provide rescreening for infants. This service was in order to educate them about UNHSI and the importance of reporting follow-up data to our program. The parent resource guide was completed and guideline documents were distributed. The HSV statewide Parent Consultant left her position and interviews for this position were conducted.

Population-Based Services
HSV collected data on newborn hearing screening and implemented a follow-up system to ensure that all infants who referred received appropriate follow-up. HSV contracted Meshawn Tarver as Follow-Up Coordinator to implement the follow-up system. HSV completed comprehensive on-site hospital visits with the second half of all birthing hospitals. HSV provided technical assistance to improve accuracy of hearing screening and follow-up data via the Electronic Birth Certificate (EBC). This technical assistance was also to assure compliance with all components of the UNHSI system: data reporting, records, program policies, parent education, and identification of providers performing follow-up testing. HSV continued to manually adjust hospital statistics for children who transferred to a NICU or expired.

Infrastructure Building Services
Monitoring activities, training, and technical support services for UNHSI were conducted. HSV provided hospitals with quarterly reports of their screening and follow-up performance, in an effort to improve accuracy of data. Educational training was provided through the regional task force system as well as comprehensive hospital visits. HSV conducted training with UNHSI guideline documents: Pediatric Audiology Guidelines; Universal Newborn Hearing Screening Guidelines for Louisiana Hospitals; and Audiological Rescreening of Infants Guidelines. The HSV program began work with an in-house IT consultant to re-design the hearing collection system. UNHSI initiated collaboration with Part C EarlySteps (ES) and the Parent-Pupil Education Program (PPEP) to assure a seamless entry into early intervention (EI) for children with hearing loss, and assure that families have immediate access to a professional knowledgeable about hearing loss.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Improve hospital data accuracy; work with VR & IT in re-design of EBC and hearing data system.				X
2. Provide training and standards for early hearing detection and intervention personnel.				X
3. Provide parent education, outreach and support; disseminate pamphlets in English and Spanish			X	X
4. Produce pamphlets in Vietnamese.			X	X
5. Maintain follow-up and tracking systems for children suspected of hearing loss.				
6. Provide audiology follow-up for UNHSI where there is no access to community services.	X	X		
7. Provide hearing aids for identified children who have no access to community services.	X	X		
8.				
9.				
10.				

b. Current Activities
Direct Services
Audiological services are provided by HSV audiologists where there is a lack of local services.

Enabling Services
Distribution of parent brochures is on-going, with plans for brochures in Vietnamese. Technical support to hospitals continues. Parent surveys were evaluated to improve the UNHSI system. HSV continues to work with PCP offices to improve follow-up reporting. The Advisory Council has revised guideline documents to reflect changes to the 2007 Joint Committee on Infant Hearing Position Statement. Mariah Ranko has been hired as the HSV Parent Consultant.

Population-Based Services
HSV maintains the Intervention Services database of children identified with hearing loss. The Follow-Up Coordinator focuses on reducing the number of infants ltfu/ltd. UNHSI contacts follow-up service providers regarding inaccurate and missing data.

Infrastructure Building Services
HSV collaborates with Vital Records (VR) and the web-design consulting firm, DB SYSGRAPH INC, as VR re-engineers the electronic birth certificate (EBC). The in-house IT consultant assisting with re-designing the hearing data system is working on other assignments, and IT will assign another programmer. HSV provides quarterly data reports to hospitals. UNHSI and PPEP provide training to EarlySteps providers establishing a seamless system of entry for families. The summary of hospitals' screening technology is being compiled.

c. Plan for the Coming Year
Objective: To increase the proportion of newborns that are screened for hearing loss before hospital discharge to 98%. The goal for number of infants screened has remained at 98%, until VR and our hearing data collection can be changed to electronically collect infant transfers and deaths. Although transfers and death are being manually adjusted approximately 60% of hospitals are reporting transfers and death by paper form. Efforts will be continued to promote the reporting of transfers and deaths.

Direct Services
Screening and follow-up services will continue to be provided by the HSV audiologists where there is no access to local community services. The HSV program audiologists will continue to establish partnerships in the private sector.

Enabling Services
HSV will continue distribution of brochures for parents and resource guideline documents. Hospitals will continue to receive technical support. HSV will improve EI access and tracking system for children who are deaf or hard of hearing. This includes training for Part C. The Follow-Up Coordinator will continue to reduce the number of infants ltfu/ltd by contacting families to improve return for follow-up appointments and reporting statistics to audiologists. UNHSI staff will continue to educate PCP offices who are also conducting follow-up rescreening, as well as monitor their reporting.

Population-Based Services
Emphasis for the coming year remains on hospital technical support, improving the UNHSI follow-up system and maintaining the Intervention Services database of children identified with permanent childhood hearing loss (PCHL). Additionally, HSV will work to increase the transfer and death hospital reporting rate.

Infrastructure Building Services
For the coming year, UNHSI will work to develop a complete web-base prototype of the data collection system. In collaboration with Vital Records, the hearing data collection system for the new EBC will be developed and tested.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	11	13	7	9	9

Annual Indicator	8.2	9.9	16.7	10.6	10.6
Numerator	99977	111448	189258	123425	123425
Denominator	1214001	1121605	1130575	1167153	1167153
Data Source					Louisiana Medicaid/SCHIP Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	8	8	8	8	8

Notes - 2008
Data is provisional and based upon the 2007 data.

Notes - 2007
Data is provisional and based upon the 2006 data.

Notes - 2006
Estimates are from the AAP, Children's Health Insurance Status Medicaid/SCHIP Eligibility and Enrollment Report September 2007. Data is final.

a. Last Year's Accomplishments
In 2007, the percentage of uninsured children from birth to 19 years was 12.3%. Though the 2007 performance objective of 9% uninsured children was not reached, the percentage of uninsured children in 2007 (12.3%) was lower than the 2006 uninsured rate of 16.7%. The 2007 and 2006 estimates are from the AAP, Children's Health Insurance Status Medicaid/SCHIP Eligibility and Enrollment Report, September 2008 and September 2007, respectively. The 2008 data is not yet available.

Of note, the percentages of uninsured children under 19 years old reported in the Louisiana Health Insurance Surveys (LHIS) are lower than the percentages documented in the AAP, Children's Health Insurance Status Medicaid/SCHIP Eligibility and Enrollment Reports. In the 2005 and 2007 LHIS reports, performed every 2 years, the percentages of uninsured children are 7.6% and 5.4%, respectively. However, the percentages of uninsured children in 2005 and 2007, according to the AAP, are 9.9% and 12.3%, respectively. LHIS results are based on over 10,000 Louisiana households representing insurance status for over 27,000 Louisiana residents and have been weighted with the most current population estimates available. The AAP results are based on the American Academy of Pediatrics analysis of the 2008 March Supplement of the Current Population Survey.

Enabling Services
The income eligibility for the state-sponsored health insurance programs were checked for pregnant women, infants, and children attending one of the Office of Public Health's Public Health Units (PHU) for WIC or other health services. Infants and children who were income eligible and uninsured were provided referral information on LaCHIP/Medicaid and an application. Also, pregnant women who were income eligible LaMOMS/Medicaid were provided applications and

referral information. In subsequent visits, those who were still eligible and uninsured were offered additional assistance and another application for the respective programs.

Population-Based Services
The MCH Program continued to work with Covering Kids and Families Initiative in their outreach efforts to enroll eligible children into the state-sponsored health insurance programs (Louisiana State Child Health Insurance Program and Medicaid). The MCH Program Director continued to serve on the Steering Committee while the MCH Child Health Medical Director and MCH Child Health Nurse Coordinator participated in the statewide coalition meetings for the Covering Kids and Families Initiative. The goals of this initiative are to 1) coordinate and conduct outreach, 2) simplify enrollment and renewal processes, and 3) coordinate health coverage programs.

Infrastructure Building Services
The MCH Program maintained a working relationship with the State Medicaid and LaCHIP staff by providing information and technical assistance, particularly in the area of access to services and enrollment. The MCH Program also worked with Medicaid staff to provide updated information regarding services in OPH Parish Health clinics throughout the state. MCH Program staff participated in the State Health Care Reform Initiatives related to health care coverage and access to care.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Eligibility screening for Medicaid/LaCHIP/LaMOM for all infants, children, & pregnant women seen in OPH.		X		
2. Provide Medicaid eligible clients with information on Medicaid and how to apply.		X		
3. Support Covering Kids and Families' outreach efforts.			X	
4. Technical assistance to the LaCHIP, LaMOM, and Medicaid Programs for enrollment eligibility and access to services.				X
5. Monitoring of and participation in Health Care Reform activities related to health care coverage and access to care.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Enabling Services
The OPH clinics continue to screen pregnant women, infants and children, who are seen for WIC or other services, for income eligibility for LaMOMS and LaCHIP/Medicaid. Those who are found income eligible are provided application forms and/or given referral information for application for these programs. Program and enrollment information are also available in Spanish and Vietnamese.

Population-Based Services
The MCH Program continues to work with Louisiana Covering Kids and Families Initiative in support of its efforts to reduce the number of uninsured children who are eligible for Medicaid or State Child Health Insurance Program (SCHIP) through statewide outreach activities by its 11 regional coalitions.

Infrastructure Building Services

In February 2009, Louisiana Medicaid began the MaxEnroll Initiative, a four-year project intended to maximize the enrollment of eligible children in Medicaid and LaCHIP. The project is being funded through the combination of a $1M Robert Wood Johnson Foundation grant and federal matching funds. The goal is to enroll 98% of children eligible for Medicaid or LaCHIP by 2013. Results are pending from a Diagnostic Assessment performed in May 2009, which will provide recommendations for improving enrollment of uninsured children and retention of children already in Medicaid and CHIP. MCH is available for technical assistance related to the implementation process.

c. Plan for the Coming Year
Objective: Decrease the percentage of uninsured children to 8%.

Enabling Services
Parish Health Units will continue screening and referral of those uninsured infants, children and adolescents who are eligible for LaCHIP/Medicaid services as well as pregnant women to LaMOMS.

Population-Based Services
The MCH Program will continue to work with Covering Kids and Families in outreach efforts to increase enrollment of eligibles into LaCHIP/LaMOMS/Medicaid Programs.

Infrastructure Building Services
The MCH Program will continue to work with Louisiana Medicaid to maximize the enrollment of eligible children in Medicaid and LaCHIP through outreach programs. MCH will provide technical assistance for the MaxEnroll Initiative to develop, test, and implement enrollment activities of eligible children in the OPH Public Health Clinics.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			12.5	12	11.5
Annual Indicator		13.2		13.8	13.8
Numerator		11781			
Denominator		89373			
Data Source					CDC PedNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	11	10.5	10.5	10.5	10.5

Notes - 2008
Data is provisional and based upon the 2007 data.

Notes - 2007
The WIC Program's application developer has been working with CDC on the criteria required for data transfer to PedNSS. The developer was able to transfer the WIC 2007 BMI data to be included in the 2007 CDC PedNSS report. Due to budget constraints and the upcoming changes in the WIC food package, 2008 data has not been transferred to PedNSS at this time. It is our hope that in the future the WIC Program's data system will be updated to automatically generate reports to be submitted to PedNSS.

Notes - 2006
In May of 2006, the WIC Program implemented a new data system. Due to this major change, data cannot be transferred to the CDC Pediatric Nutrition Surveillance System as done in the past. Therefore, no data can be reported this year.

a. Last Year's Accomplishments
Direct Services
WIC provided services in OPH and contract facilities in 113 locations for counseling and education sessions to families statewide on healthy eating and physical activity. Referrals were made to WIC for specialized nutrition counseling.

Enabling Services
The MCH Registered Dietitian (RD) provided training to 40 Child Care Health Consultants (CCHC) at the annual conference, covering food allergies, healthy eating and physical activity for children in the child care setting. The coordinator of the Louisiana Obesity Council provided an inservice to all MCH staff detailing the obesity statistics in the state, methods to solve the problem, and programs being conducted throughout the state that address childhood obesity.

Population Based Services
Through the Louisiana WIC Farmer's Market Program, 450 families received a one-time issuance of a booklet of 6 coupons for $4.00 each with a total value of $24.00 to use at farmer's markets throughout the New Orleans area. In addition, nutrition education materials promoting the benefits of fresh fruits & vegetables, recipes and instructions for participation in the WIC Farmer's Market Program were distributed to WIC participants. A WIC Nutrition Education class and cooking demonstration was also provided. In addition, two "Meet Me at the Market" days were held, in which WIC families were served refreshments and given a tour of two local farmer's markets.

Educational materials were distributed to WIC participants and other local community members entitled Fruit and Veggies: More Matters Health Message. These materials were also used to assist WIC staff to prepare participants for the WIC food package changes involving fresh fruit and vegetable availability.

The WIC education cards were updated and distributed to WIC clinics statewide. These education cards are given to participants to address proper nutrition and feeding techniques. The MCH RD developed a resource guide that includes several key public health issues, including childhood obesity. This guide is available for all internal and external MCH partners.

Infrastructure Building Services
The MCH Registered Dietitian (RD) actively participated in the Louisiana Obesity Council, who in 2007 obtained a $110,000 grant from the National Governor's Association. Through this grant, a survey of over 400 principals across the state was conducted regarding implementation of the school wellness policy. The Obesity Council was a sponsor of the first, statewide public health conference entitled, Childhood Obesity and Public Health: A Lifespan Approach to Prevention. At this conference the "Louisiana's Report Card on Physical Activity and Health for Children and Youth" was unveiled. A panel of state, national and international experts gathered by the Pennington Biomedical Research Center (PBRC) analyzed existing data, examined several categories of activities and polices that lead to good health, and assigned Louisiana a grade of D.

The MCH RD became the co-chair of Louisiana Action for Healthy Kids and participated in a workshop on Action for Healthy Kids, created to help decrease childhood obesity. It was through Action for Healthy Kids that the Coordinator of the Obesity Council obtained grant money which was awarded to two schools. These schools were the winners of The School Health Awards sponsored by the School Health Index program. This program is designed to serve as a tool to help schools assess their physical activity and nutrition policies and programs.

The MCH RD also participated in the State Nutrition Action Plan committee, which is a workgroup of USDA funded agencies, whose goal is to establish and support partnerships and collaborative interventions between the USDA nutrition assistance programs and other related groups in prevention efforts targeted at overweight and obesity.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Counseling and education sessions to families on healthy eating and physical activity.	X			
2. Referrals to WIC Services for specialized one-on-one nutrition counseling.		X		
3. PHAME software to identify at risk of overweight children.		X		
4. Utilization of educational materials on healthy weight & physical activity for infants and children.		X		
5. Training of health professionals to enhance their abilities to promote healthy lifestyles with patients.				X
6. Participation in the Louisiana Obesity Council and other committees.				X
7. Implementation of guidelines for health professionals on healthy weight and physical activities.		X		
8. Training for health professionals to utilize new methods of nutritional assessment of children age 2 -5.		X		
9. Outreach activities to encourage families to increase consumption of fruits and vegetables.			X	
10.				

b. Current Activities

Enabling Services

WIC purchased 50,000 DVDs and children's books highlighting healthy nutrition and physical activity to distribute to WIC families. In May 2009 WIC staff, participants, and vendors were trained on the new WIC food package. The MCH RD participated in the MCH CCHC Conference and trained 50 staff on healthy nutrition in the child care setting.

Population Based Services

The Louisiana WIC Farmer's Market Program continued to be promoted. Twelve new WIC educational brochures were created and six WIC infant educational cards were revised to reflect the new food package changes.

A state summit was held in which individuals from nutrition agencies discussed ways to promote increased consumption of fruits and vegetables. In addition the MCH RD helped plan and coordinate a state meeting for Louisiana Action for Healthy Kids. Sixty individuals from across the state attended and discussed methods to combat childhood obesity in Louisiana.

Infrastructure Building Services

The MCH RD is participating on a committee with the Louisiana Department of Education to help to establish and implement health curricula in all public elementary and secondary schools. The Coordinator of the Obesity Council is assisting in the development of a wellness policy toolkit to be disseminated to Louisiana schools this summer.

c. Plan for the Coming Year
Objective: Reduce the percent of children (2-5 years old) receiving WIC with a BMI at or above the 85th percentile to 11 % (?).

Direct Services
WIC will continue to provide services in OPH for counseling and education sessions to families statewide on healthy eating and physical activity.

Enabling Services
The WIC program will continue promotion and education to staff, participants, vendors, and the community to the changes to the WIC food package. The expected date of implementation of the new food package is October 2009.

The MCH RD will partner with the Nurse Family Partnership program to provide education and consultation to the nurses and families in this program. Specifically the MCH RD will collaborate with NFP to develop a program aimed at educating mothers on appropriate weight gain during pregnancy and appropriate infant and toddler feeding techniques.

Population Based Services
The MCH RD will collaborate with WIC to determine childhood obesity education materials currently being used in statewide WIC clinics. This will include determining what education materials are being utilized; how many referrals for childhood obesity are made to the high risk nutritionist; if there is a standardized process for counseling overweight/obese children; and if there is sufficient access to the high risk nutritionist for overweight/obese children. Results from this analysis will help determine the need for childhood obesity resources in the state public health units.

The Louisiana WIC Farmer's Market Program will continue to be promoted.
Through a collaboration with Chef John Folse, 1,000 WIC families will receive his latest cookbook "Cooking with Confidence" which includes healthy recipes for cooking with the foods of the new WIC food package.

The MCH RD will serve as a Child Care Health Consultant and will train the staff of at least 4 childcare centers on the topic of healthy nutrition.

Infrastructure Building Services
MCH and WIC will continue to actively participate in the Louisiana Obesity Council, Action for Healthy Kids, the Southwest Regional USDA committee, and the State Nutrition Action Plan committee. The MCH RD will also continue to participate on the committee with the Department of Education to create health and physical education curricula in all public elementary and secondary schools.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			13.8	13.5	13.5
Annual Indicator		17.7	17.7	16.6	16.6
Numerator		11117	11117	11069	11069
Denominator		62767	62767	66686	66686

Data Source					LA Pregnancy Risk Assessment Monitoring System
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	12.5	13.5	13.5	13.5	13.5

Notes - 2008
Data is provisional and based upon the 2007 data.

Notes - 2007
Data is provisional and based upon 2006 PRAMS data.

Notes - 2006
Data is provisional and based upon 2004 final PRAMS data.

a. Last Year's Accomplishments
Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS) data for 2006 indicated that 16.6% of all pregnant women reported smoking during the last three months of their pregnancy, down from the 17.7% FY 2004. More recent PRAMS data is not available.

Direct Services and Enabling Services
The MCH program collaboration with Louisiana Section of American College of Obstetricians and Gynecologists (ACOG), state Office of Addictive Disorders (OAD), and Office of Mental Health (OMH) identified a screening tool for tobacco use in pregnancy, 4Ps Plus, that also screens for substance abuse, alcohol use, depression and domestic violence. State licensure for tool use and data collection from Dr. Ira Chasnoff of the Children's Research Triangle was obtained. The tool and training are available to obstetrical providers within the state through (SBIRT-HBI) Screening, Brief Intervention, Referral and Treatment -- Healthy Babies Initiative Program for Pregnant Women. From initiation of the Baton Rouge project in May 2005 and including 3 additional pilot sites May 2007 through Sept 30, 2008, the SBIRT program in the 4 regions screened 11,225 pregnant women with 14.9% smoking since aware of pregnancy (23.3% before knew they were pregnant). Of these, referrals for smoking cessation (to FAX-To-Quit proactive tobacco cessation line and/or to 1-800-QUIT-NOW) were made for 606 women.

The Nurse-Family Partnership (NFP) nurse home visitors provide health education on smoking cessation, referrals, education, guidance and support to first time, low income mothers. Louisiana Medicaid included SBIRT screening as a pay for performance initiative for providers, but was not implemented due to funding limitations.

The Partners for Healthy Babies (PHB) social marketing campaign held strategic planning to determine project focus and direction for the next three years. Additional formative research was conducted to assure that the project remain culturally sensitive and competent. The Helpline received 3,172 calls in FY 2008. The PHB website received 16,786 webvisits, 14,105 unique visitors and 47,626 pageviews in CY 2008. MCH continued support for Partners for Healthy Babies, a comprehensive helpline and web site for client information on healthy pregnancy, included focus on smoking cessation in pregnancy. Callers to the Partners helpline are directly referred to the Louisiana Tobacco Quitline (1-800-QUIT-NOW) and receive information on Great

Start, the Perinatal Smoking Cessation Support and Helpline. MCH continued collaborations, support, technical assistance, health information to Healthy Start programs in four regions. MCH continued close collaboration with state March of Dimes CenteringPregnancy programs and for Mom & Baby Mobile Health Vans in New Orleans (primarily Latina) and Lake Charles.

Regional Feto-Infant Mortality Review (FIMR) coordinated grants from Office of Minority Health Access. This included Avoyelles Parish Community Forum for African American Ministerial groups, providing tools and information to faith-based groups in the community about the disparity in fetal and infant mortality rates among African Americans, and risks of tobacco as a negative contributor to fetal demise and infant mortality. FIMR coordinators continued collaboration with Office of Minority Health Access for April Minority Health Awareness. FIMR RN presented to the Association of Women's Health Obstetric & Neonatal Nurses on effects of tobacco use on infant and fetal mortality.

Infrastructure Building
The SBIRT-State Leadership Team included the Department of Health and Hospitals Tobacco Control Program (DHH-TCP) to address smoking cessation in women of reproductive age, as well as Louisiana (LA) ACOG, Planned Parenthood, March of Dimes, LPHI, OMH, OAD and Medicaid. SBIRT hired the former LA ACOG president as state SBIRT Director. Regional coordinators in 5 regions of the state provide treatment resources and coordinate referrals. Regional FIMRs identified tobacco use as a risk factor in poor pregnancy outcomes and began strategies for intervention on a community-wide basis. The SBIRT program provided infrastructure for smoking cessation referral services. Michael Lu, MD, presented "Preconception Strategies including tobacco" at Annual FIMR 2008 conference. MCH collaborated with the March of Dimes (MOD) to begin CenteringPregnancy programs.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide screening and referral for smoking cessation.	X	X		
2. Collaborate with OAD to initiate statewide risk screening.			X	X
3. Provide Smoking cessation programs for pregnant women using fax quit lines and direct counseling.		X		
4. Support Partners for Healthy Babies public information campaign for prenatal health.			X	
5. Provide Fetal and Infant Mortality Reduction Initiative in each region of Louisiana.		X		X
6. Provide Pregnancy Risk Assessment Monitoring System (PRAMS) surveillance system.				X
7. Collaborate with Medicaid to promote and reimburse for statewide risk screening /intervention.			X	X
8. Collaborate with LPHI, DHH-Tobacco Control Program, ACOG, and Medicaid to decrease tobacco use in pregnant women.				X
9. Continue to collaborate with Louisiana Bureau of Minority Affairs to increase awareness of tobacco use, poor birth outcomes and SIDS.				X
10.				

b. Current Activities
Direct and Enabling Services
The 5 regions continue SBIRT services. In January 2009 all OPH nurses and nutritionists working in WIC clinics statewide were trained in SBIRT and most parishes in the state are implementing SBIRT for pregnant WIC clients, adding approximately 20,000 more women. A fax-

referral for hotline assistance and proactive counseling for smoking cessation continues through the DHH-TCP. The Nurse-Family Partnership (NFP) nurse home visitors program continues to provide health education on smoking cessation, referrals, education, guidance and support to first time, low income mothers and has expanded to 50 parishes, covering all regions of the state.

Population-Based Services
The PHB campaign continues web-based and multimedia approaches to promote healthy behaviors during pregnancy.

Infrastructure Building Services
The FIMR Community Action Teams provide local infrastructure to address tobacco use. MCH staff continues education visits to providers and birthing hospitals in all regions. A contract with LPHI provides a MCH coordinator to address a policy focus on tobacco use. All SBIRT coordinators trained in the FAX-to-Quit referral process. Regional resource directories were developed and disseminated.

c. Plan for the Coming Year
Objective: Reduce the percent of women who smoke during the third trimester to 13.5%

Direct Services
The SBIRT-HBI program will continue to expand statewide among private obstetricians and WIC clinics throughout the state. The 4PsPlus tool is being provided to all obstetrical providers, and could potentially screen every pregnant woman in the state for tobacco use. Each region will have HBI coordinators and treatment resources. Epidemiological evaluation of the SBIRT-HBI program will expand.

Health units providing prenatal care will continue to screen for smoking and offer brief intervention and referral for cessation services. MCH will work with Family Planning program to expand screening to this population.

The Nurse-Family Partnership (NFP) nurse home visitors program provides education, counseling and referrals for women in need of these services.

Enabling Services
Ongoing contract with LPHI for an MCH Coordinator will expand collaboration with their extensive smoking prevention efforts. Regional FIMRs will continue to identify maternal tobacco use in infant and fetal death reviews. Client education materials will continue to be provided through SBIRT and DHH-TCP.

The NFP program will continue to address tobacco use during pregnancy, and provide education, counseling and referrals for women in need of these services.

Population-Based Services
The Partners for Healthy Babies program continues to address smoking as a risk factor in pregnancy. State PHB helpline 1800-251-BABY (2229) provides information in Spanish. Client health information is provided in Spanish and English; translation services are provided through language line. LPHI will continue to develop and address smoking prevention media messages (including second hand smoke) for the maternal and child health population. FIMR coordinators continue collaboration with Office of Minority Health Access for April Minority Health Awareness programs among African Americans, faith-based groups, Healthy Start clients, and among Latinas in the New Orleans area.

Infrastructure Building Services
Discussions will continue with Medicaid to reimburse for SBIRT screening and intervention.

Maternal tobacco use will continue to be addressed by regional FIMRs. Cessation awareness campaigns will continue. Regional resource directories and collaboration with DHH-TCP Fax-To-Quit trainings will continue. FIMR regional programs continue to expand into additional parishes.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	7.6	8.8	9.3	8.8	8.8
Annual Indicator	9.6	12.0	5.6	7.7	7.7
Numerator	33	41	18	25	25
Denominator	343717	342664	322799	323073	323073
Data Source					Louisiana Vital Records and Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	8.8	8.8	8.8	8.8	8.8

Notes - 2008
Data is provisional and based upon the 2007.

Notes - 2007
Data is provisional.

Notes - 2006
Data is final.

a. Last Year's Accomplishments
Direct Services
Louisiana Office of Public Health Adolescent School Health Initiative Program (OPH-ASHP) provided direct behavioral health counseling and referral to Louisiana's youth. There were 67 School Based Health Centers (SBHCs), 60 of which were funded by OPH-ASHP. Behavioral health concerns remained among the top 2 most common reasons for visits to SBHCs in both urban and rural areas of Louisiana. OPH-ASHP partially funded the salaries of 3 social workers in the greater New Orleans area. As part of the behavioral health component of its Kellogg grant, the Louisiana Public Health Institute (LPHI) funded a part-time psychiatrist within 4 of the OPH-ASHP SBHCs for the second consecutive year.

The Louisiana Partnership for Youth Suicide Prevention (LPYSP) continued its media campaign by funding busboards, billboards, and movie theater PSAs. Ten busboards ran on New Orleans public buses for 4 months. Billboards were posted in parishes along the roads to Baton Rouge and New Orleans for 1 month for a potential audience exposure of 5 million people. Nine movie theaters in New Orleans, Baton Rouge, Lafayette, and Lake Charles ran PSAs for 1 month for a

potential audience exposure of 666,000.

Infrastructure Building
OPH-ASHP collaborated with the State Office of Mental Health to provide behavioral health counseling, a mechanism for referral, technical assistance and quality assurance evaluations. In partnership with the Children's Health Fund, ASHP coordinated a series of 6 regional workshops on evidence based interventions specifically targeted to SBHC behavioral health professionals and a total of seventy-three SBHC behavioral health providers attended. OPH-ASHP worked closely with the Louisiana Medicaid office to successfully obtain CMS approval to reimburse SBHCs for behavioral health.

Louisiana Public Health Institute (LPHI) was in its second year of a Kellogg Foundation $8.7 million dollar grant award to re-establish SBHCs in the greater New Orleans area. These dollars continued to be used for construction of SBHC facilities and clinical services including expanded behavioral health services in existing SBHCs as well as elementary schools that do not have a SBHC.

The LPYSP sponsored 5 events to raise awareness about the program and suicide prevention. These events included a walk, a rally, a contest for school students, a conference and a coalition summit. Nine hundred fifteen people participated in these 5
events. LPYSP continued to build support for the program through presentations at national, regional, and state conferences and meetings. LPYSP has established partnerships and linkages with 114 agencies nationwide. The program launched a website with access to media tool kits, a resource directory and other supports.

Five-day Applied Suicide Intervention Skills Training (ASIST) and ASIST Training for Trainers (T4T) were held for 15 trainers. These newly trained trainers provided 24 ASIST trainings. The results of the first year's initiatives were analyzed to further refine approaches to youth suicide prevention. In addition, trainers provided training within the Youth Correctional System. Additionally, LPYSP conducted Suicide 101 workshops and Safe Talk sessions with an approximate total of 500 participants.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide mental health counseling and referrals through School-Based Health Centers.	X			
2. Participate as a member of the Louisiana Youth Suicide Prevention Task Force.				X
3. Facilitate youth suicide awareness activities with the Foster Care and Juvenile Justice systems in Louisiana.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Infrastructure Building
OPH-ASHP funded 6 planning grants to begin the process of establishing 6 new SBHCs. Additionally, OPH-ASHP is collaborating with the Office of Mental Health (OMH), the Office of

Addictive Disorders (OAD) and the Department of Education (DOE) to develop strategies for expanding behavioral health in schools without SBHCs.

LPYSP regional coalitions bolster individual agencies' efforts in the fight against youth suicide with technical assistance and access to resource materials. LPYSP assists regional efforts to develop goals and resources, and work towards specific outputs, including toolkits, resource guides, and school prevention plans based on regional culture and needs.

c. Plan for the Coming Year
Objective: Decrease the rate of suicide deaths among youths 15-19 to 8.8 (per 100,000).

Direct Services
Because of economic conditions, existing SBHCs will experience a 4% decrease to their current site budget, resulting in a total ASHP budget reduction of $328,979 in FY09-10. ASHP does not anticipate program expansion given this fiscal reality; however, current levels of behavioral health services will be maintained. Although LPHI has requested a rollover of unspent Kellogg dollars into a 4th year, these dollars will be used for site development at 5 sites and continued funding of the psychiatrist is in question.

Infrastructure Building Services
ASHP will continue to develop strategies to expand school-based behavioral health service and to work with Medicaid to develop a mechanism for SBHC reimbursement for behavioral health services.

LPYSP will be in the third year of its grant and will continue to provide general awareness and education, gatekeeper training, peer support, youth screening, infrastructure development and coalition building. Similar media campaigns, awareness events, and training sessions are being planned.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	85.2	84.7	84.8	90	90
Annual Indicator	86.0	86.8	88.4	87.7	87.7
Numerator	1146	1153	1194	1243	1243
Denominator	1333	1328	1350	1417	1417
Data Source					Louisiana Vital Records and Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	90	90	90	90

Notes - 2008
Data is provisional and based upon the 2007 data.

Notes - 2007
Data is provisional.

Notes - 2006
Data is final. Calculation of the percent of VLBW births born in Level III facilities requires an accurate list of hospitals with corresponding neonatal facility level codes. This list must be updated periodically as facility levels may change over time.

a. Last Year's Accomplishments
The percent of very low birth weight (VLBW) births delivered at high-risk facilities has been steadily increasing. In 2006, 86.1% of such births occurred in the appropriate facility. For 2007, 88.4% of VLBW birth occurred in high-risk facilities. Preliminary 2007 data is 87.8%.

Infrastructure Building Services
The Louisiana Perinatal Commission formulates a State Perinatal Plan, adopting guidelines for maternal and neonatal care and requiring a concordance in level between obstetrical and neonatal services, i.e. for a neonatal Level III facility, obstetrical services should be of Level III as well. The Louisiana Office of Public Health (OPH) continued to provide epidemiological data analysis updates through presentations at Louisiana Perinatal Commission and regional Feto-Infant Mortality Review (FIMR) meetings. The MCH Program Director and the MCH Maternity Medical Director, as members of the Perinatal Commission, and the MCH Epidemiology (EPI) group, served as a resource for data and information to the Perinatal Commission regarding VLBW and other relevant MCH issues. The EPI group updated information on VLBW deliveries by level of delivery hospital.

The lead MCH epidemiologist, Maternity Medical Director, and Maternity Nurse Coordinator, continued to provide coordination and shape to the Fetal Infant Mortality Reduction Initiative through regional FIMR meetings and the 6th annual statewide Louisiana FIMR network meeting. During 2006-07, the Louisiana FIMR network reviewed perinatal deaths in eight of the nine administrative regions to help identify important issues surrounding these deaths. The New Orleans area FIMR has resumed reviews. While the FIMR groups are evaluating contributors to fetal and infant deaths, their work focuses heavily on the high preterm births and VLBW issues in our state.

A Screening, Brief Intervention, Referral and Treatment (SBIRT) program was expanded, in conjunction with other state partners to screen/ treat pregnant women for substance use, tobacco use, alcohol use, depression, and domestic violence. The tool for this program is the 4Ps Plus developed by the National Children's Triangle of Chicago. The state group implementing the program is MCH, Louisiana Section of American College of Obstetricians and Gynecologists (ACOG), state Office of Addictive Disorders (OAD), and state Office of Mental Health (OMH). The MCH Epidemiology group provided technical assistance on development of an evaluation plan. It is hoped that with improved screening and treatment, VLBW births may decrease. State SBIRT and regional SBIRT coordinators have been identified.

Perinatal Periods of Risk methodology, an analysis of infant mortality according to birth weight and age at death, was an important component of the analyses presented to assist with the needs assessment. Data indicated that VLBW births accounted for nearly half of the total feto-infant mortality rate, indicating that VLBW births and prematurity are important factors for Louisiana.

MCH provided technical assistance in continuation of CenteringPregnancy groups, which may help address prematurity and VLBW. MCH supported March of Dimes (MOD) funded mobile

maternity clinics in underserved areas of New Orleans, especially in the Latina population.

The 6th Annual FIMR Conference focus was preconception and interconception care and its importance in prevention of prematurity.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Study distribution of VLBW infants born at all levels in the state, by region & parish.				X
2. Perform multivariate analysis of risk factors associated with mortality by hospital level and birth weight.				X
3. Update electronic MCH Data Book.				X
4. Support MCH grants for the perinatal mortality reduction initiative.				X
5. Support and promote regional Feto-Infant Mortality Reviews (FIMRs).				X
6. Disseminate analysis findings to all regional FIMRs and Perinatal Commission.				X
7. Continue collaboration with March of Dimes and other community based groups through FIMRs.				X
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services

The State Perinatal Plan remains to guide appropriate levels of maternal and neonatal care. MCH continues to work with the Commission in monitoring VLBW births.

MCH continues to support the regional FIMR groups. A FIMR Coordinator will be hired for the Houma region, completing teams in all 9 regions of the state. The FIMR review teams regularly provide recommendations to the Community Action Teams (CATs). The CATs continue to support measures to decrease the number of VLBW births and to increase the VLBW infants being born at facilities with the proper level of care. With African Americans having a significant disparity in VLBW births, this disparity is being targeted throughout the state.

The provider based SBIRT screening / treatment program for pregnant women started in 3 regions, continued in the Baton Rouge, is expanding in WIC clinics throughout the state. Resource guides for SBIRT referrals have been completed. Medicaid considered beginning reimbursement for utilization of SBIRT screening / intervention in pregnancy, but funding issue prevented this action. MCH supports the CenteringPregnancy groups, to help address prematurity and VLBW. MCH assists with the MOD funded prenatal mobile vans that provide care, especially in the New Orleans area.

c. Plan for the Coming Year

Objective: The proportion of very low birth weight infants delivered at facilities for high-risk deliveries and neonates will be at least 90%.

Infrastructure Building Services

Updates to the regional FIMR groups on risk factors associated with VLBW births at lower level facilities will occur and additional vital statistics analyses will continue to be performed.

Regional FIMR groups will continue to monitor factors associated with VLBW deaths through case reviews. Opportunity for community action where appropriate will be carried out through FIMR CATs. Plans are being made for a statewide MCH Summit for November 2009.

The provider based SBIRT screening / treatment program for pregnant women, now named the SBIRT -Healthy Baby Initiative (HBI), will be expanded to all regions of the state. WIC clinics screening will expand. With OAD assistance, regional coordinators will be in place in all regions of the state to assist providers in brief interventions, referrals and treatment. Each region will update the resource guide for referrals and treatment, which is being made available to all interested providers. Plans are in place to evaluate SBIRT program effectiveness. Discussions are ongoing with state Medicaid for reimbursement for utilization of SBIRT screening in pregnancy.

The OPH maternity program, in collaboration with regional FIMRs, will continue to refine disaster plans that are in place for pregnant women and newborns. This includes plans for evacuation of inpatients and care for evacuees that may be pregnant. The Partners for Healthy Babies hotline is monitored and updated to provide accurate regional information.

MCH anticipates further strengthening of collaborations. This includes March of Dimes, Louisiana MCH Coalition, CenteringPregnancy groups, mobile prenatal vans, other state agencies, provider groups, as well as other community based organizations. Through these collaborations, we hope to have a greater impact on the many factors that contribute to VLBW births, and where these births occur.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	84.5	85	86	87	88
Annual Indicator	85.5	87.1	87.1	86.9	86.9
Numerator	55383	52290	54696	56846	56846
Denominator	64770	60058	62820	65438	65438
Data Source					Louisiana Vital Records and Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	89	90	91	91	91

Notes - 2008
Data is provisional and based upon the 2007.

Notes - 2007
Data is provisional.

Notes - 2006
Data is final

a. Last Year's Accomplishments
Early prenatal care has increased from 82.3% in 1998 to 87.1% in 2006. Louisiana ranks favorably among all the states. The preliminary 2007 rate is 86.9%

Direct Services
For FFY 2008, comprehensive prenatal care services were provided to 1,490 pregnant women through 5,625 visits via the statewide network of parish health units (PHUs). Over 14,956 pregnancy tests were performed. WIC benefits and health education were provided to 32,602 pregnant, post-partum, and breastfeeding women through the parish health units. In medically underserved areas, contractors provided prenatal services to 580 low- income women, with approximately 2,673 visits.

MCH collaborated with the March of Dimes (MOD) to begin prenatal care by mobile health vans in southern Louisiana. Over 200 women received prenatal care on the mobile units, to primarily a hard to reach populations. Collaboration with MOD also resulted in CenteringPregnancy groups in Monroe and New Orleans regions.

Enabling Services
The Nurse Family Partnership (NFP) provided home visits and case management to 1,943 first-time mothers for a total of 18,723 visits. Home visits are provided during pregnancy and continue until the child's second birthday.

MCH funded an outreach/case management program in the Northeast Louisiana Healthy Start program that provided services to 60 pregnant women. MCH provided funding to Baton Rouge Healthy Start, which provided prenatal support and educational services to 3,829 clients, with 2,046 home visits, and 1,532 referrals to community agencies.

Population-Based Services
The Partners for Healthy Babies (PHB) social marketing campaign held a strategic planning to determine project focus and direction for the next three years. Additional formative research was conducted to assure that the project remain culturally sensitive and competent. The Helpline received approximately 3,172 calls in FY 2008. The PHB website received 16,786 webvisits, 14,105 unique visitors and 47,626 pageviews in CY 2008.

Infrastructure Building Services
Technical assistance was provided in all regions participating in prenatal services. All sites were found to provide adequate services; problematic issues were addressed through follow-up. Parishes in the lowest quartile for late entry and inadequate prenatal care were identified. This information was provided to regional Infant Mortality Reduction Initiative coordinators and utilized in ongoing regional needs assessment and strategic planning. Since Hurricane Katrina, there has been a significant influx of Hispanic women into the New Orleans area. Access to care for this group of Latina women has proven difficult. MCH played an important role in promoting access to care for these women. The March of Dimes has provided mobile clinics and funded Centering Pregnancy programs in south Louisiana, targeting Latina women in the New Orleans area. MCH worked closely with these programs.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provision of prenatal services via network of parish health units and contract agencies.	X			

2. Provide targeted case management programs, such as Nurse Family Partnership.		X		
3. Link women to prenatal care via the Partners for Healthy Babies social marketing project Helpline.			X	
4. Collect and analyze PRAMS data to provide program direction.				X
5. Provide Quality Assurance and program monitoring of all MCH funded prenatal services.				X
6. Support Regional Infant Mortality Reduction infrastructure, at each regional level, using Coordinators.				X
7. Work with Medicaid to ensure access to early and comprehensive prenatal care services.				X
8.				
9.				
10.				

b. Current Activities

Direct and Enabling Services

In regions with provider shortages, MCH provides services through the PHUs and contract agencies. NFP continues to provide case management and home visiting. Prenatal clinics, outreach and case management are ongoing in Shreveport, Baton Rouge, Northeast Delta Region, and New Orleans with MCH support.

Population-Based Services

PHB has fine-tuned its branding and is incorporating preconception promotion in its messaging and strategies. The website is being reorganized for both providers and target audience. PHB continues to use a mix of communication strategies, including public relations. The FIMR program is supported by PHB via public relations assistance, materials and consultation. A Health Education/Communication Functional Group has been established within MCH to provide PR support, health education resources, and listings of local community resources to MCH stakeholders.

Infrastructure Building Services

The prenatal infrastructure destroyed after the 2005 hurricanes has now been mostly rebuilt. MCH continues to work to expand access to services, especially in south Louisiana and rural areas.

c. Plan for the Coming Year

Objective: Increase the proportion of infants born to pregnant women receiving prenatal care beginning in the first trimester to 90%.

Direct Services

In areas with poor infrastructure, MCH will continue to support access to care through PHUs, contracts, and Healthy Start initiatives. Parishes in the lowest quartile for late and inadequate prenatal care will continue to be identified. Regional IMRI Community Action Teams will be alerted so that public and private providers can work together to improve entry to prenatal care.

Enabling Services

NFP teams continue to provide services and will expand within the next year. Perinatal depression services are provided in the New Orleans area through a HRSA grant.

Population-Based Services

Partners for Healthy Babies (PHB) will continue to work to reach out to high-risk areas of the state, including the private provider community. PHB will conduct extensive media messaging,

public relations, and other activities in these areas. Continued coordination is planned with the LaMOMS program to provide outreach to and recruitment of pregnant women. PHB will continue to train and support the regional FIMR Coordinators in public relations efforts/activities.

Infrastructure Building Services
The Louisiana Fetal and Infant Mortality Reduction Initiative (FIMRI) Community Action Teams (CATs) are being encouraged to expand their role to serve as umbrella organization for MCH issues. Regional FIMRs are expanding focus on disparity, prematurity, and infant mortality in strategic planning for the CATs. The Maternity Medical Director and Nurse Consultant are continuing the statewide visits to providers and hospitals of high-risk obstetrical populations.

The SBIRT Healthy Baby Initiative, providing screening and treatment for women with substance abuse problems, depression, and domestic violence will expand, in conjunction with other state partners. Screening is being implemented in WIC clinics statewide. Collaboration with Medicaid includes substance abuse screening, smoking cessation, and periodontal care in pregnancy.

Continued collaboration with Partners for Healthy Babies will target both patients and providers on the need for early entry into care. Parishes with poor performance on early and adequate prenatal care will be identified, and given targeted technical assistance.

MCH will continue to monitor quality assurance systems at all levels. PRAMS data is being analyzed and the final report will be widely distributed to stakeholders and made available through the Internet.

D. State Performance Measures

State Performance Measure 1: *Percent of all children and adolescents enrolled in public schools in Louisiana that have access to school-based health center services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	6.9	6.9	7.1	7.3	7.5
Annual Indicator	7.0	6.7	7.4	7.3	8.1
Numerator	49464	46868	45305	49454	56192
Denominator	704129	700534	612468	681753	690340
Data Source					Adolescent School Health Initiative Annual Report
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	7.7	8	8	8.3	8.5

a. Last Year's Accomplishments
Direct Services
The number of students with access to Office of Public Health (OPH) Adolescent School Health Program (ASHP) school-based health centers (SBHCs) was 56,192 or 8% of the approximate 690,340 students enrolled in public schools. OPH-ASHP more than met its goal of 7.5% of students enrolled. There were 51 full-time and 9 part-time, OPH-funded SBHCs, for a total of 60 ASHP sites. Of these, 2 full-time SBHCs closed in early September 2008 -- 1 site because of extensive hurricane damage and 1 because of recurring problems with mold - leaving 58

operational ASHP sites. Additionally, there were 7 non-OPH funded SBHCs.

The OPH New Orleans Lab reopened during the reporting period and is accepting labs from area SBHCs. SBHCs continue to screen high-risk students for Type 2 diabetes. Of 925 screens performed, 1.8% of tests were positive. All children with positive tests were referred for further evaluation and management.

Infrastructure Building Services
The legislature appropriated $230,375 in FY07-08 to fund 6 planning grants and $600,000 for construction of SBHCs in the New Orleans Recovery School District (RSD). During Year 3 of its Kellogg grant, Louisiana Public Health Institute (LPHI) funded construction of 2 facilities and operational costs for 1 SBHC. LPHI maintained funding for behavioral health services in previously funded sites. In Year 1 of its Robert Wood Johnson (RWJ) multi-year grant, LPHI began a pilot of an Electronic Medical Record (EMR) in 5 SBHCs.

Because most SBHCs are SCHIP/Medicaid application centers, SBHC staff conducted outreach that resulted in decreasing the percentage of uninsured students enrolled in SBHCs from 8% in 2006-2007 to 7% in 2007-2008.

OPH Immunization Program recognized SBHCs as "Health Unit-like" facilities, enhancing the SBHCs' ability to provide needed vaccines to all students.

Seven SBHC sponsors underwent a Continuous Quality Improvement (CQI) review, focusing on core sentinel conditions, including comprehensive physical exams, immunization rates, asthma management, data management, academic achievement, and health insurance enrollment. Random chart audits showed up-to-date immunization increased from 61% at the beginning of the school year to 77% by year end. For students receiving a comprehensive exam, 80% of audited charts documented STD screening, 100% showed tobacco screening and, if necessary, counseling to address tobacco use, and nearly 90% contained a yearly height, weight, blood pressure and BMI.

ASHP continued its Best Practices Program. HIV/AIDS screening was added in 2007-2008 and ASHP collaborated with the OPH HIV/AIDS program to begin SBHC staff training for onsite rapid HIV testing. STD testing became a required service for sexually active or symptomatic 9th graders and above, enrolled in SBHCs.

ASHP conducted technical assistance workshops and conference calls for the 6 planning grantees. In partnership with the Children's Health Fund, ASHP coordinated a series of 6 regional workshops and peer consultation groups on evidence based interventions targeted specifically to SBHC behavioral health professionals. A total of 73 SBHC providers attended.

Louisiana (LA) Medicaid obtained CMS approval to reimburse SBHCs for behavioral health; however, no mechanism to implement reimbursement was established. ASHP continued to collaborate with the state Department of Education (DOE) on school health related Programs, especially coordinated school health initiatives. ASHP collaborated with the Louisiana Obesity Council on prevention and intervention programs for school age children and jointly submitted and received approval for a grant proposal to Blue Cross/Blue Shield of LA Foundation for a project to diagnose and treat hypertension in SBHCs. In collaboration with Medicaid, University of Louisiana at Monroe, & LPHI, ASHP submitted an IRB to study claims data comparing asthmatics with access to an SBHC to those without.
An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. SBHCs provide comprehensive preventive and primary physical and mental health services.	X	X		
2. Set policies and standards for SBHC operation.				X
3. Provide technical assistance, monitoring, continuous quality improvement in SBHCs.	X			X
4. Work to raise level of funding to support SBHC operation.				X
5. Publish Louisiana School-Based Health Centers Annual Services Report.				X
6. Collaborate with various entities to promote coordinated school health model.				X
7. Provide resources to policy makers, educators, service providers, etc. on school health issues.				X
8. Generate statistical reports on service delivery in Louisiana SBHCs.				X
9.				
10.				

b. Current Activities

Direct Services

ASHP awarded planning grants to 6 SBHC sponsors and provides ongoing technical assistance to ensure readiness to become fully operational in FY09-10. ASHP is supporting and assisting the 2 closed SBHCs in their efforts to reopen as soon as possible. One RSD site completed construction and started providing services in March 2009. Another RSD site will be completed by summer 2009. ASHP continues to support LPHI's work to introduce EMRs into SBHCs. ASHP is assisting with the interface between the adopted EMR and ASHPs Clinical Fusion data collection system, as well as the EMR and LINKS, LA's Immunization Network.

Infrastructure Building

ASHP holds periodic conference calls with 4 subcommittees comprised of SBHC representatives to get input on Best Practices, resulting in a recommendation that STD testing be a required service for sexually active or symptomatic 5th through 8th graders enrolled in SBHCs. Six SBHCs underwent on-site CQI review.

ASHP continues to work with Louisiana Medicaid to implement a reimbursement procedure for behavioral health services in SBHCs. With Children's Health Fund, ASHP sponsors a series of regional behavioral health workshops.

ASHP collaborates with DOE on coordinated school health initiatives and with the LA Obesity Council. The Asthma Study IRB was approved and data collection has started.

c. Plan for the Coming Year

Objective: Maintain the percent of all children and adolescents enrolled in public schools that have access to school-based health centers at a level between 7.7% and 8%.

Because of economic conditions, existing SBHCs will experience a 4% decrease to their current site budget, resulting in a total ASHP budget reduction of $328,979 in FY09-10. ASHP will not receive $1 million in additional monies requested to allow the 6 FY08-09 planning grant sites to become operational in FY09-10. ASHP does not anticipate program expansion given this fiscal reality. LPHI has requested a rollover of unspent Kellogg dollars into a 4th year. If approved, these dollars will be used for site development at 5 sites. LPHI will use Year 2 RWJ funding to expand EMR use to 5 or 6 additional sites, making the total 10 -- 12 sites with EMR.

Direct Services

The ASHP Program will continue to fund, provide technical assistance, and monitor the state-

funded SBHCs. Current services provided will continue to be available to students served by existing SBHCs. Required STD testing of enrolled students grades 5 through 8 who are sexually active or symptomatic will begin. The Hypertension grant will begin implementation in June 2009.

Infrastructure Building Services
ASHP will engage in the MCH Needs Assessment process with other LA MCHB-funded programs. ASHP will continue to develop strategies to expand school-based behavioral health services and to work with Medicaid to develop a mechanism for SBHC reimbursement for behavioral health services. The DOE and LA Obesity Council will partner with ASHP on coordinated school health and obesity issues. The Asthma Study will continue.

ASHP plans to conduct 11 CQI site visits in 2009-2010. ASHP, in conjunction with its subcommittees, will revise its Performance Effectiveness Review Tool (PERT) to include quality improvement measures recently recommended by the National Assembly on School-Based Health Care (NASBHC).

State Performance Measure 2: *Percent of women in need of family planning services who have received such services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	23.5	24	24.5	25	24.5
Annual Indicator	25.4	20.4	17.7	18.8	19.1
Numerator	77228	62142	53975	57124	58158
Denominator	304270	304270	304270	304270	304270
Data Source					Louisiana Family Planning Program
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	25	25.5	26	26.5	27

Notes - 2008
Data is for the calendar year.

Notes - 2007
Data is for the calendar year.

Notes - 2006
Data is for the calendar year.

a. Last Year's Accomplishments
The number of female clients that received comprehensive reproductive health care services through the Family Planning Program (FPP) increased by almost 2% to 58,158 in 2008 from 57,214 in 2007. An estimated 515,960 women in Louisiana are in need of publicly funded family planning services. Of these, 304,270 women have incomes below 250% of the federal poverty level. Approximately 90% of female clients receiving such services were 100% and below the federal poverty level.

In September 2008, Louisiana experienced Hurricanes Gustav and Ike. Several health units in Regions 3 and 5 were affected; however, clients were accommodated at surrounding health units.

With the exception of Cameron Parish Health Unit in Region 5, all health units are operational.

Direct Services
The Office of Public Health, Family Planning Program (FPP) received supplemental funding from Title V and provided comprehensive medical, educational, nutritional, psychosocial, and reproductive health care services to women and men. The FPP provided services in 69 state-administered facilities and 6 contract sites. The FPP also collaborated with providers who provided services during non traditional work hours, specifically evenings and Saturdays.

On July 1, 2008, the FPP, with funding provided by the Maternal and Child Health Program, began offering folic acid awareness educational information and materials, and supplements to every female FPP client capable of becoming pregnant. The goal of the project was to teach all female clients the importance of getting enough folic acid every day. From July 2008 to December, 9,094 female clients received the folic acid vitamin. As of December 31, 2008, a total of 10,809 female clients received folic acid vitamins, whereas in 2007, 498 female clients received folic acid vitamins.

Enabling Services
October 2006, a Research and Demonstration Waiver under Section 1115 of the Social Security Act was granted to the Louisiana Department of Health and Hospitals to expand eligibility for family planning services to women ages 19-44, with family incomes up to 200% of the federal poverty level. The FPP participated in the Family Planning Waiver Program, entitled Take Charge. Take Charge Coordinators from each region facilitated outreach activities to women 19-44. The annual Take Charge Statewide meeting was held in August 2008 to increase efforts for targeting eligible women. As of September 2008, 83,807 applications were received, 68,239 applications were approved and 50,945 women were enrolled in the Family Planning Medicaid Waiver Program.

Population Based
New Orleans Regional nurses completed a Spanish course, which enabled them to provide better assistance to the increasing Hispanic population. AT&T Language Line posters and Spanish educational materials were distributed to all family planning service sites to better serve the Limited English Proficiency (LEP) clients. In addition, client consent forms were translated to Spanish and Vietnamese. A Health Education and Outreach Plan was developed to assist staff with conducting outreach activities and help improve services to the changing population.

Infrastructure Building Services
While collaboratively working with the Center for Health Training, the FPP conducted training activities on topics including new and emerging contraception, preconception care and counseling, family involvement in reproductive health, and intimate partner violence. The FPP also promoted folic acid to women of childbearing age to help prevent neural tube defects.

To assess the need of availability of services for women in need of family planning services, the Mystery Caller Quality Assurance Study was conducted. The study identified barriers to family planning services and training needs. A corrective action plan was developed from the findings.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provision of family planning services throughout the state in over 69 sites.	X	X		
2. Improving efficiency and quality of care in state-run and contract service sites.				X
3. Provision of community outreach and education to women in need of family planning services.		X		

4. Training of family planning service providers on topics that enhance family planning services.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct Services

The FPP continues to increase the number of women served. The program also continues to identify providers who are able to provide services during evenings and Saturday hours, and is actively seeking additional contract service sites.

Enabling Services

The FPP have increased access to family planning services through the Family Planning Medicaid Waiver Program, Take Charge. The Take Charge Coordinators conduct outreach in the community as well as in the Parish Health Units to enroll women ages 19-44 in the Waiver Program.

Population Based

In an effort to strengthen FP clinics' ability to address the needs of clients from diverse populations, the program distributes reproductive health education material that is culturally and language appropriate. To help structure outreach activities and direct services where needed most, the Health Education and Outreach Plan is being implemented in all service sites.

Infrastructure Building Services

In working closely with the Center for Health Training, the FPP continues to develop training activities and events focusing on adolescent education and counseling, family involvement, infant adoption training initiatives, and male reproductive services and communication.

The FPP currently supplies all female clients who are of childbearing age a one year supply of folic acid vitamins and provides educational materials to the community.

c. Plan for the Coming Year

Objective: Increase to 20% the proportion of women in need of family planning services who have received such services.

Direct Services

The FPP will continue to monitor family planning services, identify regional and/or statewide trends, and develop a corrective action plan to improve program performance. The FPP will persist in expanding services to increase the program's ability to serve the women in need of such services.

Enabling Services

The FPP will continue to work with the Medicaid program to increase enrollment in the Take Charge Waiver Program. Take Charge Coordinators will continue to work in conjunction with the Medicaid Coordinators, attending clinics and conducting outreach activities. Take Charge applications and brochures will continue to be distributed at outreach events throughout the state, at the local Medicaid offices, and available on line.

The FPP will increase collaboration efforts with the HIV Program in providing counseling and testing, available resources, and region-specific HIV treatment sites to family planning clients. In

colloboration with the STD Program, the FPP will support and promote routine screening of women to reduce chlamydia prevalence and pelvic inflammatory disease (PID) incidence in women through the Infertility Prevention Program.

Population Based
The Health Education and Outreach Plan will continually undergo updates to include the changing needs of the community. Appropriate educational materials will be updated and distributed following approval from the FPP Advisory Board Information and Education Subcommittee. Additional family planning materials will be translated in applicable languages and made available to LEP clients.

Infrastructure Building Services
Collaboratively working with the Center for Health Training, the FPP will continue to provide training activities to improve the quality of care and increase the program's capacity to provide services. The program will disseminate the annual training needs assessment and develop a training plan based on the needs assessment results. Future topics will include human papillomavirus (HPV), new and emerging contraceptive methods, and managing abnormal pap smears.

The FPP will increase women's health needs by ensuring all female clients capable of becoming pregnant receive folic acid education and supplements.

State Performance Measure 3: *Rate of children (per 1,000) under 18 who have been abused or neglected.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	7.7	7.6	8.7	9	9
Annual Indicator	9.3	9.2	9.9	9.6	8.4
Numerator	10832	10815	10525	10360	9276
Denominator	1169276	1169276	1066952	1079560	1107973
Data Source					LA Department of Social Services
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	8.3	8.2	8.1	8	7.9

Notes - 2008
Numerator is based on Office of Community Services reports of unduplicated number of children 17 years of age and younger who experienced abuse and neglect, CY 2008. Denominator is the number of children in Louisiana ages 0-17 years, using July 2008 census data.

Notes - 2007
Numerator is based on Office of Community Services reports of unduplicated number of children 17 years of age and younger who experienced abuse and neglect, CY 2007. Denominator is the number of children in Louisiana ages 0-17 years, using July 200 7 census data.

Notes - 2006

Numerator is based on Office of Community Services reports of unduplicated number of children 17 years of age and younger who experienced abuse and neglect, CY 2006. Denominator is the number of children in Louisiana ages 0-17 years, using July 2005 census data.

a. Last Year's Accomplishments

During 2008, there were 18,994 validated allegations of abuse and neglect in children under age 18. The unduplicated count of 9,276 victims yields a rate of 8.4 victims per 1,000 children, a decrease from last year.

Direct Services

Public health staff provide parenting education materials and counseling to families. Public Health Nurses (PHNs) were available, upon referral only, to perform health assessments of children suspected of medical neglect from families under OCS (Office of Community Services) investigation. One assessment was performed between October 2007 and September 2008.

MCH contracted with Children's Bureau of New Orleans' Project Last to provide clinical grief/trauma assessments, home, school-based, family and group therapy, and crisis intervention services. Between October 2007 and September 2008, Project LAST served153 new families (276 adults and 192 children) impacted by violence (abuse, homicide, other), non-criminal deaths, Katrina-related traumas, SIDS, and other sudden unexpected infant deaths. Crisis intervention services were provided to 355 students and adults at schools which experienced loss of life and/or violence.

Enabling Services

Between October 2007 and September 2008, the Nurse-Family Partnership (NFP) program added an OPH team in Region 6 and one in Region 7. NFP expanded the Jefferson and St. Tammany Parish programs to full teams. The 13 NFP teams served a total of 1943 families in 41 parishes. Clinical trials and longitudinal studies show NFP significantly reduces validated child abuse and neglect.

Population-Based Services

Approximately 65,027 Happy and Healthy Kids parenting newsletters were distributed to parents via parish health units, provider offices, health fairs, and vital records complimentary birth certificates. The system to monitor/track distribution efforts through vendor reports, newsletter addendum, and annual reports was implemented. The process evaluation was completed and results analyzed.

Infrastructure Building Services

Eighty one PHNs, social workers, and other professionals were trained in infant mental health (IMH). This 36-hour curriculum provides information and skills regarding early social-emotional development and parenting to improve identification of risk factors for child abuse and neglect, and cultural and ethnic influences on parenting. Availability of this program was extended to other state programs that serve infants and young children, including Early Steps, child protection, and Early Childhood Supports and Services (ECSS). An additional 123 Head Start staff, 50 public health social workers received a brief overview of infant mental health. Training on child care consultation was provided, and members of the police and Region 1 crisis team members received training on perinatal depression. Trainings to Orleans Parish Healthy Start staff included overview and assessment of perinatal depression, IMH, and client comfort. 50 Healthy Start staff in Region 8 also received awareness training on perinatal depression.

MCH managed the Louisiana Child Death Review, which includes state and local panels. The MCH Child Safety Coordinators continued to serve as the local Child Death Review Panel coordinators. The State and the local CDRP's reviewed all unexpected deaths of children under the age of 15 years. In 2008, at least 121 unexpected infant and child deaths were reviewed.

The Oral Health Program monitored the number of abuse and neglect cases reported by dental

professionals; there were eighteen abuse and/or neglect cases in calendar year 2008; eight cases were validated, eight were not validated, and two cases are pending.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Child Health Record psychosocial assessment for children 0-6 in health units.	X			
2. Home visitation services for low-income families.		X		
3. Infant mental health services to low-income families through Best Start and NFP programs.		X		
4. Statewide training in infant mental health, perinatal depression, and related issues to public health nurses and other early childhood professionals.				X
5. Collection, analysis, and assessment of unexpected child deaths by the Child Death Review Panel.				X
6. Monitoring of child abuse and neglect referrals by dental professionals.				X
7. Public education through new parent's newsletter, Happy and Healthy Kids.				X
8. Targeted psycho-educational services for at-risk mothers.			X	
9. Targeted psycho-educational and support services for at-risk children and their families.		X		
10.				

b. Current Activities

Population-based services

1916 new subscribers enrolled for the Happy and Healthy Kids parenting newsletter between October 2008-May 2009. Distribution monitoring occurs via vendor reports and newsletter addendums.

Direct Services

Project Last in New Orleans provides clinical assessments, and home, school-based, family and group therapies to families who experience violence, loss, Katrina-related trauma, and sudden unexpected infant deaths.

Enabling Services

The NFP program added a full team in Region 2 and a partial team in Region 9; the program serves 52 parishes. Mental health consultation was provided to six NFP teams. Best Start served 98 pregnant women and women with infants in Region 5; the Region 1 Perinatal Depression Program served 49 women.

Infrastructure Building Services

58 nurses and other professionals received the 36-hour Infant Mental Health training. The NFP Annual Conference included presentations on perinatal depression (PD), PTSD, and cultural issues. 80 professionals were trained on diagnosis and treatment of PD, and 50 attended a workshop on interpersonal therapy. Over 320 nurses, nutrition professionals, mental health clinicians and substance abuse counselors received basic training on PD.

The State and Local Child Death Review Panels (CDRP) review unexpected deaths of children under age 15. MCH has a new State CDRP Coordinator; the MCH Child Safety Coordinators coordinate the local CDRP's. More than 48 infant/child death cases have been reviewed this year.

c. Plan for the Coming Year
Objective: To reduce the rate of children (per 1,000) under 18 who have been abused or neglected to 8.3.

Direct Services and Enabling Services
Expansion of the NFP services in Region 2 and Region 9 is planned for the coming year. Currently, 7 of the 9 regions have Medicaid funding; DSS-TANF also is providing funding for NFP, and MCH-OPH is working closely with Medicaid and TANF to ensure coverage. Grant support and legislative advocacy for state general funds are being pursued by community entities to further strengthen and expand NFP. The Best Start program will continue to serve Region 5. The Perinatal Depression Program in Region 1 will offer assessment and treatment of perinatal depression and other mental health needs to clients served in Healthy Start and Orleans NFP programs. Grief/trauma services to children and families in Orleans and Jefferson Parish will be provided via the Children's Bureau's Project Last program. Children's Bureau also provides education and support to families who experience SUID or other unexpected infant deaths.

Population-Based Services
MCH will continue to distribute the multicultural parenting newsletter, Happy and Healthy Kids, which focus on psychosocial development and positive parenting. Issues of the newsletter will continue to be distributed through public health units, provider offices, health fairs, and with the complimentary birth certificate provided to families by Vital Records. Evaluation results will be used to guide future distribution mechanisms and operations.

The Oral Health Program will educate oral health professionals on reporting abuse and neglect through the Louisiana Dental Association Journal and the Louisiana Dental Hygiene Association Newsletter.

Infrastructure Building Services
Infant Mental Health trainings will be offered bi-annually. In addition, introductory trainings on infant mental health and maternal depression will be provided to other state and nonprofit agencies. The purpose is to increase awareness of these issues and facilitate appropriate referrals. Culture-specific issues are addressed in these trainings.

The State Child Death Review will continue reviews of child deaths under 15 years of age, including sudden unexplained infant deaths; support the local CDR panels; initiate new and improve current injury prevention interventions at the state and local levels; implement the CDC web-based case reporting system; provide trainings on effective infant and child death investigations to CDRP and FIMR coordinators, coroners/medical examiners, death scene investigators, physicians, nurses, first responders, and others involved in the investigative process.

State Performance Measure 4: *Percent of CSHS patients with case management (follow-up visits) from a nurse, social worker, or nutritionist.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	55	57	64	66	85
Annual Indicator	51.5	62.8	81.6	72.6	78.6
Numerator	2760	3287	3965	3370	3473
Denominator	5363	5236	4858	4645	4421
Data Source					Louisiana CSHS Program

Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	85	85	85	85	85

a. Last Year's Accomplishments

Direct and Enabling Services

Staff continued to provide case management (follow-up services) to CSHCN and their families in CSHS direct service clinics in all 9 regions of the state. 78.56 % of CSHCN in CSHS clinics received follow-up services from a nurse, social worker or nutritionist. Staff linked 99.6% of CSHCN who attended CSHS clinics statewide to Medical Homes (MHs). MHs were sent a copy of the CSHS clinic notes to promote continuity of care. Children ages 14 -- 18 were screened for transition service needs, with staff providing services for all identified needs. Assistance was provided to families who re-located after Hurricanes Gustav and Ike. As families returned to their homes in the hurricane affected areas, staff worked to make linkages to all needed services. One region of the state (New Orleans area) continued the pilot comprehensive care coordination (CC) program for transition age youth using a Family Needs Assessment. This new program included web-based software. These services linked families to appropriate services in their communities. The goal was to assess two adolescents per clinic, which was the basis for the development of an individual care plan. Family priority was emphasized in the development of the care plan.

Population Based Services

The CSHS website was updated to include links to state and local agencies, disease specific organizations, transition services, family/CSHCN groups, as well as meetings for families and CSHCN. Care coordinators in the 3 MH project practices continued to utilize a care coordination system that was designed for use in a MH. One of the MH practices was located in an inner city area (New Orleans) and served a predominately African-American population. The 2nd practice was located in a rural area. The 3rd practice was in a public hospital in Baton Rouge. The care coordinator for the practice in New Orleans moved out of state in April 2008 and the position was not able to be refilled.

Infrastructure Building

CSHS administrative staff worked with 2 regions to refine the pilot CC program. Staff also worked with Families Helping Families (FHF) regarding collaboration with the new Family to Family Health Information Centers (F2F HICs) to coordinate some of the services of the CSHS CC program. The F2F HICS are operated in the regional FHF offices. New nursing, nutrition and social service staff in CSHS were given a 4 day skills training on working with CSHCN in June 2008. The Statewide CSHS Parent Consultant and Parent Trainer provided several exercises during the training that gave a parent's perspective of having a CSHCN and how to work with families.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide case management services for children attending CSHS clinics.	X	X		
2. Provide assessment and linkage to needed services for CSHCN.	X	X		
3. Provide intensive care coordination services for children and families identified with high level of service need in 2 regions of the state.	X	X		
4. Collaborate with primary care practices to improve case management /care coordination for CSHCN.		X	X	
5. Provide technical assistance to Medical Home practices on issues related to facilitating care coordination services.			X	

6. Train new staff on issues related to working with CSHCN.	X		X	
7. Train CSHS staff statewide on intensive care coordination services.				X
8. Collaborate with F2F HICs to coordinate care coordination services.			X	
9. Participate in DHH/DSS data integration project to improve care coordination for CSHCN.				X
10.				

b. Current Activities

Direct and Enabling Services

CSHS continues to provide follow-up services to children attending CSHS clinics. The CC program was expanded to another region of the state. The initial population served is YSHCN ages 14 and older and focuses on transition services. Staff is working with families to develop emergency preparedness plans and to assist families that have relocated/returned after the hurricanes of 2008. The CSHS nursing assessment was revised to include an assessment of nutrition risk factors. All CSHCN that have an identified nutrition risk factor are referred to a nutritionist working in CSHS clinics or to a nutritionist in another agency.

Population Based Services

CSHS continues to update its website. Care coordinators in the MH practices continue to provide access to CC and transition services. A new statewide care coordinator supervisor was hired for the care coordinators working in pediatric practices.

Infrastructure Building Services

A 4 day training on CC was provided to staff in the 2nd regional area in February 2009. Administrative staff is providing technical assistance for CC during weekly conference calls and monthly visits. CSHS collaborates with the F2F HICs on ways to coordinate services between the 2 programs. CSHS is working with other agencies in the Department of Health and Hospitals (DHH) and Department of Social Services (DSS) to integrate data. This will assist agencies to identify and link CYSHCN to eligible programs within these departments.

c. Plan for the Coming Year

Objective: To increase to 85% the percent of CSHS patients who have received case management (follow-up visits) from a nurse, social worker, or nutritionist.

Direct and Enabling Services

CSHS will continue to provide follow-up services to children attending direct services in CSHS clinics statewide. CC will be expanded in two other regions in the upcoming year. The initial CC focus will be YSHCN ages 14 and above and focus on transition services. CC services will phase-in for other CSHCN at higher risk after implementation of the initial services in all regions. CSHS staff will continue to provide follow-up services to all CSHCN and their families in CSHS direct services clinics. CSHS nursing staff will continue to screen CSHCN for nutrition risk factors and refer to a nutritionist, as indicated.

Population Based Services

The CSHS website will continue to be updated. Care coordinators will continue to support the two MH project practices. CSHS plans to expand support for CC to private MH practices in other areas of the state.

Infrastructure Building Services

On-site training will be given to staff in each region as the CC program is implemented statewide. CSHS will continue to collaborate with Louisiana Rehabilitation Services, Office for Citizens with

Developmental Disabilities, Louisiana Department of Education, FHF, and F2F HICs to coordinate services for CSHCN. CSHS will continue to provide a training for all new nursing, nutrition and social services staff on issues related to working the CYSHCN and their families. CSHS will continue to work with DHH and DSS in the development of the data integration project.

State Performance Measure 7: *Percent of women who use alcohol during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			2.8	5	5
Annual Indicator	2.9	6.8	6.8	8.9	8.9
Numerator	1811	4258	4258	5935	5935
Denominator	62014	62405	62405	66686	66686
Data Source					LA Pregnancy Risk Assessment Monitoring System
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	6.7	5	5	5	5

Notes - 2008
Data is provisional and based upon the 2007 data.

Notes - 2007
Data is provisional and is based upon the 2004 PRAMS data.

Notes - 2006
Data is based upon the 2004 PRAMS data.

a. Last Year's Accomplishments
2006 Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS) data indicates that 8.9% of pregnant women reported drinking during pregnancy. This is an increase from 6.8% noted in 2004 which was an increase from 2.9% in 2003.

Direct and Enabling Services
The MCH program in collaboration with Louisiana Section of ACOG, Louisiana Office of Addictive Disorders (OAD), and Office of Mental Health (OMH) identified a screening tool for alcohol use in pregnancy. This tool, the 4Ps Plus, screens for substance abuse, alcohol use, depression and domestic violence. State licensure for tool use and data collection from Dr. Ira Chasnoff of the Children's Research Triangle was obtained. The tool and training are available to obstetrical providers within the state. This program is titled (SBIRT-HBI) Screening, Brief Intervention, Referral and Treatment -- Healthy Babies Initiative Program for Pregnant Women. Four of the 9 DHH regions had coordinators and were actively screening.

From initiation of the Baton Rouge project in May 2005 and including 3 additional pilot sites May 2007 through Sept 30, 2008, the SBIRT program in the 4 regions screened 11,225 pregnant women with 5.1% drinking alcohol since aware of pregnancy (19.3% before knew they were pregnant). There were 570 pregnant women given the Brief Intervention and offered referral.

Discussion began with Louisiana Medicaid to make SBIRT screening a pay for performance

initiative for providers, but delayed due to funding issues.

The voluntary pregnancy testing program for OAD clients continued with 1,632 receiving tests. The positive pregnancy rate last year was 2.8%. This program allows more rapid diagnosis of pregnancy and referral for prenatal care. For those with negative tests, referrals are made for those desiring family planning services.

The Nurse-Family Partnership (NFP) nurse home visitors provided health education on smoking cessation, referrals, education, guidance and support to first time, low income mothers in 51parishes.

MCH collaborated with the March of Dimes (MOD) to begin CenteringPregnancy programs.

Population-Based Services
The Partners for Healthy Babies (PHB) social marketing campaign held a strategic planning to determine project focus and direction for the next three years. Additional formative research was conducted to assure that the project remain culturally sensitive and competent. The Helpline received approximately 3,172 calls in FY 2008. The PHB website received 16,786 webvisits, 14,105 unique visitors and 47,626 pageviews in CY 2008.

Infrastructure Building Services
Substance abuse services continued to be identified as a priority need. The Fetal Infant Mortality Reduction Initiative (FIMR) focused on factors contributing to high infant mortality and prematurity rates. Alcohol use is a significant contribution to these rates. Regional Feto-Infant Mortality Reviews (FIMRs) are looking at problems and solutions at the local level. The MCH Maternity Medical Director and Nurse Consultant continued visits to OB Medicaid providers and birthing hospitals, providing education and resources. Discussion began with Louisiana Medicaid to make SBIRT screening a pay for performance initiative for providers. Dr. Ira Chasnoff presented programs on effects of maternal alcohol use during pregnancy. MCH Nurse Consultant conducted Substance Abuse awareness trainings in Monroe SBIRT pilot region.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue support of statewide perinatal substance abuse plan with the Office of Addictive Disorders and National Training Institute.				X
2. Support Home visitation to low-income mothers and infants.	X	X		
3. Support the Partners for Healthy Babies media and helpline.			X	
4. Support Centering Pregnancy groups.	X	X		X
5. Expand alcohol use in pregnancy screening to all regions of state and in WIC clinics throughout the state.	X	X		
6. Provide voluntary pregnancy testing and referral in Office of Addictive Disorder (OAD) clients.	X			
7. Support Partners for Healthy Babies Prenatal Care Fairs.	X		X	
8. Collaborate with Medicaid on Quality of Care issues and recommendations for funding substance abuse treatment.				X
9. Support regional Feto-Infant Mortality Reviews (FIMRs) to target substance abuse as one of leading risk factors for pre-term labor.				X
10. Collaborate with LPHI to support alcohol prevention messages and activities.				X

b. Current Activities

Direct and Enabling Services

SBIRT-Healthy Babies Initiative expanded services now in 6 regions. Plans are in place to expand services to all 9 regions of the state in 2009. SBIRT training was provided to all nurses and nutritionists working in OPH WIC clinics and screening in state WIC clinics is being implemented. WIC clinics in the Baton Rouge area have begun screening. NFP continues to address alcohol use in pregnancy in all areas of the state. MCH continues to support CenteringPregnancy programs.

Population-Based Services

MCH collaborated with Native American tribal group and Bureau of Minority Health Access grant, initiating the FIMR program in a central Louisiana military base. The PHB campaign continues web-based and multimedia prevention messages and referral information.

Infrastructure Building Services

FIMR Community Action Teams (CATs) provide local infrastructure to address maternal alcohol use. MCH staff continues education visits to private OB's and birthing hospitals in all regions.Regional FIMR meetings are providing information on the need for standardized message of "no alcohol use in pregnancy".

c. Plan for the Coming Year

Objective: Reduce the percent of women who use alcohol during pregnancy to 6.7%.

Direct and Enabling Services

The SBIRT-HBI program will expand statewide and be utilized in WIC clinics throughout the state. This tool is being provided to all obstetrical providers, and could potentially screen every pregnant woman in the state for alcohol use. Use of the tool in Family Planning clinics is being planned. Each region will have SBIRT-HBI coordinators and treatment resources. Epidemiological evaluation of the SBIRT program will begin.

Health units providing prenatal care will continue to screen for alcohol and offer brief intervention and referral for cessation services.

The NFP home visiting program will continue to address substance abuse during pregnancy, providing education, counseling and referrals for women in need of these services in all regions of the state.

Population-Based Services

PHB will continue the promotion of healthy pregnancy campaigns, with prevention of alcohol use in pregnancy as a part of that message. Two prenatal care fairs are scheduled through the Partners for Healthy Babies campaign.

Infrastructure Building Services

The SBIRT-HBI will continue to build local support for screening, intervention, treatment, and prevention of alcohol use in pregnancy. All regions of the state will have activities. Legislative efforts to criminalize pregnant women who use substances are being countered by attempts to expand screening and access to treatment.

State MCH is continuing to work with Regional MCH FIMRs. These groups will promote local strategic planning to provide infrastructure to address alcohol use and its impact on pregnancy. The MCH Medical Director and Nurse Consultant will continue to visit and educate private OB providers with large Medicaid practices and birthing hospitals, reaching all 9 regions.

MCH will continue to meet with Medicaid to promote efforts to enhance quality of care issues. Discussions will continue with Medicaid to reimburse and implement a pay for performance for

SBIRT screening / intervention.

A manager level individual is in place with LPHI to address MCH concerns, including alcohol use in pregnancy.

State Performance Measure 8: *Rate of infant deaths due to Sudden Infant Death Syndrome.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	0.8	1.1	1.1	1	1
Annual Indicator	0.8	1.3	0.9	1.3	1.3
Numerator	51	77	54	83	83
Denominator	64956	60531	62416	65656	65656
Data Source					Louisiana Vital Records and Statistics
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	0.8	0.8	0.8	0.8	0.8

Notes - 2008
Data is provisional and is based upon 2007. Vital Statistics Data is used this year.

Notes - 2007
Data is provisonal. Vital Statistics Data is used this year.

Notes - 2006
Data is provisional. Vital Statistics Data is used this year. SIDS Program Data is not available at this time.

a. Last Year's Accomplishments
The Sudden Infant Death Syndrome (SIDS) death rate per 1,000 live births was 0.9 in 2006. The SIDS rate for African Americans in 2006 was 1.4. The SIDS rate for Caucasians in 2006 was 0.7. Overall the racial disparity for 2006 was 2. PRAMS data indicates that back sleeping has increased from 32% in 1997 to 52% in 2006.

Direct and Enabling Services
Children's Bureau continued to provide counseling for families of SIDS/OID (Other Unexpected Infant Death) victims. Children's Bureau served 12 families with counseling and support for SIDS/OID and continued its network of parent peer contacts and community health educators to provide additional counseling and resources for SIDS/OID families. The Office of Public Health (OPH) provided counseling to 9 families in the rest of the state.

Population-Based Services
A social marketing public information campaign about SIDS and safe sleep environment continued to be implemented within high-risk areas of the state, with focus on creating a safe sleeping environment. Campaign efforts targeted racial disparities through the use of community and professional outreach. SIDS information continues to be distributed statewide to birthing hospitals, healthcare and daycare providers. The SIDS Program continued collaboration with community-based agencies to provide 123 educational sessions to daycare providers, public health nurses, social workers and the general public.

Infrastructure Building Services
The SIDS Medical Director reviewed autopsy and death scene investigations. The Louisiana Child Death Review Panel (CDRP) reviewed all unexpected deaths in children under age 15, including all SIDS deaths. There were a total of 73 sudden unexplained infant deaths that were reviewed by the Louisiana CDRP. The Child Death Review Panel collaborated with the SIDS Program in the first annual "Infant and Child Fatality Investigation" conference to educate coroners, death scene investigators, first responders, and stakeholders on conducting death scene investigations in a culturally competent manner consistent with standard protocol. Other topics included causes of unexpected infant death and demonstrating sensitivity in their role in addressing family needs.

The pilot research plan implemented to provide safe sleep environment education in WIC clinics was completed and the results were analyzed.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Review Autopsy and death scene investigations.				X
2. Present SIDS related education programs to health professionals, law enforcement and the public.			X	X
3. Distribute educational materials to hospitals, health providers and daycare centers.				X
4. Collaborate with community-based organizations to disseminate SIDS risk reduction message.			X	
5. Disseminate new American Academy of Pediatrics Safe Sleep Guidelines to healthcare professionals.				X
6. Completed pilot research plan implemented to provide safe sleep environment education in WIC clinics and analyzed the results.			X	X
7. Administer social marketing campaign about safe sleep environment promotion within high-risk areas.			X	
8. Provide grief counseling for families of SIDS/OID victims through agency collaboration.		X	X	
9. Promote regulatory guidelines for safe sleep environment in day care and family day home centers.		X		
10.				

b. Current Activities
Direct and Enabling
The SIDS Program continues to coordinate with Children's Bureau to provide grief counseling for families of SIDS/OID victims in the New Orleans area.

Population-Based Services
The social marketing public information campaign about safe sleep environment continues within high-risk target population areas through media, community outreach, and medical profession outreach. Current campaign efforts continue to target racial disparities through media materials and media placement to reach low income populations based on formative, qualitative, and market research.

Infrastructure Building Services
The SIDS Program continues to provide technical assistance for development of policy related to safe sleep environment in licensed childcare facilities. MCH collaborates with community-based agencies in dissemination of risk reduction messages. The SIDS Program continues provision of

training for licensed childcare providers related to safe sleep environment. The SIDS Medical Director continues to review autopsy and death scene investigations. The SIDS Medical Director conducts coroner outreach in an effort to educate on the SIDS policy and ensure seamless submission of documents used to identify SIDS cases. The CDRP continues reviewing all unexpected deaths in children under the age of 15, including all SIDS deaths. The CDRP is collaborating with the SIDS Program to revise the home visiting policy and develop standardized bereavement resources.

c. Plan for the Coming Year

Objective: To reduce to 0.8 per 1,000 live births the number of infant deaths due to Sudden Infant Death Syndrome.

Direct and Enabling Services

Children's Bureau will continue to provide counseling and resources for families who are victims of SIDS/OID (Other Infant Deaths) as needed in the Greater New Orleans area. The OPH will continue to provide bereavement support to SIDS families in the remainder of the state.

Population-Based Services

The social marketing public information campaign about safe sleep environment promotion will continue to be implemented within high-risk target population areas of the state through media, community outreach and medical profession outreach. Qualitative research and evaluation results based on current media material and messaging will be used to develop culturally competent educational materials. Market research will continue to be used to develop new campaign strategies to effectively target hard to reach populations. The SIDS Program will continue to collaborate with MCH Child Safety Coordinators in regional risk reduction activities such as educational and crib giveaway programs.

Infrastructure Building Services

The SIDS Program will continue interagency collaboration with existing community-based agencies and organizations in promotion of safe sleep environment messages. The SIDS Program will continue to provide technical assistance for development of policy and/or regulatory standards related to safe sleep environment in licensed childcare and develop a template policy for childcare providers. The SIDS Program plans to continue provision of training for licensed childcare and family day home providers related to safe sleep environment.

Autopsy and death scene investigations will continue to be reviewed by the SIDS Medical Director. Infant Death Scene Investigation trainings will continue at the regional level to ensure that coroners, death scene investigators, first responders, and stakeholders possess the necessary skills to respond in a supportive, culturally competent manner to families who have experienced a sudden unexpected death and ensure protocol is followed. The Child Death Review Panel will continue reviewing all SIDS deaths as. Special reports on infant mortality will continue to be provided to the State Commission on Perinatal Care and Infant Mortality and other interested groups. The OPH home visitation protocol will be revised and bereavement support information standardized.

State Performance Measure 9: *Percent of state fetal and infant deaths reviewed by a Feto-Infant Mortality Review (FIMR).*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			7.5	15	20
Annual Indicator	7.7	11.7			

Numerator	66	78	132	164	189
Denominator	857	666			
Data Source					Louisiana Vital Records and Statistics
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	30	50	50	50	50

Notes - 2008
2006-2007 data on number of fetal and infant deaths is not available from Louisiana Vital Statistics at the time.

Notes - 2007
2006 -2007 data on number of fetal and infant deaths is not available from Louisiana Vital Statistics at the time.

Notes - 2006
2006 data on number of fetal and infant deaths is not available from Louisiana Vital Statistics at the time.

a. Last Year's Accomplishments
Population-Based Services
Recommendations from the regional FIMR CATs resulted in population-based interventions. Partners for Healthy Babies activities have been coordinated with regional FIMRs.

Infrastructure Building Services
In 2001, Louisiana MCH program began the promotion and development of a state-wide FIMR process by supporting regional communities in the development of a standard fetal and infant death review process. This review is an important part of understanding the factors contributing to the deaths in our state, informing the community of the issues, and mobilizing the community to action to prevent these deaths. The reviews began in regions with the strongest infrastructure, systematically expanding to encompass all nine regions in Louisiana. The plan was to focus on the largest parish in each of the nine regions of the state, with each regional team expanding to address additional parishes in the region over time. MCH funds a FIMR coordinator in each of the active regions. The coordinator abstracts and summarizes death charts, conducts a home visit to the mother and presents the cases to the Case Review Team (CRT), and works to organize and maintain the local Community Action Team (CAT).

Regional FIMRs have evolved into active MCH Coalitions, with CRT and CAT members advocating for the needs of mothers and infants, including developing resource lists, involvement in media campaigns for SIDS, SIUDS, substance use, depression, domestic violence, legislative contacts regarding health policy and reform, minority health events and outreach efforts, and involvement of more local government and business leaders. FIMRs conducted CRT meetings and CAT meetings in the eight active regions. The FIMR program has been endorsed by the state Perinatal Commission and declared it free from discoverability in legal cases.

Eight of nine DHH regions now have a coordinator and are actively involved in the FIMR review process. CRTs in the active regions reviewed 189 cases in 2008 and 164 cases in 2007, to help identify important issues surrounding these deaths.

Collaborations with organizations co-fund the salary of the FIMR coordinator in Healthy Start in New Orleans. Family Road of Greater Baton Rouge and Family Tree, each Healthy Start sites, supported the regional FIMR through supplies and administrative support and contracts. Collaboration with regional Office of Public Health (OPH) Medical Directors and Administrators and regional epidemiologists supported the FIMR coordinators. Obstetricians and pediatricians

from regional hospitals participated on Case Review Team and functioned as FIMR Medical Directors in the regions. Regional community organizations participated on each FIMR Community Action Team meeting. Over 500 community and provider groups statewide participate in the FIMR program. A statewide 6th Annual FIMR Annual Meeting was held in Baton Rouge in March 2008, focusing on preconception health with Dr. Michael Lu as primary speaker.

An electronic FIMR reporting system, Basinet, is being utilized.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support and assist regional FIMR Case Review Teams (CRT).				X
2. Support FIMR CRT expansion into additional hospitals.				X
3. Help facilitate identification of deaths for FIMR review through vital records system.				X
4. Provide technical assistance to FIMR coordinators.				X
5. Present state and regional epidemiologic data to FIMRs.				X
6. Support FIMR forums and Community Action Teams.				X
7. Assist regional FIMR community teams with intervention ideas and/or implementation of activities to improve outcomes.			X	X
8. Coordinate FIMR and Injury Prevention activities.				X
9.				
10.				

b. Current Activities

Population-Based Services

MCH, in collaboration with regional FIMRS, assure that regional disaster plans are in place.

Infrastructure Building Services

A FIMR coordinator will be hired August 1, 2009 which will complete coverage in all regions. The reluctance of some hospitals to work with FIMR has been addressed by the State Perinatal Commission via licensure ruling requiring cooperation. The Perinatal Commission is working with Coroners to urge involvement with FIMR. Work continues with state Vital Records on the timely provision of death certificate information to FIMR Coordinators.

In 2008, 189 cases were abstracted at 29 birthing hospitals and reviewed in eight regional FIMR CRTs. In the Monroe region, a grant was obtained to expand FIMR reviews in the region. May 2009 bereavement training conducted by RTS Bereavement Services, Gunderson Lutheran Medical Foundation was held in New Orleans and included 6 FIMR nurses, resulting in plans to develop a standardized state grief support program. Regional CATs include members of faith-based, hospitals, social service agencies, March of Dimes, tobacco programs, public health staff. The Baton Rouge FIMR has been active in presenting at all area Rotary Clubs and involving their members in the CAT. The Lafayette region has been instrumental in promoting regional breastfeeding and have a faith based coalition. SW Louisiana FIMR has been active with SIDS and SIUDS initiatives and is frequently seen on regional television programs.

c. Plan for the Coming Year

Objective: Increase the percentage of fetal and infant deaths reviewed by a FIMR to 30%

Population-Based Services

Recommendations from the regional FIMR CATs and forums continue to result in population-based interventions including expanding resource directories to include services for substance use, domestic violence, and depression. FIMR will coordinate activities with Injury Prevention

Program and Breastfeeding Coalitions. The Partners for Healthy Babies program works with FIMR coordinators in educational efforts.

Infrastructure Building Services
All nine regions of the state will be active in FIMR reviews with the most recent region having a coordinator effective August 2009. While work with Vital Records has allowed access to death certificates, the timeliness of this process could be improved. Work in that arena will continue.

Regional FIMRs will continue to review cases and support community interventions. Opportunity for community action will be carried out through FIMR community groups and regional forums. The FIMR review teams regularly provide recommendations to the established Community Action Teams. These Community Teams continue to support measures to address circumstances surrounding fetal and infant deaths at the community level throughout Louisiana. The Screening, Brief Intervention, Referral and Treatment for substance use, domestic violence and depression (SBIRT)-Healthy Babies Initiative (HBI) will expand to all regions of the state, and include WIC clinics. FIMR groups are working closely with regional SBIRT-HBI coordinators to identify needs, community resources, and provide education through CRT/CAT meetings.

In addition to case reviews, as a result of FIMR conference held in October 2008, regional FIMR groups are involved in updating emergency plans for MCH populations, especially pregnant women, new mothers, and infants and coordinate with regional Red Cross and Public Health offices.

FIMR will continue to work with the State Perinatal Commission to advance support for this important review process. MCH anticipates further strengthening collaborations with March of Dimes, ACOG, and the Louisiana MCH Coalition as well as other community-based organizations through the Regional FIMR teams. Targeted educational activities to regional providers and stakeholders will help encourage regional action to address prematurity and VLBW births. Tulane University's MCH Leadership Training grant will continue to provide teleconference education for FIMR coordinators. Plans are being made for a statewide MCH Summit for November 2009. Continued use of the online, electronic reporting system, Basinet, will occur, with data aggregation of cases reviewed.

State Performance Measure 10: *Percent of licensed day care centers with a health consultant contact.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	55	35	39	40	95
Annual Indicator	31.0	38.4	32.4	85.4	100.0
Numerator	673	833	565	1490	1753
Denominator	2170	2170	1744	1744	1753
Data Source					LA Department of Social Services
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	98	99	100	100	100

Notes - 2008
FY08 data is based on data from the Louisiana Department of Social Services (DSS), Bureau of Licensing.

Notes - 2007

FY07 data is based on a report provided by the Louisiana DHH Center for Environmental Services. The report documents the number of child care facilities that met the DHH Center for Environmental Services requirements for licensure during the Block Grant FY. Child care staff is required by DHH to have three hours of health and safety training provided by Child Care Health Consultants (CCHC). Parish Sanitarians inspect centers for proof of the three hours of health and safety training provided by a CCHC and for other requirements to ensure a safe environment. Louisiana DHH Center for Environmental Services compiles a database of the centers that pass this inspection and are recommended for licensure.

Notes - 2006
FY 2006 data is based on the Child Care Health Consultant monthly report system.

a. Last Year's Accomplishments
There were 1,753 licensed Class A and Class B child care facilities in Louisiana. This information is based on data from the Louisiana Department of Social Services (DSS), Bureau of Licensing as reported in the KIDS COUNT Data Center. The Louisiana Department of Social Services licenses child care centers in Louisiana. Licensed facilities must meet minimum standards regarding program activities, staff training, environment, child/staff ratios, and health and safety. The Louisiana Department of Health and Hospitals (DHH) requires all child care staff in Class A and B child care facilities to have three hours of health and safety training in order to obtain/maintain licensure with DSS. The health and safety trainings must be provided by state-trained and approved Child Care Health Consultants (CCHCs) only. Therefore, 100% or all of the licensed child care facilities in 2008 had to have at least one contact with a child care health consultant to meet DHH's 3 hours of mandatory health and safety training.

Infrastructure Building Services
The Louisiana Annual Child Care Health Consultant Training was held April 30-May 2, 2008, and approximately 80 health and safety professionals were trained and approved as CCHCs. Training topics are based on the curriculum recommended by the National Training Institute for Child Care Health Consultants. By October 2008, there were 149 state trained and approved CCHCs.

MCH Child Safety (Injury Prevention) Coordinators are also state trained and approved CCHC's. Through more than 40 training sessions, they provided health and safety training to over 2,269 child care staff on such topics as general injury prevention in a child care setting, food safety, poisoning prevention, child passenger safety, and SIDS risk reduction/safe sleep environments.

Technical assistance was provided by the Child Care Health Consultant Program Director to child care providers, CCHCs, the DSS Office of Family Support and (Child Care) Bureau of Licensing, and parents, in accordance with AAP guidelines for child care centers; Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs, 2nd Edition; Department of Health and Hospitals' Louisiana Administrative Code; and the Department of Social Services, Office of Family Support and Bureau of Licensing. Technical assistance was also provided by CCHCs to child care center providers.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide technical assistance in health and safety in child care to CCHCs, child care providers, DHH, DSS (Office of Family Support and Bureau of Child Care Licensing) healthcare providers, and parents/caregivers.				X
2. Plan, initiate and coordinate annual training of Child Care Health Consultants.				X
3. Provide educational materials and training to child care providers on services related to health and safety, including				X

children with special needs.				
4. Serve as a child care health resource to child care providers and others.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services

A priority for the Louisiana Child Care Health Consultant Program this year is to streamline the program's primary operations of training and technical assistance. CCHC core competency training is the primary focus of the annual training this year. Also, candidacy for CCHC training this year, and in the future, will be limited to licensed physicians, nurses, social workers, and dieticians as well as public health child safety/injury prevention specialists. Technical assistance is being provided by the Child Care Health Consultant Program Director to child care providers, CCHCs, the DSS Child Care Licensing Regulatory Section, and parents and by the CCHCs to child care center providers. Training and technical assistance are in accordance with AAP guidelines for child care centers; Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs, 2nd Edition; Department of Health and Hospitals' Louisiana Administrative Code; and the Department of Social Services, Office of Family Support and Bureau of Licensing.

c. Plan for the Coming Year

Infrastructure Building Services

Based on available data, 100% of the child care centers that were licensed in 2008 had received at least one contact by a child care health consultant. Therefore, Louisiana will no longer report the percent of licensed day care centers with a health consultant contact as a state performance measure.

The MCH Program will continue to support the operations of the Louisiana CCHC Program, which includes providing annual training of and technical assistance to child care health consultants who provide health and safety training to child care providers.

State Performance Measure 11: *Percent of Louisiana resident women giving birth who undergo screening for substance use, depression, and domestic violence using the SBIRT-HBE approved methods.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective					
Annual Indicator					6.4
Numerator					4271
Denominator					66686
Data Source					Louisiana Vital Records and Statistics
Is the Data Provisional or Final?					Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	8	9	11	13	15

Notes - 2007
The performance measure was newly added in 2009.

Notes - 2006
Teh performance measure was newly added fin 2009.

a. Last Year's Accomplishments
Prior SPM 06 transitioned into a new performance measure due to adoption of the SBIRT-HBI program to replace the former Louisiana Risk Assessment tool. There were 6.4% (4,271 women) of 66,686 deliveries screened using the SBIRT Program in 2008.

Direct and Enabling Services
MCH, partnering with Office of Addictive Disorders, started to pilot the 4Ps Plus risk assessment developed by Dr. Ira Chasnoff for substance abuse, perinatal depression, and domestic violence during pregnancy. This risk assessment is administered to pregnant women at their obstetrician's offices, thereby providing opportunity for earlier establishment of risk factors for pregnancy and child outcomes, and providing a window for earlier intervention. This is the SBIRT Program in Louisiana. Four of the 9 DHH regions had coordinators and were actively screening.

From initiation of the Baton Rouge project in May 2005 and adding 3 additional pilot sites May 2007 through Sept 30, 2008, the SBIRT program in the 4 regions screened 11,225 pregnant women with 5.1% drinking alcohol since aware of pregnancy (19.3% before knew they were pregnant). Other results: marijuana use- 5.6% before aware, 2.7% since aware; cigarettes- 23.5% before, 14.9% since; drug use- 0.6% before, 0.3% since. There were 468 women screened at risk for domestic violence and 648 at risk for depression. In total 3,600 women received Brief Interventions and were offered a referral. Referral directories have been developed in each region of the state and are being updated as needed.

Plans have been developed to implement SBIRT-HBI screening within WIC clinics throughout the state, and this is being implemented and supported by MCH during the current year. MCH will continue to meet with regional and WIC personnel for technical support of the screening tool use, appropriate brief intervention techniques, and referral sources. Aggregate data on results of screening will be periodically provided back to individual WIC sites.

Infrastructure Building Services
MCH with its other SBIRT-HBI partners will continue to urge adoption of the screening tool by all providers within the state, public and private. The tool is being implemented in all 9 public health regions of the state. MCH worked with Medicaid to make use of the screening tool and brief intervention a reimbursable service under the Medicaid program. Prior efforts were unsuccessful due to funding issues. Private providers continued to receive technical support and screening result data. The work with MCH Epidemiology staff to begin data analysis of pregnancy outcomes on women with intervention and treatment from the program continued.

Substance abuse services continued to be identified as a priority need. The Fetal Infant Mortality Reduction Initiative (FIMR) focused on factors contributing to high infant mortality and prematurity rates. Alcohol and substance use is a significant contribution to these rates. Regional Feto-Infant Mortality Reviews (FIMRs) are looking at problems and solutions at the local level. The MCH Maternity Medical Director and Nurse Consultant continued visits to OB Medicaid providers and birthing hospitals, providing education and resources. Discussion began with Louisiana Medicaid to make SBIRT screening a pay for performance initiative for providers. Dr. Ira Chasnoff presented programs on effects of maternal alcohol use during pregnancy. MCH Nurse Consultant conducted Substance Abuse awareness trainings in Monroe SBIRT pilot region via AMCHP grant to ALL Collaborative.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand SBIRT-HBI activities in all regions of the state.	X	X	X	X
2. Perform SBIRT- HBI screening in WIC clinics.	X			
3. Update resource manuals for SBIRT-HBI referrals for treatment.				X
4. Assist to identify service shortages (especially substance abuse, depression, domestic violence treatment) and promote expansion of services for pregnant women.			X	X
5. Translate the SBIRT Screening tool in to Spanish.			X	
6. Work with Medicaid to provide reimbursement for SBIRT-HBI activities.				X
7.				
8.				
9.				
10.				

b. Current Activities

Direct and Enabling Services

SBIRT-HBI expanded to a total of 6 regions. Plans are in place to expand services to all 9 regions of the state in 2009. OPH RN and nutritionist training conducted by Ira Chasnoff in January 2009 to begin SBIRT screening in state WIC clinics . WIC clinics in the Baton Rouge area currently screen and each region is beginning implementation. Referral directories are developed in each region of the state and are updated as needed. Discussion continues for Medicaid to reimburse for screening and brief intervention services. NFP continues to address alcohol and substance use in pregnancy in all areas of the state.

Discussions are underway with the state Office of Mental Health (OMH) to increase access to mental health services for those who screen positive and need further evaluation / treatment. State Office of Addictive Disorders (OAD) continues to offer priority treatment to pregnant women. Referral directories previously developed are being updated as needed.

Infrastructure Building Services

The past president of Louisiana ACOG has been hired as state SBIRT Director and is working with both private and public sector providers to enhance use of screening tool, and expand access to services. Dr. Kudla works closely with both OAD and OMH in coordination of referrals.

c. Plan for the Coming Year

Objective: Increase the number of pregnant women screened by SBIRT-HBI to 8%.

Direct and Enabling Services

The SBIRT-HBI program will expand statewide and be utilized in WIC clinics throughout the state. This tool is being provided to all obstetrical providers, and could potentially screen every pregnant woman in the state for alcohol use. Use of the tool in Family Planning clinics is planned. Each region will have SBIRT-HBI coordinators and treatment resources. Resource directories are updated as needed. Epidemiological evaluation of the SBIRT program will begin.

Health units providing prenatal care will continue to screen for alcohol and offer brief intervention and referral for cessation services.

The NFP home visiting program will continue to address substance abuse during pregnancy, providing education, counseling and referrals for women in need of these services in all regions of the state.

Population-Based Services
Partners for Healthy Babies public information campaign will continue the promotion of healthy pregnancy campaigns, with prevention of alcohol / substance use in pregnancy as a part of that message. Two prenatal care fairs are scheduled through the Partners for Healthy Babies campaign.

Infrastructure Building Services
The SBIRT-HBI will continue to build local support for screening, intervention, treatment, and prevention of alcohol / substance use in pregnancy. All regions of the state will have activities. Legislative efforts to criminalize pregnant women who use substances are being countered by attempts to expand screening and access to treatment.

State MCH is continuing to work with Regional MCH FIMRs. These groups will promote local strategic planning to provide infrastructure to address alcohol use and its impact on pregnancy. The MCH Medical Director and Nurse Consultant will continue to visit and educate private OB providers with large Medicaid practices and birthing hospitals, reaching all 9 regions.

MCH will continue to meet with Medicaid to promote efforts to enhance quality of care issues. Discussions will continue with Medicaid to reimburse and implementation a pay-for-performance using the SBIRT screening / intervention.

E. Health Status Indicators

Introduction

Health Status Indicators are an evaluative measure that can be used to compare the state's death rates to past rates and to other states' rates. MCH can assess the achievement of efforts, appropriateness of efforts, and effectiveness of preventive interventions and allocated resources over time. Death rates are just one of several measures of our state's health status. Awareness of the leading causes of death can more efficiently and effectively target our efforts and resources toward building a healthier and safer community. HSI serves as a surveillance or monitoring tool to identify the causes of death, risk factors, and the "at risk" groups based on age, race, and ethnicity and to plan preventive interventions. The state can enhance data capacity through the improvement of existing data linkages and the establishment of new data linkages and surveillance systems. Current linkages between the birth files, infant death files, Medicaid eligibility files, WIC files, and newborn screening data will continue to allow in depth analyses and evaluation by the MCH and CSHCN Programs, which identify priority needs for programs and interventions.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	11.0	11.5	11.4	11.2	11.2
Numerator	7112	6821	7226	7378	7378
Denominator	64949	59442	63184	65656	65656
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a					

3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data is provisional and is based upon 2007 data.

Notes - 2007
2007 data is provisional.

Notes - 2006
2006 data is final.

Narrative:
/2010/ In 2005, the percent of live births weighting less than 2,500 grams was 11.5 % of all births. This was an increase from 11.0% in 2004. Final 2006 data is 11.4%. Preliminary 2007 is 11.2%.
Low birth weight can provide valuable information as a general indicator of the state's maternal health status and prenatal care provision. While a surrogate marker for prematurity, it can also identify infants who have intrauterine growth restriction. By analyzing low birth weight infants by regions, patient characteristics, and specific population groups such as payer type, it can help direct resources to those areas in most need. By following this figure over time, one can obtain a general measure of risks and results of interventions.
Specific interventions include the Infant Mortality Reduction Initiative, smoking cessation program, dental services program, substance abuse and depression screening programs. Louisiana's has a family planning waiver, Take Charge, to assist service access for Medicaid eligible women. Work is in progress to link enhanced preconception services, especially folic acid use, to the family planning program. The SBIRT program is providing screening / intervention services for substance abuse and mental disorders. The SBIRT program is statewide, and in selected WIC clinics.
Take Charge family planning waiver has been found to be underutilized due to limitations in scope of coverage. Folic acid is provided in state family planning clinics. An expanded focus on preconceptional and interconceptional health services is occurring, especially in regard to prevention of adverse pregnancy outcomes.
Data linkages are with Louisiana Hospital Inpatient Discharge Data, Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS), Louisiana Birth Defects Survey, and the Caring Community Youth Survey are ongoing to increase data analysis and dissemination of information.
The state can enhance data capacity through the improvement of existing data linkages and the establishment of new data linkages and surveillance systems. Current linkages between the birth files, infant death files, Medicaid eligibility files, women, infant, and child program (WIC) eligibility files, and newborn screening data will continue to allow in depth analyses and evaluation by the MCH and CSHCN Programs, which identify priority needs for programs and interventions. //2010//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	9.1	9.5	9.5	9.3	9.3
Numerator	5697	5461	5775	5874	5874
Denominator	62803	57476	61068	63384	63384
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data is provisional and based upon 2007 data.

Notes - 2007
2007 data is provisional.

Notes - 2006
2006 data is final

Narrative:
/2010/ In 2005, the percent of live singleton births weighing less than 2,500 grams was 9.5% of all births. This was an increase from the 9.1% rate noted in 2004.
The final 2006 data remains at 9.5%. Preliminary 2007 data is 9.3%.
Low birth weight can provide valuable information as a general indicator of the state's maternal health status and prenatal care provision. While a surrogate marker for prematurity, it can also identify infants who have intrauterine growth restriction. Multiple gestations have much higher rates of low birth weight deliveries. By following the percent of low birth weight in singleton births, it allows a better analysis of prenatal systems of care, maternal risks, and the effectiveness of treatments. By following this figure over time, one can obtain a general measure of risks and results of interventions.
Specific interventions include the Infant Mortality Reduction Initiative, smoking cessation program, dental services program, substance abuse and depression screening programs. Louisiana has a family planning waiver, Take Charge, to assist in access to these services for Medicaid eligible women. Work is in progress to link enhanced preconception services, especially folic acid use, to the family planning program. The SBIRT program is providing screening / intervention services for substance abuse and mental disorders. The SBIRT program is statewide, and in selected WIC clinics.
Take Charge family planning waiver has been found to be underutilized due to limitations in scope of coverage. Folic acid is provided in state family planning clinics. An expanded focus on preconceptional and interconceptional health services is occurring, especially in regard to prevention of adverse pregnancy outcomes. The SBIRT program is statewide, and in selected WIC clinics.

Data linkages are with Louisiana Hospital Inpatient Discharge Data, Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS), Louisiana Birth Defects Survey, and the Caring Community Youth Survey are ongoing to increase data analysis and dissemination of information.
The state can enhance data capacity through the improvement of existing data linkages and the establishment of new data linkages and surveillance systems. Current linkages between the birth files, infant death files, Medicaid eligibility files, WIC files, and newborn screening data will continue to allow in depth analyses and evaluation by the MCH and CSHCN Programs, which identify priority needs for programs and interventions. //2010//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**

Annual Indicator	2.1	2.3	2.2	2.2	2.2
Numerator	1371	1353	1380	1440	1440
Denominator	64949	59442	63184	65656	65656
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data is provisional and based upon 2007 data.

Notes - 2007
2007 data is provisional.

Notes - 2006
2006 data is final.

Narrative:
/2010/ In 2005, the percent of live births weighing less than 1,500 grams was 2.3% of all births. This was an increase from the 2004 rate of 2.1%. The 2006 rate was 2.2%. Preliminary 2007 rate is also 2.2%.
Very low birth weight can provide valuable information as a general indicator of the state's maternal health status and prenatal care provision. While a surrogate marker for prematurity, it can also identify infants who have extreme intrauterine growth restriction. By analyzing very low birth weight infants by regions, patient characteristics, and specific population groups such as payer type, it can help direct resources to those areas in most need. By following this figure over time, one can obtain a general measure of risks and results of interventions.
Specific interventions include the Infant Mortality Reduction Initiative, smoking cessation program, dental services program, substance abuse and depression screening programs. Louisiana'sTake Charge family planning waiver has been found to be underutilized due to limitations in scope of coverage. Folic acid is provided in state family planning clinics. An expanded focus on preconceptional and interconceptional health services is occurring, especially in regard to prevention of adverse pregnancy outcomes. The SBIRT program screening and making referrals for substance use, depression and domestic violence in pregnant women is statewide, and in selected WIC clinics.
Data linkages are with Louisiana Hospital Inpatient Discharge Data, Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS), Louisiana Birth Defects Survey, and the Caring Community Youth Survey are ongoing to increase data analysis and dissemination of information.
The state can enhance data capacity through the improvement of existing data linkages and the establishment of new data linkages and surveillance systems. Current linkages between the birth files, infant death files, Medicaid eligibility files, WIC files, and newborn screening data will continue to allow in depth analyses and evaluation by the MCH and CSHCN Programs, which identify priority needs for programs and interventions. //2010//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.7	1.8	1.7	1.8	1.8
Numerator	1074	1047	1063	1130	1130
Denominator	62603	57476	61068	63384	63384
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data is provisional and based upon the 2007 data.

Notes - 2007
2007 data is provisional.

Notes - 2006
2006 data is final.

Narrative:
/2010/ In 2005, the percent of live singleton births weighing less than 1,500 grams was 1.8% of all births. The 2004 rate in singletons was 1.7%. The 2006 rate was 1.7%. Preliminary 2007 rate is 1.8%.
Very low birth weight can provide valuable information as a general indicator of the state's maternal health status and prenatal care provision. While a surrogate marker for prematurity, it can also identify infants who have extreme intrauterine growth restriction. Multiple gestations have much higher rates of very low birth weight deliveries. By following the percent of very low birth weight in singleton births, it allows a better analysis of prenatal systems of care, maternal risks, and the effectiveness of treatments. By following this figure over time, one can obtain a general measure of risks and results of interventions.
Specific interventions include the Infant Mortality Reduction Initiative, smoking cessation program, dental services program, substance abuse and depression screening programs. Louisiana'sTake Charge family planning waiver has been found to be underutilized due to limitations in scope of coverage. Folic acid is provided in state family planning clinics. An expanded focus on preconceptional and interconceptional health services is occurring, especially in regard to prevention of adverse pregnancy outcomes. The SBIRT program screening and making referrals for substance use, depression and domestic violence in pregnant women is statewide, and in selected WIC clinics.
Data linkages are with Louisiana Hospital Inpatient Discharge Data, Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS), Louisiana Birth Defects Survey, and the Caring Community Youth Survey are ongoing to increase data analysis and dissemination of information.
The state can enhance data capacity through the improvement of existing data linkages and the establishment of new data linkages and surveillance systems. Current linkages between the birth files, infant death files, Medicaid eligibility files, WIC files, and newborn screening data will continue to allow in depth analyses and evaluation by the MCH and CSHCN Programs, which identify priority needs for programs and interventions. //2010//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	18.2	12.2	13.0	13.1	13.1
Numerator	175	115	117	116	116
Denominator	963046	946320	897508	888587	888587
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data is provisional and based upon the 2007.

Notes - 2007
2007 data is provisional.

Notes - 2006
2006 data is final.

Narrative:
/2010/ Final Louisiana data show that fewer children under 15 years of age died of unintentional injuries in 2006, with a final rate of 13.0 per 100,000, than in 2005 (15.9 per 100,000) and 2004 (18.2 per 100,000). Preliminary 2007 data suggests no significant change from 2006, with a rate of 13.1 per 100,000.
Louisiana's injury data surveillance show that unintentional injuries are a leading cause of morbidity and mortality of children ages 1month through 14 years. The leading mechanisms include, motor vehicle crashes; exposure to smoke and fire; accidental drowning/submersion; and suffocation. Most unintentional injury fatalities can be prevented. Therefore, injury surveillance can identify behavioral risk factors and "at risk" groups; serve as a starting point for community assessment of needs; and measure preventable deaths. Community advocates and policy makers can use information from injury surveillance to create a safe community by prioritizing and planning prevention interventions and by triggering community and/or legislative action which targets behaviors that endanger children.
As an evaluative measure, MCH can assess the effectiveness and appropriateness of the injury prevention interventions of and resource allocations for the MCH Child Safety (Injury Prevention) Coordinators as well as outreach and education efforts of other such MCH-supported child safety programs as SIDS Risk Reduction and Safe Sleep Program, for safe sleeping environments; Child Care Health Consultant Program, for healthy and safe child care environments; School Base Health Centers, for healthy and safe schools; Safe Kids Louisiana, Inc., for safe homes, communities, recreation/play, and child passenger safety; Public Health Units, for healthy and safe families; and State and Local Child Death Review Panels, for case reviews and prevention interventions recommendations. //2010//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	7.0	4.4	4.8	5.7	5.7
Numerator	67	42	43	51	51
Denominator	963046	946320	897508	888587	888587
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data is provisional and based upon the 2007.

Notes - 2007
2007 data is provisional.

Notes - 2006
2006 data is final.

Narrative:
/2010/ According to Louisiana final data, fewer children under 15 years of age died from unintentional injuries due to motor vehicle crashes in 2006, at a rate of 4.8 per 100,000, than in 2005 (5.1 per 100,000) and 2004 (7.0 per 100,000). However, provisional 2007 data suggests an increase in the death rate to 5.7 per 100,000.
Motor vehicle crashes (MVCs) are one of the most common and preventable causes of unintentional injuries in this age group. The most effective ways to reduce deaths from MVCs are to wear seat belts and to properly restrain child passengers. Injury surveillance of deaths due to motor vehicle crashes can identify behavioral risk factors and "at risk" groups; serve as a starting point for community assessment of needs; and measure preventable deaths. Community advocates and policy makers can use information from injury surveillance to create a safe community by prioritizing and planning prevention interventions and by triggering community and/or legislative action which targets behaviors that endanger children.
As an evaluative measure, MCH can assess the effectiveness and appropriateness of the injury prevention interventions of and resource allocations for the MCH Child Safety (Injury Prevention) Coordinators, who are national child passenger safety technicians and who distribute and install infant car seats and child booster seats as well as outreach and education efforts of other such MCH-supported child safety programs as Safe Kids Louisiana, Inc., for child passenger safety, pedestrian safety, ATV safety, and back roll-over prevention; Public Health Units, for healthy and safe families; School Base Health Centers, for child passenger safety and pedestrian safety; and State and Local Child Death Review Panels, for case reviews and prevention intervention recommendations. //2010//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	36.2	28.5	34.4	35.8	35.8
Numerator	255	199	223	235	235
Denominator	705107	699069	647755	657229	657229
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data is provisional and based upon the 2007.

Notes - 2007
2007 data is provisional.

Notes - 2006
2006 data is final.

Narrative:
/2010/ According to Louisiana final data, fewer teens and young adults children ages 15 through 24 years died from unintentional injuries due to motor vehicle crashes in 2006, at a rate of 34.4 per 100,000, than in 2005 (35 per 100,000) and 2004 (36.2 per 100,000). However, provisional 2007 data suggests an increase in the death rate to 35.8 per 100,000. Motor vehicle crashes (MVCs) is one of the most common preventable causes of unintentional injuries in this age group. The most effective way to reduce deaths from MVCs is to wear seat belts. Injury surveillance of deaths due to motor vehicle crashes can identify behavioral risk factors and "at risk" groups; serve as a starting point for community assessment of needs; and measure preventable deaths. Community advocates and policy makers can use information from injury surveillance to create a safe community by prioritizing and planning prevention interventions and by triggering community and/or legislative action which targets behaviors that endanger children.
As an evaluative measure, MCH can assess the effectiveness and appropriateness of the injury prevention interventions of and resource allocations for the MCH Child Safety (Injury Prevention) Coordinators to work collaboratively with Louisiana Passenger Safety Task Force and the state Injury Research Prevention Programs well as outreach and education efforts of other such MCH-supported child safety programs as Safe Kids Louisiana, Inc., for passenger safety, pedestrian safety, and ATV safety ; Public Health Units, for healthy and safe families; and School Base Health Centers, for passenger safety and pedestrian safety. //2010//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	219.1	219.1	265.4	265.4	265.4

Numerator	2101	2101	2382	2382	2382
Denominator	958711	958711	897508	897508	897508
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data is provisional, based upon 2006 data. However, since 2002, improved methods for injury data collection have been implemented. Data is based upon nonfatal hospitalized injuries.

Notes - 2007
Data is provisional, based upon 2006 data. However, since 2002, improved methods for injury data collection have been implemented. Data is based upon nonfatal hospitalized injuries.

Notes - 2006
Data is final. A different method of data collection was used for 2001. However, since 2002, improved methods for injury data collection have been implemented. Data is based upon nonfatal hospitalized injuries.

Narrative:
/2010/ Louisiana 2007 data is provisional. Final data shows that the rate per 100,000 of all non-fatal injuries among children aged 14 years and younger has increased again in 2006 to 265.4 per 100,000 from 249.9 per 100,000 in 2005, 219.1 per 100,000 in 2004, and 164.6 per 100,000 in 2003.
Louisiana's injury data surveillance show that unintentional injuries are a leading cause of morbidity and mortality of children ages 1month through 14 years. Most unintentional injuries can be prevented. Therefore, injury surveillance can identify behavioral risk factors and "at risk" groups; serve as a starting point for community assessment of needs; and measure preventable injuries. Community advocates and policy makers can use information from injury surveillance to create a safe community by prioritizing and planning prevention interventions and by triggering community and/or legislative action which targets behaviors that endanger children.
As an evaluative measure, MCH can assess the effectiveness and appropriateness of the injury prevention interventions of and resource allocations for the MCH Child Safety (Injury Prevention) Coordinators as well as outreach and education efforts of other such MCH-supported child safety programs as SIDS Risk Reduction and Safe Sleep Program, for safe sleeping environments; Child Care Health Consultant Program, for healthy and safe child care environments; School Base Health Centers, for healthy and safe schools; Safe Kids Louisiana, Inc., for safe homes, communities, recreation/play, and child passenger safety; Public Health Units, for healthy and safe families; and State and Local Child Death Review Panels, for case reviews and prevention interventions recommendations.
Most injuries can be prevented. Therefore, non-fatal Injury data surveillance is needed to enable policy makers to identify causes of non-fatal injuries; identify behavioral risk factors and the "at risk " groups; prioritize, plan, and implement prevention interventions; and trigger community and/or legislative action which targets behaviors that endanger children. //2010//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	42.5	42.5	19.2	19.2	19.2
Numerator	407	407	172	172	172
Denominator	958711	958711	897508	897508	897508
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data is provisional, based upon 2006 data.

Notes - 2007
Data is provisional, based upon 2006 data.

Notes - 2006
Data is final. The numerateor is a low number because there were many missing e-codes.

Narrative:
/2010/ Louisiana 2007 data is provisional. According to final 2006 data, the rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger is 19.2 per 100,000, which is significantly less than the rate of 42.5 per 100,000 in 2005 and 2004. In 2003, the rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger was 49.5 per 100,000. The numerator for 2006 is a low number because there were many missing e-codes.
Motor vehicle crashes (MVCs) are one of the most common and preventable causes of unintentional injuries in this age group. The most effective ways to reduce deaths from MVCs are to wear seat belts and to properly restrain child passengers. Surveillance of injuries due to motor vehicle crashes can identify behavioral risk factors and "at risk" groups; serve as a starting point for community assessment of needs; and measure preventable deaths. Community advocates and policy makers can use information from injury surveillance to create a safe community by prioritizing and planning prevention interventions and by triggering community and/or legislative action which targets behaviors that endanger children.
As an evaluative measure, MCH can assess the effectiveness and appropriateness of the injury prevention interventions of and resource allocations for the MCH Child Safety (Injury Prevention) Coordinators, who are national child passenger safety technicians and who distribute and install infant car seats and child booster seats as well as outreach and education efforts of other such MCH-supported child safety programs as Safe Kids Louisiana, Inc., for child passenger safety, pedestrian safety, ATV safety, and back roll-over prevention; Public Health Units, for healthy and safe families; School Base Health Centers, for child passenger safety and pedestrian safety; and State and Local Child Death Review Panels, for case reviews and prevention intervention recommendations. //2010//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	139.2	139.2	85.2	85.2	85.2
Numerator	980	980	552	552	552
Denominator	704198	704198	647755	647655	647655
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data is provisional, and based on 2006. Since 2002, the primary data source of analysis and reporting for this indicator is the Louisiana Hospital Inpatient Discharge Data (LAHIDD). LAHIDD is compiled by the Health Statistics Department of the Louisiana Office of Public Health, and EMS/Injury Research and Prevention Program analyzes the data needed for this indicator. Since participation in reporting hospital inpatient discharge data is not mandatory in Louisiana, then differences in the number, size, and type of hospitals reporting annually will affect our data reported. This variability limits year-to-year comparison analyses.

Notes - 2007
Data is provisional, and based on 2006. Since 2002, the primary data source of analysis and reporting for this indicator is the Louisiana Hospital Inpatient Discharge Data (LAHIDD). LAHIDD is compiled by the Health Statistics Department of the Louisiana Office of Public Health, and EMS/Injury Research and Prevention Program analyzes the data needed for this indicator. Since participation in reporting hospital inpatient discharge data is not mandatory in Louisiana, then differences in the number, size, and type of hospitals reporting annually will affect our data reported. This variability limits year-to-year comparison analyses.

Notes - 2006
Data is final. The numerator is a low number beacuse thre were many missing e-codes. Since 2002, the primary data source of analysis and reporting for this indicator is the Louisiana Hospital Inpatient Discharge Data (LAHIDD). LAHIDD is compiled by the Health Statistics Department of the Louisiana Office of Public Health, and EMS/Injury Research and Prevention Program analyzes the data needed for this indicator. Since participation in reporting hospital inpatient discharge data is not mandatory in Louisiana, then differences in the number, size, and type of hospitals reporting annually will affect our data reported. This variability limits year-to-year comparison analyses. Also, since the CDC has changed the 2004 Census population data for Louisiana from 4,515,770 to 4,506,685, then the 2004 statistics reported are based on the new population data.

Narrative:
/2010/ Louisiana 2007 data is provisional. According to final 2006 data, the rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth and young adults ages 15 years through 24 years was 85.2 per 100,000, which is significantly less than the rate of 135.1 per 100,000 in 2005 and 139.2 per 100,000 in 2004. The numerator for 2006 is a low number because there were many missing e-codes.

Motor vehicle crashes (MVCs) is one of the most common preventable causes of unintentional injuries in this age group. The most effective way to reduce deaths from MVCs is to wear seat belts. Injury surveillance of deaths due to motor vehicle crashes can identify behavioral risk factors and "at risk" groups; serve as a starting point for community assessment of needs; and measure preventable deaths. Community advocates and policy makers can use information from injury surveillance to create a safe community by prioritizing and planning prevention interventions and by triggering community and/or legislative action which targets behaviors that endanger children.
As an evaluative measure, MCH can assess the effectiveness and appropriateness of the injury prevention interventions of and resource allocations for the MCH Child Safety (Injury Prevention) Coordinators to work collaboratively with Louisiana Passenger Safety Task Force and the state Injury Research Prevention Programs well as outreach and education efforts of other such MCH-supported child safety programs as Safe Kids Louisiana, Inc., for passenger safety, pedestrian safety, and ATV safety; Public Health Units, for healthy and safe families; and School Base Health Centers, for passenger safety and pedestrian safety. //2010//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	40.3	29.6	35.2	37.7	42.7
Numerator	6853	4981	5741	6147	6960
Denominator	169957	168289	162944	162944	162944
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
The population source is from the 2008 population estimate from U.S. Census Bureau.

Notes - 2007
The population source is from the 2008 population estimate from U.S. Census Bureau.

Notes - 2006
The population source is from the 2008 population estimate from U.S. Census Bureau.

Narrative:
/2010/ In 2008, the rate per 1,000 women aged 15-19 years with a reported case of chlamydia was 42.71, up from the 2007 rate of 37.72 and surpassing the 2005, pre-Hurricane Katrina rate of 31.61. The higher rate from 2007 data may indicate that more adolescents have access to screening as the state more fully recovers from hurricane-related impact on health services.

Public health efforts to lower this rate include the continued implementation of STI screening best practices for school-based health centers (SBHCs) throughout the state and incorporation of STI screening as part of the continuous quality improvement initiative of the Adolescent School Health Program (ASHP). In 2008-2009, ASHP required all SBHCs

to provide onsite STI screening and treatment for students, 9th Grade and higher, who are sexually active and/or symptomatic. In 2009-2010, ASHP will require SBHCs to provide onsite STI screening and treatment for students in middle school (5th -- 8th grades) who are sexually active and/or symptomatic.

The Office of Public Health Family Planning and STD programs routinely screen for Chlamydia in public health clinics. In April of 2008, the Office of Public Health Laboratory changed to amplified technology for Chlamydia. This new technology allows for a non-invasive collection method that is more sensitive than the previous technology.

This Health Status Indicator serves as a monitoring tool and evaluative measure that will help Louisiana focus its resources on continued efforts to bring down the infection rates. By reducing the proportion of adolescents and young adults with Chlamydia Trachomatitis infections, Louisiana can prevent the resulting complications of this infection.

Public health efforts to lower this rate include the routine screening in Family Planning and STD clinics. The STD Program includes Chlamydia screening as a routine part of patient care for all women attending a STD clinic. The Family Planning Program guidelines call for routine screening of women thirty and younger and women over thirty who are symptomatic or at increased risk for infection. //2010//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	12.4	9.5	10.6	12.1	13.8
Numerator	10059	7685	8723	9162	10466
Denominator	813300	811918	825380	757929	757929
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
The population source is from the 2008 population estimate from U.S. Census Bureau.

Notes - 2007
The population source is from the 2008 population estimate from U.S. Census Bureau.

Notes - 2006
The population source is from the 2008 population estimate from U.S. Census Bureau.

Narrative:
/2010/ In 2008, the rate per 1000 women aged 20 through 44 years with a reported case of Chlamydia was 13.81, up from 2007 when it was 12.09 per 1000 women aged 20 -- 44 years.

The Adolescent School Health Program (ASHP) serves students through age 21 if they are still in school. Through ASHP's School-Based Health Centers (SBHC), women age 20 and 21 receive onsite screening and treatment for STIs.

Public health efforts to lower this rate include the routine screening in Family Planning and STD clinics. The STD Program includes Chlamydia screening as a routine part of patient care for all women attending a STD clinic. The Family Planning Program guidelines call for routine screening of women thirty and younger and women over thirty who are symptomatic or at increased risk for infection. In April of 2008, the Office of Public Health Laboratory changed to amplified technology for Chlamydia. This new technology allows for a non-invasive collection method that is more sensitive than the previous technology.

This Health Status Indicator serves as a monitoring tool and evaluative measure that will help Louisiana focus its resources on continued efforts to bring down the infection rates. By reducing the proportion of adults with Chlamydia Trachomatitis infections, Louisiana can prevent the resulting complications of this infection. //2010//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	61218	36123	22488	398	831	26	1352	0
Children 1 through 4	236939	135061	92468	1512	3520	90	4288	0
Children 5 through 9	295773	170471	113717	1967	4213	139	5266	0
Children 10 through 14	294657	170295	113929	1882	4157	120	4274	0
Children 15 through 19	323073	187311	125322	2343	4473	135	3489	0
Children 20 through 24	334156	202540	120525	2385	5192	151	3363	0
Children 0 through 24	1545816	901801	588449	10487	22386	661	22032	0

Notes - 2010
Vital Records 2007 data final.

Vital Records 2007 data final.

Vital Records 2007 data final.

Vital Records 2007 data final.

Vital Records 2007 data final.

Vital Records 2007 data final.

Narrative:

/2010/ Please refer to data in FORM 21.

This measure provides information on the state's residents because it provides Public Health risk and health information based upon these factors.

The indicator provides guidance for age specific programs such as immunization, family planning, school based health and maternity care. For infants 0-1, almost 37% were African American. This data informs and directs social marketing campaigns that address the disparities in this population with higher rates of prematurity, low birth weight and Sudden Infant Death Syndrome (SIDS).

In 2007, the Hispanic/Latino population is at 4% of the population for all ages of infants and children 0-24 years. After Hurricanes Katrina and Rita, it appears that the Hispanic/Latino population in Louisiana, and particularly New Orleans, is growing. This indicator merits future monitoring of a shift in this population, a shift that would dictate new tools and methods of maternal and child health care.
Louisiana continues to monitor its shift in the Hispanic population. Many community education programs, particularly in New Orleans, are now developing print materials in Spanish and English.

MCH will continue to monitor the demographics of our children in order to evaluate the best provision for appropriate levels of service. //2010//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	59070	2148	0
Children 1 through 4	228035	8904	0
Children 5 through 9	284367	11406	0
Children 10 through 14	284303	10354	0
Children 15 through 19	313163	9910	0
Children 20 through 24	321962	12194	0
Children 0 through 24	1490900	54916	0

Notes - 2010
Vital Records 2007 data final.

Vital Records 2007 data final.

Vital Records 2007 data final.

Vital Records 2007 data final.

Vital Records 2007 data final.

Vital Records 2007 data final.

Narrative:

/2010/ Please refer to data in FORM 21.

This measure provides information on the state's residents because it provides Public Health risk and health information based upon these factors.

The indicator provides guidance for age specific programs such as immunization, family planning, school based health and maternity care. For infants 0-1, almost 37% were African American. This data informs and directs social marketing campaigns that address the disparities in this population with higher rates of prematurity, low birth weight and Sudden Infant Death Syndrome (SIDS).

In 2007, the Hispanic/Latino population is at 4% of the population for all ages of infants and children 0-24 years. After Hurricanes Katrina and Rita, it appears that the Hispanic/Latino population in Louisiana, and particularly New Orleans, is growing. This indicator merits future monitoring of a shift in this population, a shift that would dictate new tools and methods of maternal and child health care.
Louisiana continues to monitor its shift in the Hispanic population. Many community education programs, particularly in New Orleans, are now developing print materials in Spanish and English.

MCH will continue to monitor the demographics of our children in order to evaluate the best provision for appropriate levels of service. //2010//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	170	41	128	0	0	0	1	0
Women 15 through 17	2691	1002	1631	17	10	0	31	0
Women 18 through 19	6177	2778	3240	52	43	1	63	0
Women 20 through 34	50818	29689	19002	382	858	8	879	0
Women 35 or older	5799	3956	1498	30	220	0	95	0
Women of all ages	65655	37466	25499	481	1131	9	1069	0

Notes - 2010

Narrative:
/2010/ Please refer to data in FORM 21.

This measure provides information on the state's residents because it provides pregnancy information based upon these factors.

This measure provides guidance for age specific programs such as prenatal care, family planning, and direction of resources to the under or uninsured.

Live births are occurring predominately in White and African-American populations. In 2007, 56% of all births to women ages 19 and under are to African-Americans. Seventy-eight percent of births are to women between 20 and 34 years. In 2007, Hispanic/Latino live births are at about 5% of total births for all ages compared to 4% in 2006.

MCH will continue to monitor the demographics of live births to women in order to evaluate the best provision for appropriate levels of service. //2010//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	167	3	0
Women 15 through 17	2577	114	0
Women 18 through 19	5924	253	0
Women 20 through 34	48292	2500	26
Women 35 or older	5471	296	32
Women of all ages	62431	3166	58

Notes - 2010

Narrative:
/2010/ Please refer to data in FORM 21.

This measure provides information on the state's residents because it provides pregnancy information based upon these factors.

This measure provides guidance for age specific programs such as prenatal care, family planning, and direction of resources to the under or uninsured.

Live births are occurring predominately in White and African-American populations. In 2007, 56% of all births to women ages 19 and under are to African-Americans. Seventy-eight percent of births are to women between 20 and 34 years. In 2007, Hispanic/Latino live births are at about 5% of total births for all ages compared to 4% in 2006.

MCH will continue to monitor the demographics of live births to women in order to evaluate the best provision for appropriate levels of service. //2010//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**

Infants 0 to 1	585	230	350	0	4	0	1	0
Children 1 through 4	97	38	53	2	4	0	0	0
Children 5 through 9	52	31	20	0	1	0	0	0
Children 10 through 14	79	48	30	1	0	0	0	0
Children 15 through 19	300	164	129	3	3	0	1	0
Children 20 through 24	497	285	207	3	1	0	1	0
Children 0 through 24	1610	796	789	9	13	0	3	0

Notes - 2010

Narrative:
/2010/ Final data shows that there were fewer deaths for ages 0 through 24 years in 2006 of 1,674 than in 2005 (1,807). As in 2005, most were non-Hispanic (1,640), and ages 1-24 years (1,041). However, in 2006, the number of African Americans deaths (834) was slightly higher than the number of Caucasians deaths (815). For the 633 deaths of infants under 1 year of age, more were black (388), non-Hispanic (616), and only 8 were Asian. For the 1,041 deaths in the 1-24 years of age subgroup, most were Caucasian (580) and non-Hispanic (1,024). Of note, for ages 1-9, there was little difference between the number of African American deaths (76) and Caucasian deaths (71). For Hispanic deaths (22), 11 were under 1 year of age and 11 were ages 1-24 years. Of the 19 Asian deaths, 8 were under 1 year of age. Preliminary 2007 data suggests that total deaths decreased to 1,610.
This category of data will assist in directing public health efforts to reduce the number of deaths by identifying behavioral risk factors and the "at risk" groups based on age, race, and ethnicity and addressing risk factors to change behaviors through targeted, preventive interventions, including education and outreach; appropriate allocation of resources; and, if needed, legislation or public policy change. The data also serves as a public health call to action at the state and local/regional levels for the 9 regional MCH Child Safety Coordinators, the State and local Child Death Review Panels, community and state leaders as well as with the SIDS Risk Reduction and Safe Sleep Program, Louisiana SAFE KIDS, Injury Research and Prevention Program, and the Louisiana Youth Suicide Prevention Task Force.

Death rates are just one of several measures of our state's health status. Awareness of the leading causes of death can more efficiently and effectively target our efforts and resources toward building a healthier and safer community. As an evaluative measure, by comparing the state's death rates to past rates and to other states' rates, MCH can assess achievement of efforts, appropriateness of efforts, and effectiveness of preventive interventions and allocated resources over time. //2010//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	565	12	8
Children 1 through 4	93	4	0

Children 5 through 9	51	1	0
Children 10 through 14	79	0	0
Children 15 through 19	294	6	0
Children 20 through 24	480	17	8
Children 0 through 24	1562	40	16

Notes - 2010

Narrative:
/2010/ Final data shows that there were fewer deaths for ages 0 through 24 years in 2006 of 1,674 than in 2005 (1,807). As in 2005, most were non-Hispanic (1,640), and ages 1-24 years (1,041). However, in 2006, the number of African Americans deaths (834) was slightly higher than the number of Caucasians deaths (815). For the 633 deaths of infants under 1 year of age, more were black (388), non-Hispanic (616), and only 8 were Asian. For the 1,041 deaths in the 1-24 years of age subgroup, most were Caucasian (580) and non-Hispanic (1,024). Of note, for ages 1-9, there was little difference between the number of African American deaths (76) and Caucasian deaths (71). For Hispanic deaths (22), 11 were under 1 year of age and 11 were ages 1-24 years. Of the 19 Asian deaths, 8 were under 1 year of age. Preliminary 2007 data suggests that total deaths decreased to 1,610.
This category of data will assist in directing public health efforts to reduce the number of deaths by identifying behavioral risk factors and the "at risk" groups based on age, race, and ethnicity and addressing risk factors to change behaviors through targeted, preventive interventions, including education and outreach; appropriate allocation of resources; and, if needed, legislation or public policy change. The data also serves as a public health call to action at the state and local/regional levels for the 9 regional MCH Child Safety Coordinators, the State and local Child Death Review Panels, community and state leaders as well as with the SIDS Risk Reduction and Safe Sleep Program, Louisiana SAFE KIDS, Injury Research and Prevention Program, and the Louisiana Youth Suicide Prevention Task Force.

Death rates are just one of several measures of our state's health status. Awareness of the leading causes of death can more efficiently and effectively target our efforts and resources toward building a healthier and safer community. As an evaluative measure, by comparing the state's death rates to past rates and to other states' rates, MCH can assess achievement of efforts, appropriateness of efforts, and effectiveness of preventive interventions and allocated resources over time. //2010//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	1211660	699261	467924	8102	17194	510	18669	0	2007
Percent in household headed by single	42.0	0.0	0.0	0.0	0.0	0.0	0.0	42.0	2007

parent									
Percent in TANF (Grant) families	1.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	2008
Number enrolled in Medicaid	570098	200191	325534	1932	4143	247	4321	33730	2008
Number enrolled in SCHIP	134727	61226	61224	471	1351	51	854	9550	2008
Number living in foster home care	4293	0	0	0	0	0	0	4293	2008
Number enrolled in food stamp program	259770	0	0	0	0	0	0	259770	2008
Number enrolled in WIC	145667	61733	78859	1156	1342	523	2054	0	2008
Rate (per 100,000) of juvenile crime arrests	1000.0	0.0	0.0	0.0	0.0	0.0	0.0	1000.0	2007
Percentage of high school drop-outs (grade 9 through 12)	10.0	0.0	0.0	0.0	0.0	0.0	0.0	10.0	2007

Notes - 2010
Louisiana Vital Statistics preliminary 2007 data.

Children under age 18 who live with their own single parent either in a family or subfamily. Data Source: Notes: Updated September 2008. Population Reference Bureau, analysis of data from the U.S. Census Bureau, The data for this measure come from the 2000 and 2001 Supplementary Survey and the 2002 through 2007 American Community Survey (ACS).

Percent: The average number of children served by the Family Independence Temporary Assistance Program (FITAP) in a state fiscal year (July 1-June 30) per 100 children. Data Source: FITAP Numbers: Louisiana Department of Social Services, Office of Family Support, Quality Assurance Division. Population Data: Population Estimates Program, Population Division, U.S. Census Bureau Washington D.C. Release Date: August 7, 2008. Available at http://www.census.gov/popest/estimates.php Notes: FITAP provides cash assistance to families with children when the financial resources of the family are insufficient to meet subsistence needs. The average family consists of a mother and two children. The average grant in Louisiana is $200 per month.

From Medicaid: Unduplicated Count of Eligibles by Race FFY 2008 (October 2007- September 2008). Ages 0-19. Hispanic or Latino includes Hispanic or Latino (no other race information) AND Hispanic or Latino and one or more races. Ethinicity not reported includes Invalid Race Code AND More than One Race (Hispanic or Latino not indicated) AND Unknown.

From Medicaid: Unduplicated Count of Eligibles by Race FFY 2008 (October 2007- September 2008). Ages 0-19. Hispanic or Latino includes Hispanic or Latino (no other race information) AND Hispanic or Latino and one or more races. Ethinicity not reported includes Invalid Race Code AND More than One Race (Hispanic or Latino not indicated) AND Unknown

Number: The average number of children served by the Food Stamp program in a given state fiscal year (July 1-June 30).
Data Source: Food Stamp data: Louisiana Department of Social Services, Office of Family Support, Quality Assurance Division.

Data is for FFY 2008. The number was derived by adding the number of infants and children that participated in the reporting year, based on the average number of vouchers. This was found to be more accurate versus using unique identifiers. Past counts of unique identifiers included children later found to be ineligible or duplicates.

The racial and ethnic breakdown were derived from the PHAME Report. Information based upon Race/Idenity as entered into PHAME. This was used to pull a percentage of race and apply to the actual participation numbers. The participation numbers are not unique pass ID's, they reflect the actual number of people served (holding WIC benefits).

Data source: Analysis of arrest data from the FBI's Crime in the United States 2007 (Washington, DC: Federal Bureau of Investigation, 2008), tables 5 and 69, and population data from the National Center for Health Statistics' Estimates of the July 1, 2000–July 1, 2007, United States Resident Population From the Vintage 2007 Postcensal Series by Year, County, Age, Sex, Race, and Hispanic Origin [machine-readable data files available online at http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm, released 9/5/2008]. Juvenile arrest rates are calculated by dividing the number of arrests of persons ages 10–17 by the number of persons ages 10–17 in the population.

Teenagers between the ages of 16 and 19 who are not enrolled in high school and are not high school graduates.
Notes: Updated September 2008.
The data for this measure come from the 2000 and 2001 Supplementary Survey and the 2002 through 2007 American Community Survey (ACS). The 2000 through 2004 ACS surveyed approximately 700,000 households monthly during each calendar year. Beginning in January 2005, the U.S. Census Bureau expanded the ACS sample to 3 million households (full implementation), and in January 2006 the ACS included group quarters. The ACS, fully implemented, is designed to provide annually updated social, economic, and housing data for states and communities. (Such local-area data have traditionally been collected once every ten years in the long form of the decennial census.) This measure focuses on teens ages 16 to 19 rather than young adults 16 to 24 because a large share of 18- to 24-year-olds migrate across state lines each year. The high interstate migration rates confound the connection between state policies and programs and state dropout rates. Raw numbers are rounded to the nearest thousand.

Source: Louisiana Department of Social Services/Office of Community Services. Data is for Calendar Year 2008.

Narrative:
/2010/ Please refer to data in FORM 21.

This indicator provides information on the state's residents because it provides Public Health risk and health information based upon these factors.

This data provides guidance for race and ethnicity specific programs such as SCHIP, Medicaid and WIC. The data informs the MCH program in providing advice to other miscellaneous programs. This data informs and directs health and social marketing campaigns that address disparities in this population.

For children aged 0-19 years of age, Annie Casey Foundation 2008 Report ranks LA 49th with 42% in a household with a single parent. For teenagers between the ages of 16 and 19 who are not enrolled in high school and are not high school graduates, Louisiana ranks 49th in the nation with a drop out rate at 10%. Louisiana's rate of juvenile arrests is 2,717 per 100,000 persons. This is compared to a national rate of 2,312 per 100,000 persons under the age of 18. //2010//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	1168938	42722	0	2007
Percent in household headed by single parent	0.0	0.0	42.0	2007
Percent in TANF (Grant) families	0.0	0.0	1.0	2008
Number enrolled in Medicaid	529477	15565	25056	2008
Number enrolled in SCHIP	124602	3248	6877	2008
Number living in foster home care	0	0	4293	2008
Number enrolled in food stamp program	0	0	259770	2008
Number enrolled in WIC	137548	8119	0	2008
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	1000.0	2007
Percentage of high school drop-outs (grade 9 through 12)	0.0	0.0	10.0	2007

Notes - 2010
Annie E. Casey Foundation, KIDS COUNT (http://aecf.org/kidscount/) This is for Children under age 18 who live with their own single parent either in a family or subfamily. Updated September 2008. No further ethnicity breakdown is given.

Number: The average number of children served by the Food Stamp program in a given state fiscal year (July 1-June 30).
Data Source: Food Stamp data: Louisiana Department of Social Services, Office of Family Support, Quality Assurance Division. No further racial breakdown is given.

Data source: Analysis of arrest data from the FBI's Crime in the United States 2007 (Washington, DC: Federal Bureau of Investigation, 2008), tables 5 and 69, and population data from the National Center for Health Statistics' Estimates of the July 1, 2000–July 1, 2007, United States Resident Population From the Vintage 2007 Postcensal Series by Year, County, Age, Sex, Race, and Hispanic Origin [machine-readable data files available online at http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm, released 9/5/2008]. Juvenile arrest rates are calculated by dividing the number of arrests of persons ages 10–17 by the number of persons ages 10–17 in the population. No further racial breakdown is given.

Teenagers between the ages of 16 and 19 who are not enrolled in high school and are not high school graduates.
Notes: Updated September 2008.
The data for this measure come from the 2000 and 2001 Supplementary Survey and the 2002 through 2007 American Community Survey (ACS). The 2000 through 2004 ACS surveyed

approximately 700,000 households monthly during each calendar year. Beginning in January 2005, the U.S. Census Bureau expanded the ACS sample to 3 million households (full implementation), and in January 2006 the ACS included group quarters. The ACS, fully implemented, is designed to provide annually updated social, economic, and housing data for states and communities. (Such local-area data have traditionally been collected once every ten years in the long form of the decennial census.) This measure focuses on teens ages 16 to 19 rather than young adults 16 to 24 because a large share of 18- to 24-year-olds migrate across state lines each year. The high interstate migration rates confound the connection between state policies and programs and state dropout rates. Raw numbers are rounded to the nearest thousand. No further racial breakdown is given.

Source: Louisiana Department of Social Services/Office of Community Services. Data is for Calendar Year 2008. No further ethnic breakdown is available.

Narrative:
/2010/ Please refer to data in FORM 21.

This indicator provides information on the state's residents because it provides Public Health risk and health information based upon these factors.

This data provides guidance for race and ethnicity specific programs such as SCHIP, Medicaid and WIC. The data informs the MCH program in providing advice to other miscellaneous programs. This data informs and directs health and social marketing campaigns that address disparities in this population.

For children aged 0-19 years of age, Annie Casey Foundation 2008 Report ranks LA 49th with 42% in a household with a single parent. For teenagers between the ages of 16 and 19 who are not enrolled in high school and are not high school graduates, Louisiana ranks 49th in the nation with a drop out rate at 10%. Louisiana's rate of juvenile arrests is 2,717 per 100,000 persons. This is compared to a national rate of 2,312 per 100,000 persons under the age of 18. //2010//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	652051
Living in urban areas	940869
Living in rural areas	360667
Living in frontier areas	5227
Total - all children 0 through 19	1306763

Notes - 2010

Narrative:
/2010/ Please refer to data in FORM 21.

This indicator provides information on the state's residents because it provides Public Health risk and health information by geographic area. Risk to children may be based upon rural or metropolitan living environments.

For children ages 0-19 years of age, 75% live in metropolitan areas with 72% living in

urban areas. Almost one third of this population, or 28%, lives in rural or frontier areas. //2010//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	4410796.0
Percent Below: 50% of poverty	9.4
100% of poverty	16.1
200% of poverty	35.9

Notes - 2010
Source: Population Division, U.S. Census Bureau, Annual Estimates of the Resident Population for Counties of Louisiana: April 1, 2000 to July 1, 2008 (CO-EST2008-01-22). Release Date: March 19, 2009.

Source: QT-P34. Poverty Status in 1999 of Individuals: 2000 U.S. Census Bureau, Census 2000 Summary File 3, Matrices PCT 9, PCT50, PCT51, PCT52, PCT53, PCT 54, and PCT55.

Source: U.S. Census Bureau, Current Population Survey, 2008 Annual Social and Economic Supplement POV 46.

Source: U.S. Census Bureau, Current Population Survey, 2008 Annual Social and Economic Supplement POV 46.

Narrative:
/2010/ Please refer to data in FORM 21.

Two in ten people in Louisiana are at the poverty level with almost one in ten at 50% of the poverty level.

This measure provides information on the state's residents because it provides Public Health risk and health information by poverty level. Risk to individuals may be evaluated based upon poverty level. //2010//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	1211660.0
Percent Below: 50% of poverty	12.0
100% of poverty	27.0
200% of poverty	49.0

Notes - 2010
Louisiana Vital Records 2007.

The share of children under age 18 who live in families with incomes less than 50 percent of the federal poverty level, as defined by the U.S. Office of Management and Budget. Data Source: Population Reference Bureau, analysis of data from the U.S. Census Bureau, Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2007 American Community Survey. Notes: Updated September 2008. The data for this measure come from the 2000 and 2001 Supplementary Survey and the 2002 through 2007 American Community Survey (ACS). The 2000 through 2004 ACS surveyed approximately 700,000 households monthly during each calendar year. In general but particularly for these years, use caution when interpreting estimates for less populous states or indicators representing small subpopulations, where the sample size is relatively small. Beginning in January 2005, the U.S. Census Bureau expanded the ACS sample to 3 million households (full implementation), and in January 2006 the ACS included group quarters. The ACS, fully implemented, is designed to provide annually updated social, economic, and housing data for states and communities. (Such local-area data have traditionally been collected once every ten years in the long form of the decennial census.)
The federal poverty definition consists of a series of thresholds based on family size and composition. In 2000, a 50% poverty threshold for a family of two adults and two children was $8,731. Poverty status is not determined for people in military barracks, institutional quarters, or for unrelated individuals under age 18 (such as foster children).

The share of children under age 18 who live in families with incomes less than 200 percent of the federal poverty level, as defined by the U.S. Office of Management and Budget. Data Source: Population Reference Bureau, analysis of data from the U.S. Census Bureau, Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2007 American Community Survey. Notes: Updated September 2008. The data for this measure come from the 2000 and 2001 Supplementary Survey and the 2002 through 2007 American Community Survey (ACS). The 2000 through 2004 ACS surveyed approximately 700,000 households monthly during each calendar year. In general but particularly for these years, use caution when interpreting estimates for less populous states or indicators representing small subpopulations, where the sample size is relatively small. Beginning in January 2005, the U.S. Census Bureau expanded the ACS sample to 3 million households (full implementation), and in January 2006 the ACS included group quarters. The ACS, fully implemented, is designed to provide annually updated social, economic, and housing data for states and communities. (Such local-area data have traditionally been collected once every ten years in the long form of the decennial census.) The federal poverty definition consists of a series of thresholds based on family size and composition. In 2000, a 200% poverty threshold for a family of two adults and two children was $34,926. Poverty status is not determined for people in military barracks, institutional quarters, or for unrelated individuals under age 18 (such as foster children).

Narrative:
/2010/ Please refer to data in FORM 21.

In 2007, Annie Casey Foundation 2008 report 27% of children in Louisiana are living at the 100% of the poverty level with almost 50% at 200% of the poverty level. Children live in higher rates of poverty than the population as a whole.

This measure provides information on the state's children because it provides Public Health risk and health information by poverty level. Risk to children may be evaluated based upon poverty level. //2010//

F. Other Program Activities

Infrastructure Building Services

Surveillance
MCH, in conjunction with the Genetics and Lead Section in the Office of Public Health (OPH), has been the recipient of a CDC lead surveillance and prevention grant to establish a statewide population based childhood lead surveillance system. This Program utilizes data from the surveillance system to develop initiatives in those areas of the State with the highest prevalence of childhood lead poisoning. Initiatives include outreach, public and professional education, and developing partnerships with community agencies and organizations to decrease childhood lead poisoning. A Plan For the Elimination of Childhood Lead Poisoning has been developed and is in the process of implementation. /2007/Funding of the Louisiana Childhood Lead Poisoning Program (LaCLPPP) by CDC, through a cooperative agreement, was renewed for another 5 year cycle through 2010 to continue providing electronic blood lead level surveillance and case management prevention services for children.//2007// /2009/ Outreach to pediatric providers emphasized state mandatory child lead screening regulations. //2009// ***/2010/ New state regulations mandate universal lead screening of all children 6 months to 72 months of age. //2010//***

Other information systems to monitor health include development of a statewide immunization registry (LINKS), ongoing pediatric nutrition surveillance of children through the Pediatric Nutrition Surveillance System (PDNSS), and a State Child Death Review Panel, which also coordinates and supports Local Child Death Review Panels. /2009/ LA Child Death Review received training on the CDC web-base case reporting tool. //2009//
The CSHS program has implemented recent legislation for a Birth Defects Monitoring Network for surveillance and referral to services. The system began surveillance activities in January 2005. /2008/The Birth Defects Monitoring System currently provides surveillance for approximately 50% of births in Louisiana. The program will receive $230,000 additional state funding and a new position for 2008 to aid in gradual expansion to a statewide system that also provides families with referral information for appropriate diagnosis related services.//2008// /2009/ The Birth Defects Monitoring Network received additional funding and is in the process of expanding to cover 70% of births. A healthcare resource guide was developed which will be sent to parents of infants in the system. //2009// ***/2010/ New Governor- approved representatives will serve on the State Child Death Review Panel for the next 3 years. //2010//***

Coordination/Policy Development
The MCH Program has participated in the development and implementation of the Early Childhood Supports and Services Program. This 6 parish pilot program is an initiative of the Office of Mental Health that establishes a local system for referral of children from birth to 5 years who are at risk for the development of poor mental health, emotional, or developmental outcomes. Children who are screened and found to be at risk for poor outcomes are referred to a local multi-agency coordinating group who develop a plan to provide the supports and services that are needed to improve the outcomes for the individual children and their families. A system for screening and referral of infants in the pilot parishes through the local public health units has been implemented. In addition, a pilot collaboration of the ECSS and EarlySteps Regional Advisory groups has been initiated to reduce duplication in services to children birth to age 3. This program is planned to be expanded to an additional 8 parishes in 2005. /2009/ The Louisiana Early Childhood Supports and Services Program currently has 9 sites in 13 parishes. //2009//

Through the federally funded State Systems Development Initiative for Early Childhood Comprehensive Services Systems (ECCS), the MCH Program has worked with the Louisiana Children's Cabinet and its Advisory Group to establish a framework for the implementation of a system of comprehensive services for the early childhood period. A Needs Assessment focusing on the areas of a Medical Home, Mental Health/Socio-emotional Services, Child Care and Early Education, Parent Education, and Family Support Services had been completed and a Strategic Plan is being completed with plans to begin implementation of the plan in the next year.

/2007/Louisiana's Early Childhood Comprehensive Systems Initiative (ECCS), under the direction

of the MCH Program and the auspices of the Governor's Children's Cabinet, has completed an extensive strategic and implementation plan. The strategic plan will enable Louisiana to build a sustainable, comprehensive, coordinated, efficient, and effective system to yield high quality programs and an infrastructure to support and sustain early childhood services.

The MCH Program will have the lead role in the development of Louisiana's MCH Emergency Preparedness and Response Consensus Recommendations for natural and manmade disasters and mass casualty incidents. The planning process will be a collaborative effort of MCH and EMS-C Programs, through the office of Public Health, the Louisiana Chapter of the American Academy of Pediatrics, the State Perinatal Commission, and key community partners.//2007// /2009/ Louisiana BrightStart (ECCS) is completing its second implementation year. //2009// ***/2010/ BrightStart (ECCS) and the Louisiana Partnership for Children and Families have developed a social marketing campaign around BrightStart and early childhood issues. //2010//***

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

Children's Special Health Services has completed the redesign and transfer of the Part C of IDEA system in Louisiana to the Office of Public Health. In addition to the involvement of parents and stakeholders in redesign activities, other offices in OPH as well as DHH continue to be involved in the Part C Program named Early Steps. EarlySteps staff have participated in the ECCS grant activities. The number of enrolled children in Part C has increased by 43% in the first two years of implementation. Due to the tremendous increase in infants and toddlers served, budget overruns occurred. The program is in the process of a restructuring to make the most efficient use of limited funds. The restructuring of EarlySteps will have significant impact on the system of services for young children in Louisiana. New eligibility requirements and asking families to participate in the cost of services will establish cost containment but limit services to children with a moderate degree of developmental delay. /2008/Following Hurricanes Katrina and Rita the number of children served by the program was decreased due to the mobility of families and providers, with many leaving the state. In the 2008 state application for Part C funding, eligibility criteria were broadened and cost participation of families was eliminated before ever being implemented. The program will be moved to the Office for Citizens with Developmental Disabilities in July 2007, which serves children beginning at age 3 years. The addition of Early Steps will permit OCDD to serve children with disabilities from birth.//2008// ***/2010/ CSHS is collaborating with programs from OCDD and DSS to create an integrated Master Patient Database to assist with provision of care coordination services. //2010//***
/2010/ CSHS participates in several healthcare reform committees including the DHH CSHCN workgroup, the AAP CSHCN workgroup, and the LHCQF Medical Home Advisory Board. //2010//

G. Technical Assistance

/2010/ Technical Assistance needs are described in Form 15. Please see this form for a complete list of anticipated needs. //2010//

V. Budget Narrative

A. Expenditures

Successful efforts to redirect funding began soon after the Office of Public Health downsizing in 2001. A plan was developed based on the 2000 MCH Needs Assessment to establish new infrastructure for MCH activities through contract agencies. Since 2001, MCH staff has been establishing partnerships in each region to build MCH infrastructure and services. The success of these efforts is reflected in the increase in expenditures in fiscal years 2002 through 2004. Expenditures have increased to pre-2001 levels.

On Form 3, FY 2004 budgeted figures for Unobligated Balance was zero and the expended amount was $2,017,772. This was due to under-collection in the Program Income category. Program Income was projected to be much higher than was actually collected. This was due to delays in obtaining federal approval from the Centers for Medicare and Medicaid for the expansion of the Nurse Family Partnership Program as a Medicaid covered service in 3 additional regions of the state. Approval was given in the following fiscal year and will be reflected in the FY 2005 expenditure report. This delay in obtaining approval and collections resulted in this amount of unobligated MCH funds expended during FY 2004. /2007/ State Funds: In SFY 2005, fewer State Funds were expended than originally budgeted because the state increased its collection from Title XIX, Medicaid, and was able to use those funds instead. Local MCH Funds: In SFY 2005, fewer Local MCH Funds were expended than originally budgeted because the state increased its collection from Title XIX, Medicaid, and was able to use those funds instead. Program Income: In SFY 2005, Program Income expended was greater than originally budgeted due to changes in Medicaid Billing requirements. The State was able to retroactively bill for newly approved services areas in the Nurse Family Partnership Program, resulting in higher than projected collections. //2007// /2008/ On Form 3, FY 2006 budgeted amount for Federal Allocation was much higher than the expended amount due to hurricanes Katrina and Rita. Office of Public Health lost staff who relocated out of state and contracts were cancelled due to staff leaving Louisiana. Recruiting new staff continues to be problematic in post-hurricane Louisiana. For the same reason, Program Income also had much lower expenditures than the budgeted amount for FY 2006. Also for this same reason Local MCH Funds was higher than the budgeted amount for FY 2006.//2008//

On Form 4, FY 2004 budgeted amount for Pregnant Women was set too low compared to expenditures. Prenatal care and Nurse Family Partnership contracts that began in FY 2003 became fully operational in FY 2004, thus increasing the expended amount. The FY 2004 budgeted amount for children 1 to 22 years was set too high, and the expended amount was consistent with prior fiscal years. The FY 2004 budgeted amount for the Other category was set too low compared to the expended amount, which is consistent with the amount budgeted for Family Planning services. The FY 2004 expended amount for Administration was lower than the budgeted amount due to the overall expenditures being lower than the budgeted amount. /2007/ Pregnant Women: In FY 2005, the budgeted amount for Pregnant Women was set too low compared to expenditures. The number of pregnant women served in 2005 increased. Nurse Family Partnership mothers served and number of visits increased by about 20% each from the previous year, thus increasing the expended amount. CSHCN: In SFY 2005, the Office of Public Health made significant cuts to the budget in the area of contractual services. This was due to overall agency reductions to remain in budget. Because Children's Special Healthcare Services (CSHS) has a large part of their budget in contractual services of physicians, hospitals, parent support and special projects, the program was affected to a significant degree during this time period.//2007//

/2008/ On Form 4, Pregnant Women expenditures was much lower than the budgeted amount for FY 2006 due to the loss of all clinic facilities and providers in the New Orleans region due to hurricane Katrina. Four large prenatal clinics were closed due to the hurricane as well as contracted enabling services for pregnant women in the region. Expenditures for Infants under-1-

year-old were higher than the budgeted amount due to the prioritization of immunizing children in post hurricane Louisiana, resulting in higher expenditures in the Immunization Program. Expenditures for the Other category was lower than the budgeted FY 2006 amount. The Other category is dedicated to the Family Planning Program services and there was a reduction in the number of patients served by over 13% in post-hurricane Louisiana. All Family Planning clinics in New Orleans, including the largest clinic in the state, was closed post-Katrina and continues to be closed. The Administration category also had expenditures lower than the budgeted amount due to the overall decrease in expenditures.//2008//

On Form 5, in FY 2004, expenditures on Direct Services decreased while expenditures on Enabling Services increased. This was due to the increase in Nurse Family Partnership expenditures resulting from program expansion and the continuing decrease in direct maternity and child health services delivered by the Parish Health Units. Expenditures on Infrastructure Building services were less than the budgeted amount due to loss of the reporting mechanism that previously extracted Regional Office of Public Health Infrastructure expenditures from the Direct Services category. /2007/ Infrastructure: In SFY 2005, MCH offered an educational program to every region on expense coding. Nurses and management were encouraged to only code to Child Health and Maternity Infrastructure in limited cases where true infrastructure activities were performed and then by only Regional or Central Office staff. Expended Infrastructure costs were less than those budgeted due to this clarification in assigning expenses. //2007//
/2008/ On Form 5, the expended amount for Direct Health Care Services was lower than the FY 2006 expended amount due to the loss of over half of the population in New Orleans, the loss of clinic facilities, the loss of contract providers and Office of Public Health staff resulting from Hurricanes Katrina and Rita.//2008//

/2009/ On Form 3, FY 2007 budgeted amount for Federal Allocation continued to be higher than the expended amount due to the impact of Hurricanes Katrina and Rita. The attrition in agency and contract staff continued and recruiting staff in the hurricane impacted areas continued to be problematic. On Form 3, FY 2007 Local MCH Funds were budgeted low due to Hurricanes Katrina and Rita, but funding and need increased by the end of the fiscal year.

On Form 4, Pregnant Women expenditures were lower than budgeted amount for FY 2007 due to loss of clinic facilities and providers in the New Orleans region due to Hurricane Katrina. Prenatal clinics funded by MCH continued to be closed during FY 2007. Infant expenditures were lower than budgeted amount for FY 2007 due to loss of agency and contract staff in the areas impacted by Hurricanes Katrina and Rita. CSHCN budgeted amount was set too low anticipating similar reductions as found in other populations. Since there was a drastic loss of pediatric subspecialists in the hurricane affected areas, the CSHCN Program provided a greater amount of direct clinical services because the need was so great. Others expenditure was lower than budgeted amount for FY 2007 due to loss of the largest Family Planning clinic facility in New Orleans. The overall Administration expenditures for FY 2007 continued to be lower than the budgeted amount due to the loss of agency and contract staff due to Hurricanes Katrina and Rita, resulting in lower expenditures for Administration.

On Form 5, the overall expenditures for FY 2007 Direct Health Care Services, continued to be lower than the budgeted amount due to the loss of agency and contract staff due to Hurricanes Katrina and Rita, resulting in lower expenditures for direct services. The overall expenditures for FY 2007 Enabling Services, continued to be lower than the budgeted amount due to the loss of agency and contract staff due to Hurricanes Katrina and Rita, resulting in lower expenditures for enabling services. //2009//

/2010/ On Form 3, FY 2008 budgeted amount for Federal Allocation was higher than the expended amount due to additional state funding available in FY 2008, requiring less federal funding to cover expenditures. On Form 3, FY 2008 the State Funding expended amount was higher than the budgeted amount, due to additional state funding available

and utilized in FY 2008. On Form 3, FY 2008 budgeted amount for Local Funds was higher than the expended amount due to additional state funding available and utilized in FY 2008, requiring less local funding to cover expenditures.

On Form 4, FY 2008 budgeted amount for infants was higher than the expended amount. FY 2008 expenditures for infants were consistent with previous years while the budgeted amount was set too high. On Form 4, FY 2008 budgeted amount for Others was higher than the expended amount due to additional state funding utilized in FY 2008, requiring less federal funding to cover expenditures for family planning services. On Form 4, FY 2008 budgeted amount for Administration was lower than the expended amount due to the FY 2008 budgeted amount for Administration being set too low, with expenditures growing at a consistent level over the past few years post-hurricanes Katrina and Rita.

On Form 5, FY 2008 budgeted amount for Population-Based Services was higher than the expended amount due to FY 2008 the budgeted amount being set too high, with expenditures consistent with previous years. On Form 5, FY 2008 budgeted amount for Infrastructure Building Services was higher than the expended amount due to the FY 2008 budgeted amount being set too high, with expenditures consistent with previous years. //2010//

B. Budget

The following services and projects are funded by the MCH Block Grant, Title XIX, patient fees, insurance reimbursements, and local and state funds:

1. Maternity/Family Planning
2. Child Health Preventive/primary services for children birth to 21.

a. Child Health
b. Communicative Disorders Preventive
c. Immunization

3. Children's Special Health Services

a. Children's Special Health Services

The MCH Block Grant supports the state central and regional administrative consultative staff who sets standards of care, develop policies and procedures, train field staff, and provide quality assurance. The amount budgeted for the Central Office of Public Health MCH staff represents the cost of building the capacity of the state to develop community based systems of care. This amount is presented for each of the program components. In addition, other core public health services, direct personal health services, enabling services, and population-based services are included in the following budget. Please see the attachment, Tables 1, 2 and 3, for each type of service for each program component.

The service areas (reporting categories), which relate to preventive and primary care services for children, are provided in Table 2 (see attachment). The amount of funds budgeted in these service areas for fiscal year 2006 exceeds 30 percent of the total MCH Block grant. Thus, there is no need to redirect the MCH program in order to comply with this requirement. Compliance verification based on the actual funds disbursed will be performed and documented by the Fiscal Office at the end of each state fiscal year.
/2007/ For Fiscal Year 2007, the amount of funds budgeted for Preventive and Primary Care Services for children exceeds 30% of the total MCH Block Grant. Thus, there is no need to redirect the MCH program in order to comply with this requirement. //2007//

A minimum of 30 percent of federal funds received for use in subsequent fiscal years and the associated match will be budgeted for use in programs that provide services for children with special health care needs. The amounts listed on Table 3 (see attachment) will be budgeted for fiscal year 2006. Compliance verification based on the actual funds disbursed will be performed

and documented by the Fiscal Office at the end of each state fiscal year.
/2007/ For Fiscal Year 2007, the amount of funds budgeted for Children with Special Health Care Needs exceeds 30% of the total MCH Block Grant. Thus, there is no need to redirect the MCH program in order to comply with this requirement. //2007//

Sources of State Match and Overmatch Funds
Funds for Maternal and Child Health Services will be obtained from state general funds.

Program Income
Program income comes from Title XIX funds, fees, and third party payers. Table 4 (see attachment) presents the distribution of this income by program component.

Budgeting for Cross cutting Programs
The Office of Public Health is able to associate all expenditures including each staff person's work activity with the correct funding source by a system using reporting categories. The Office of Public Health budget is divided into many service areas, each identified by a reporting category. Most Office of Public Health employees utilize this Reporting Category system to allocate their time and other expenditures to a particular project or service area. This system allows staff working across many programs to allocate their time and other expenditures appropriately.

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

Fees
Maternal and child health patients receiving services at parish health units and are above 100% of the poverty level are charged $5 per clinic visit and $5 for pharmacy services. Individuals receiving only immunizations, and that are above 100% of the poverty level, are charged $10.00. Family planning patients are charged fees according to a sliding fee scale.

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

Office of Assistant Secretary-Management Information Systems (MIS)
Human Resources Section - Policy, Planning and Evaluation
Administrative Services Operations and Support Services
Statewide Costs (Purchasing, Civil Service, Treasurer, Fiscal, etc.)

Collectively these are referred to as Executive Overhead costs. Compliance verification of the 10 percent administrative restriction will be performed and documented by the Fiscal Office at the end of each state fiscal year. The estimated administrative costs for the total budget are $4,376,520 for fiscal year 2005-2006. The estimated Federal share is $1,420,352 or 10.0% of the federal funds requested.
/2007/The estimated administrative costs for the total budget are $4,094,726 for fiscal year 2006-2007. The estimated Federal Share is $1,356,503 or 10.0% of the federal funds requested. //2007//

Administrative Cost Limit - The administrative budget represents no more than 10.0% of the federal funds requested.

/2007/"30 30" Minimum Funding Requirements - The preventive and primary care services for children represent 35.06% of the Block Grant and Children with Special Health Care Needs represent 32.02% of the Block Grant budget. The definitions and descriptions of the services for these project components can be found in the program narratives.//2007//

/2008/ The MCH Block Grant supports the state, central, and regional administrative consultative staff who sets standards of care, develop policies and procedures, train field staff, and provide quality assurance. The amount budgeted for the Central Office of Public Health MCH staff represents the cost of building the capacity of the state to develop community based systems of care. This amount is presented for each of the program components. In addition, other core public health services, direct personal health services, enabling services, and population-based services are included in the following budget. Please see the attachment, Tables 1, 2 and 3, for each type of service for each program component, including the amount budgeted for the service separated into the federal contributions.

The service areas (reporting categories), which relate to preventive and primary care services for children, are provided in Table 2 (see attachment). The amount of funds budgeted in these service areas for fiscal year 2008 exceeds 30 percent of the total MCH Block grant. Thus, there is no need to redirect the MCH program in order to comply with this requirement. Compliance verification based on the actual funds disbursed will be performed and documented by the Fiscal Office at the end of each state fiscal year.

A minimum of 30 percent of federal funds received for use in subsequent fiscal years and the associated match will be budgeted for use in programs that provide services for children with special health care needs. The amounts listed on Table 3 (see attachment) will be budgeted for fiscal year 2008. Compliance verification based on the actual funds disbursed will be performed and documented by the Fiscal Office at the end of each state fiscal year.

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

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Program income comes from Title XIX funds, fees, and third party payers. Table 4 (see attachment) presents the distribution of this income by program component.

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

Fees
Maternal and child health patients receiving services at parish health units and are above 100% of the poverty level are charged $5 per clinic visit and $5 for pharmacy services. Individuals receiving only immunizations, and that are above 100% of the poverty level, are charged $10.00. Family planning patients are charged fees according to a sliding fee scale.

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

Office of Assistant Secretary-Management Information Systems (MIS)

- Human Resources Section - Policy, Planning and Evaluation
Administrative Services Operations and Support Services
Statewide Costs (Purchasing, Civil Service, Treasurer, Fiscal, etc.)

Collectively these are referred to as Executive Overhead costs. Compliance verification of the 10 percent administrative restriction will be performed and documented by the Fiscal Office at the end of each state fiscal year. The estimated administrative costs for the total budget are $4,376,520 for fiscal year 2006-2007. The estimated Federal share is $1,356,503 or 10.0% of the federal funds requested.

Administrative Cost Limit - The administrative budget represents no more than 10.0% of the federal funds requested.

"30 30" Minimum Funding Requirements - The preventive and primary care services for children represent 38.7% of the Block Grant and Children with Special Health Care Needs represent 32.0% of the Block Grant budget. The definitions and descriptions of the services for these project components can be found in the program narratives.//2008//

/2009/ "30 30" Minimum Funding Requirements - The preventive and primary care services for children represent 35.4% of the Block Grant and Children with Special Health Care Needs represent 30.0% of the Block Grant budget. //2009//

/2010/ "30 30" Minimum Funding Requirements - The preventive and primary care services for children represent 32.7% of the Block Grant and Children with Special Health Care Needs represent 31.5% of the Block Grant budget. //2010//

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

Allocation for Activity Conducted to Continue Consolidated Health Programs
The following federally funded programs were consolidated by the Maternal and Child Health Block Grant in fiscal year 1981 1982 in Louisiana:
1. Maternal and Child Health Program;
2. Crippled Children's Services Program (in Louisiana called Children's Special Health Services);
3. Supplemental Security Income/Disabled Children's Program
4. Lead Based Paint Poisoning Prevention Program (previously funded only in City of New Orleans in Louisiana);
5. Genetic Diseases Program (incorporated previous funds for sickle cell disease at Flint Goodridge Hospital in N.O.);
6. Sudden Infant Death Syndrome (SIDS) not funded in Louisiana; and
7. Adolescent Pregnancy Program not funded in Louisiana.

The following state funded programs in effect in Louisiana at the time of Block Grant Legislation in 1981 were also incorporated into the Maternal and Child Health Block Grant:
1. Genetic Diseases Program statewide screening for certain inherited disorders such as PKU, hypothyroidism, and sickle cell anemia.
2. Sudden Infant Death Syndrome (SIDS) Program follow up and counseling of affected families statewide.

Special Projects In Effect Before August 31, 1981

1. Maternal and Infant Care Project discontinued;
2. Children and Youth Project discontinued;
3. Family Planning absorbed into general Family Planning Program; Title V funding for Family Planning Program is budgeted at $1,925,000;
4. Dental Health For Children reduced services current funding for Dental Services for Children's Special Health Services New Orleans District Office;
5. Neonatal Intensive Care absorbed by Louisiana State University Medical Center in Shreveport.

An attachment is included in this section.

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.