Maternal and Child Health Services Title V Block Grant

State Narrative for Massachusetts

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

Massachusetts hereby attests to all of the Assurances and Certifications required for this Application. Copies signed for this application are on file with the Massachusetts Department of Public Health and are available upon request to either the Title V Director or the Department's Chief Financial Officer.

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

/2008/The Family Initiatives Director worked with Family TIES to organize focus groups of parents of CSHCN in each DPH region and a focus group conducted in Spanish. Families of CSHCN identified needs related to the 6 MCH core outcomes that were incorporated as initiatives on the state's Family Support Plan. The state's SSDI project supports involvement of more diverse families in these activities.

The BFCH developed a web site to accept comments on existing priorities, measures, and key activities. Information encouraging use of the web site or a new email address specifically for comments was distributed through WIC, at a statewide meeting of parents of CSHCN, and at a youth advisory group. Comments received to date were in support of existing plans.

The new DPH Commissioner, John Auerbach, completed meetings for input about public health priorities in each DPH region. A decision was made not to hold separate hearings on the MCH Block Grant alone, but to use information gathered from these events. Public comment also addressed MCH concerns. Current MCH priorities and initiatives are in line with the expected Departmental priorities.//2008//

/2009/ The DPH Commissioner held follow-up meetings in each DPH region similar to 2008 to report priorities and gather additional input including about MCH issues. MCH priorities and initiatives continue to be in line with Departmental priorities. The Regional Directors helped ensure broad participation and input. The information from these sessions especially in relation to early childhood and family involvement was utilized in the process of reviewing and updating the application.
Over 240 parents and family members of CSHCN provided substantial consultation through various venues for the Family Support Plan/MCH. As further described in the needs assessment section, easy access to resource information and short term support in crisis situations emerged as the most important, followed by a simplified service system (comparable agency eligibility requirements and a single point of entry for multiple agencies). Families asked for DPECSHN

help reminding providers, the community and other DPH programs that CYSHCN are still children with issues similar to their typically developing peers around sexuality, violence prevention, nutrition, physical activity, obesity, etc.
The public comment website was updated to accept comments on all priorities, measures, and key activities. Comments were consistent with existing MDPH activities. Attention to life-threatening allergies and collaboration with groups involving fathers was advocated. Persons who provide contact information with comments are sent information about related existing programs.

Attached to this section is an updated list of advisory committees that help inform the Title V program. Each advisory group discusses aspects of the Title V application and needs assessment that pertain to it. Input over the course of the year helps keep Title V up to date. //2009//

/2010/ During May 2009, the DPH Commissioner held another round of "Regional Health Dialogues" in each DPH region. Focus areas included the impact of budget cuts, emergency preparedness, the new Mass in Motion wellness campaign, and regional public health priorities. MCH priorities and initiatives continue to be in line with Departmental priorities. The Regional Directors helped ensure broad participation and input. The information from these sessions, especially in relation to early childhood and family involvement, was utilized in the process of reviewing and updating the application.

Over 350 parents and family members of CSHCN have provided substantial consultation through various venues for the Family Support Plan/MCH. Families reported issues similar to prior year. DPH and MA Consortium for CSHCN also co-hosted an invitational meeting of 33 MA child health leaders to identify top priorities to improve the system of care for CYSHCN. Medical home, family support, and constituency-building were identified as priorities. See the needs assessment section IIA for further details.

The public comment website was updated to accept comments to reflect new activities. Comments were consistent with existing MDPH activities. Linkage with a website for fathers was advocated and questions were raised about SSI and resources for respite and home modifications for families with children with autism. Persons who provide contact information with comments are sent information about related existing programs.

Attached to this section is an updated list of advisory committees that help inform the Title V program. Each advisory group discusses aspects of the Title V application and needs assessment that pertain to it. Input over the course of the year helps keep Title V up to date. //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.

C. Needs Assessment Summary

/2010/ The Massachusetts Title V program continues to monitor the needs of the MCH populations and the state's capacity to meet these needs on an ongoing basis.

The Title V Director and senior staff participate in major state level initiatives and high-level planning groups that may impact the health of MCH populations, gaining information about needs and a channel to enhance capacity. In FY09, both the outgoing Title V Director and new one, Ron Benham, included a focus on services for children with significant physical and cognitive delays, mental health, birth defects, early childhood services including implementation of universal behavioral/developmental screening and newborn screening. Ron Benham also participated in a secretariat level initiative to encourage medical homes for the adult Medicaid population, to encourage attention to children as well. The MCH Director, Karin Downs, works closely with several interagency committees to address maternal and infant mental health, perinatal disparities, safe sleep, Shaken Baby Syndrome, and pregnant and parenting women with addictions. She also coordinates a statewide Perinatal Advisory Committee with representatives from birth hospitals and professional organizations and has participated in regional meetings that focus on incorporating a lifecourse perspective in MCH.

The Commissioner of Public Health held regional "health dialogues" to obtaining input to the Department Priorities and programs, particularly related to budgetary concerns.

The BFHN solicits input from consumers, service providers and other stakeholders through advisory groups, focus groups, a web site, dedicated email address, and staff attendance at meetings where outside groups and individuals articulate their needs and raise issues about capacity of the system to meet them. Input that may alter chosen state measures and priorities is raised to the BFHN leadership team for review. More specific input is reviewed within the related area (for example, nutrition or CYSHCN). WIC and EI hold public hearings. Focus groups surface parent and provider needs, and strategies to meet them are developed. For example, over the past several months, through an MCHB grant that is funding a social marketing campaign for new parents, staff have conducted focus groups and worked with clients to create digital stories reflecting their experiences in receiving care for depression, parenting of newborns, family violence and family planning.

DPH employs a variety of mechanisms to gather information from families/consumers about their support needs. During FY08, staff from BFHN Family Initiatives projects attended conferences and regional and local meetings where families whose children have special health needs might be found. Questionnaires in both English and Spanish were distributed and explained at community outreach visits and skill building sessions. All families were asked about unmet/under-met health needs, experiences with DPH programs, knowledge of health care transition, need for support around emergency preparedness, how they obtain information about resources and supports and how best DPH could provide assistance. Every family interview included questions about how family centered were the services received from BFHN programs and what could be done to make services more family friendly. The questionnaires allow families to indicate any other information they feel DPH needs to know in order to ensure that programs and services are flexible, family-directed and meet their needs.

Additional information was obtained through the following mechanisms:
• Questions on a survey disseminated at the annual Federation for Children with Special Needs conference;
• Questions included in calls received by the Family TIES project, the statewide Information and Referral and Parent-to-Parent program and the DPH Community Support Line;
• Questions posted to the Family TIES and Early Intervention Parent Leadership Project websites;
• Survey questionnaires sent to 65 Family Advisors
• Discussions between care coordinators and their client families; and
• Information gathered by the DPH Public Benefits Specialist during her talks and trainings with individuals and families statewide.

Face to face contact was made with over 100 families. An additional 150 responded to questionnaires.
Themes that emerged included:

• Access to information. Families continued to cite as their primary need reliable, easily accessible, up-to-date sources of information about resources, public programs, funding, etc.
• Respite and other flexible funding options
• Better coordination of and ease of access to services among multiple human service agencies
• Lack of in-home nursing services
• Difficulty in accessing durable medical equipment
• Lack of knowledge of specific issues relating to children and youth with complex special health needs among health and education providers
• Need to embed an understanding of the need for core public health issues such as nutrition, physical activity, sexuality for CYSHCN
• Short-term intensive supports during crisis periods and life cycle transitions

Extensive consumer and provider involvement in articulating needs or reporting satisfaction and thereby shaping block grant activities to meet needs is further described in the application narrative, especially in the public input section (IE), the measure report for NPM#2 (CSHCN families partner in decision making), and in relation to other measures and priorities to which the input related.

A range of data and reports regularly inform needs assessment, including:
--Major DPH and other state agency data releases (such as births, deaths, youth and adult behavioral risk factor surveillance, health insurance, hospital discharge, emergency room visits).
--Routinely-collected program data, surveillance data (e.g., PRAMS 2008 data, Youth Health Survey/Youth Risk Behavior Survey 2007, BRFSS 2007 data released), special surveys or other one-time or occasional data collection efforts, and linked data sets such as the Pregnancy to Early Life Longitudinal (PELL) data set.
--Reports by state agencies, universities, private agencies, health care providers, and advocacy groups.
--Targeted analyses (e.g.gestational diabetes and C-sections this year).

An invitational meeting of 33 child health leaders in MA was held to identify top priorities for investment to improve system of care for CYSHCN and their families. Medical home, family support programs and constituency-building were among the highest priorities identified.

In addition to planning for the Five-Year Needs Assessment, staff began work in three

major areas: 1) the Title V Director and staff participated in the Region 1 Technical Assistance project organized through Boston University School of Public Health staff about the life course perspective and medical home; 2) Staff further updated A Shared Vision for Massachusetts Youth and Young Adults and participated in development of a report on disability that includes children and 3) The Title V and CSHCN Directors continued a CYSHCN Program-wide strategic planning initiative, which is now linked to the MCH Needs Assessment. //2010//

III. State Overview

A. Overview

The people of Massachusetts enjoy better overall health status and access to health care services than in many other states. These benefits derive in significant part from favorable natural resources, relatively high levels of income and education, a diverse economy, a history of strong legislative support for funding health and social service programs, and strong public health leadership both in state government and in community and advocacy organizations. The Bureau of Family and Community Health (BFCH), within the Center for Community Health, is the Title V program. /2008/ As the result of a recent reorganization within MDPH, the Center for Community Health no longer exists and the Bureau of Family and Community Health is a free-standing unit reporting directly to the Commissioner of Public Health. BFCH remains the Title V agency for the Commonwealth. //2008// /2009/ A further reorganization in 2008 split the BFCH into two separate Bureaus -- Bureau of Family Health and Nutrition (BFHN) and Bureau of Community Health Access and Promotion. The BFHN continues to be the primary Title V entity for the Commonwealth. //2009// As such, it plays a key role in assuring access to comprehensive multidisciplinary service networks and systems. It emphasizes public/private partnership and collaboration in building such networks and systems. A major focus is on the at-risk and underserved populations of the Commonwealth whose health status and access to care may be compromised. The Title V program is well-positioned and has long standing relationships with others outside as well as inside state government who address inadequate or poorly distributed health care resources. The MDPH and Title V have been active participants in a number of collaborations to address disparities.

All of the topics discussed in this Overview are presented in greater detail in our Five-Year Needs Assessment. /2007/ Please see our Five-Year Needs Assessment and State Overview Update (a separate Word document attached to Part II that updates Part II, Section C.) for a systematic review of changes affecting Title V capacity. //2007//

/2008/ A separate Needs Assessment and State Overview Update document is not being provided this year. However, an extensive update on Health Care Reform in Massachusetts is provided later in this overview section. This is the major change occurring in the Commonwealth and will have a great impact on both Title V and the families living in Massachusetts. //2008//

Geography and Demographics

Massachusetts is the sixth smallest state in landmass, measuring just 150 miles in its longest direction; however, it ranks 13th in population. Of Massachusetts' estimated 6,349,097 residents, according to the Census 2000, 26% (1,675,113) were children and youth through 19 years of age and 22% (1,422,476) were women ages 15-44. For 2004, the Census Bureau estimates the Massachusetts population at 6,416,505. Massachusetts is a relatively dense and urbanized state. The Census 2000 recorded nine percent of Massachusetts' residents living on the eastern seaboard in Boston (pop. 589,141), the state capital and largest city. Nearly 44% (43.7%) were living within the combined area of metropolitan Boston, Cambridge, and Quincy. After Boston, the next two largest cities are Worcester in central Massachusetts (pop. 172,648) and Springfield in the west (pop. 152,082).

There are also numerous smaller cities in Massachusetts, many of which are historically based in the mill industries, as well as island populations. In eastern Massachusetts, there are 1,500 miles of coastline on the Atlantic Ocean. Two islands, Nantucket and Martha's Vineyard, are located 16 and 5 miles off the Cape Cod shore. With a combined year-round population of approximately 24,500 and a summer population that swells to three times that number, these rural island communities face particular challenges in meeting their health care needs.

Rural areas predominate in the western section of the state, where the Berkshire Mountains separate many small towns with limited health services. Franklin County in the northwest has just 102 people per square mile. About 18.5% of Massachusetts' residents live in 193 communities in the west and other parts of the state that meet one of the several federal definitions of rural. These communities cover about 65% of the state's landmass. Farming is still a significant industry in rural areas. To facilitate understanding of rural communities, MDPH and the Massachusetts Rural Health Advisory Council have clustered geographically and historically

related rural communities for analytic purposes, calling them rural clusters.
The entire state is incorporated (there are no frontier areas) into 351 cities and towns, which are the functioning units for most local services, including public health, below the state level. There are no county health systems. However, the Commonwealth's cities and towns have been grouped into 27 Community Health Network Areas (CHNAs). In each CHNA, health and human service providers come together with residents to engage in systematic community planning, building on existing coalitions and cooperative efforts. For emergency preparedness, the state has been clustered into 10 different geographic areas. The Executive Office of Health and Human Services (EOHHS) utilizes six regional clusters, which the Department of Public Health recognizes. Other EOHHS Departments use variants of these regional clusters.
The state's overall population grew slowly in the 1990s (up 5.5% from 1990 to 2000, that modest increase due only to immigration). The most recent population assessment indicates that Massachusetts has experienced a decrease in population.

Socio-demographic Factors
Immigration and Race/Ethnicity Trends
Racial and ethnic minorities made up more than 12% of the state's population in 1990 (black non-Hispanics at 5%, Hispanics at 4.8%, and Asians at 2.4%). However, a decade later in 2000, minorities made up more than 16% (blacks at 5.4%, Hispanics at 6.8%, Asians at 3.8%, and two or more races at 2.3%). By 2010, Massachusetts' population is projected to be 6,690,740 with minority populations continuing to account for population growth. Hispanics are projected to increase by more than 38% and blacks by 32%. In several Massachusetts communities, including Boston, minority groups constitute the majority of the population.
In 2000, Massachusetts ranked 8th in the U.S. in its population of immigrants -- many of whom arrived within the last decade. A 2005 report concerning Puerto Ricans and immigrants found that one in seven residents of Massachusetts was born in the U.S. territory of Puerto Rico or a foreign country. In 2004, these residents made up 17% of the labor force. Immigrants play a vital role in Massachusetts' development and will continue to play the main role in our labor force growth for the foreseeable future. In 1980, the labor market was composed of 9.4% foreign-born residents; in 2004, 14.3% of Massachusetts' workers came from other countries.
Estimates of immigrants and refugees may vary due to the inherent difficulty in counting changing populations whose language is not English and who experience cultural isolation. The following countries provided the largest percentages of Massachusetts' newest citizens: Portugal, China/HK/Taiwan, Dominican Republic, former USSR, Haiti, Vietnam, Italy, India, El Salvador and Brazil. Since the Census 2000, the hospitality industry has recruited a large of number Brazilians; almost one in five immigrants entering the state from 2000 to 2003 was Brazilian.
Based on the 2000 Census, approximately 6% of Massachusetts non-Hispanic white residents were foreign-born. Immigration from Europe (overall, with exceptions noted above) and Canada has decreased over recent decades. Puerto Rican in-migration to Massachusetts has also decreased. Nearly half of all recent immigrants are from Latin America and the Caribbean; almost one-quarter from various countries in Asia. In addition, smaller numbers of populations increasingly come from varying linguistic groups in countries of Africa. Decreases in births among women born in the US simultaneously with increasing births among foreign-born women also contribute to changing demographics in the state.
Nationally, the influx of Spanish speakers has outpaced the immigration of other groups. Massachusetts differs in that its foreign-born population is diverse across multiple race and linguistic groups and within racial categories. Understanding this phenomenon helps us examine health disparities among broad race groups--white non-Hispanic, black non-Hispanic, Hispanic, Asian, and American Indian--and is crucial for understanding differences in disease risk, health outcomes, and inequities in the delivery of medical care. It is also important to look within each broad racial group, since in some instances, there are greater differences in outcomes and risk among detailed ethnicity groups within one race category than between race categories. The following sections provide a brief overview of the various population groups; additional details are provided in the Needs Assessment.
Note that Census 2000 allowed individuals to identify more than one race category when responding. In order to account for this change, MDPH created the MDPH Population Estimate

for 2000 that accounted for individuals who checked "some other race alone," "some other race in combination with other races," and those who indicated more than one race. The figures below are based on this method and they may differ somewhat from others in this document.
Asian: Since the 1990 census, the Asian population has grown by 74% and now comprises approximately 4% of the total population. Asians are 26% of the foreign-born population, and 72% of Asians are foreign-born. Although the largest ethnic Asian group is Chinese (35% of the Asian population), 11 other groups have been identified (in decreasing order of Asian population share): Asian Indian, Vietnamese, Cambodian, Korean, Japanese, Filipino, "other Asian," Laotian, Thai, Pacific Islanders, and Pakistani. Each ethnicity has different customs, health beliefs and language, and differs markedly in socioeconomic indicators. Boston, Lowell, Cambridge, Quincy, Worcester and Brookline are cities with the largest Asian populations.
Black: According to this estimate, blacks are 6.2% of the MA population. About 24% of blacks were foreign-born, with 66% from the Caribbean and 26% from Africa. The birth certificate enables mothers to identify both their race and ethnicity. These include: African American, Haitian, Jamaican, Cape Verdean, Nigerian, Barbadian, Other African, Other West Indian/Caribbean. In addition, the foreign-born population has significant representation from: Western, Eastern and South Africa, Trinidad and Tobago. These ethnic groups have different languages and customs. Although some countries might have English as one of the official languages, most residents maintain tribal traditions and languages, thus making it difficult to categorize them with common attributes. An increasing number of individuals are entering as refugees or fleeing the conflicts in Africa. Blacks can be found in communities throughout the state with larger concentrations in: Boston, Springfield, Brockton, Worcester, Cambridge, Randolph, Lynn, Lawrence, and Milton.
Hispanic: Hispanics were the largest minority group identified in Census 2000 and the second fastest growing population group in MA. Of Hispanics, 31% are foreign-born and 23% born in Puerto Rico. Nearly half of all immigrants and Puerto Ricans who arrived in MA between 2000 and 2004 were from Latin America and the Caribbean. The Hispanic population grew by 49% between 1990 and 2000. As with other broadly defined groups, Hispanics are often assumed to be homogenous in language and customs. This is not the case with Hispanics in Massachusetts. Although their numbers are falling, Puerto Ricans still comprise the largest group (approximately 47% of all Hispanics) in Massachusetts. In most other US states, the Hispanic population differs from the pattern, with Mexicans being the largest group. In Massachusetts, other ethnic populations include: Other Hispanics, Dominicans, Mexicans, Other Central American, Salvadorans, Other South American, Colombians, and Cubans. Growing ethnicities within this group include Mexicans and Other Hispanics. Boston had the biggest Hispanic population, but Lawrence had the largest concentration (60% of its residents). In addition, 14 communities have Hispanic populations totaling more than 10% of the population: Chelsea (48%), Holyoke (41%), Springfield, Southbridge, Lynn, Worcester, Fitchburg, Boston, Lowell, Salem, Leominster, Framingham, and New Bedford.
Unauthorized Immigrants: A 2005 study estimates the number of "unauthorized migrants" (encompassing individuals often termed "undocumented") in Massachusetts to be between 200,000 and 250,000. The unauthorized population has been increasing since the last half of the 1990s and in Massachusetts is estimated to be between 20% and 29% of the foreign-born population. /2009/ As a result of a major immigration raid in February 2007, this population continues to feel threatened, with many families not seeking services readily and living in fear even if children are citizens. //2009//
Children: Of children age 17 and under, 75% are white non-Hispanic (compared to 84% for the total population), 7% are black non-Hispanic, 11% are Hispanic, 4% Asian, and 1% other. These figures are for families who chose to select one race category only. An additional 3% of families selected more than one race category to describe their children.

Language and Linguistic minorities
The recent shift in immigration, away from European and other English-speaking countries, to those where English is not the primary language, presents challenges for Massachusetts. An increasing number of new immigrants do not speak English at all, or do not speak English well. The 2000 Census recorded almost one in five MA residents (18.7% in MA compared to 17% in

US) 5 years and older who spoke a language other than English at home. Of those, 22% spoke English "not well" or "not at all." This is a significant increase from the 1990 census when only 1 in 10 (12.4%) residents fell in that category.
It is estimated that more than 150 languages are spoken in Massachusetts. Spanish-speakers accounted for 30% of those who speak a language other than English; 51% speak some other Indo-European language; 15% an Asian or Pacific Islander language; and 4% spoke some other language. Among those who spoke Spanish at home, 27% described their ability to speak English as "not well" or "not at all." A labor market study indicates that in 2000 almost 137,000 adult immigrants and Puerto Ricans did not speak English at all, or did not speak it well.
The Massachusetts Department of Education First Language Not English (FLNE) Report provides data specific to children. It identifies those communities whose FLNE public school population was 10% or more and provides information on the smaller subset of children who are unable to perform their classroom work in English (Limited English Proficient students). These data are useful indicators of younger families who may be linguistically isolated or experience increased need due to their limited English proficiency. In 2002, one in seven public school students had a language other than English as the first language. In one out of two FLNE students, Spanish was the first language. Of these more than 37% were identified with Limited English Proficiency. In forty-two communities FLNE students make up 10% or more of their student body and in another 23 communities FLNE students comprise between 5 and 9% of the student population. Children in Massachusetts classrooms speak 132 languages. The more frequently encountered languages are: Spanish (49% of total FLNE), Portuguese (10.3%), Cape Verdean Creole (6.1%), Chinese (5.9%), Vietnamese (4.3%), Haitian Creole (3.2%), Khmer (3.19%), Russian (2.8%) and Arabic (1.2%).

Poverty and Disparities
Massachusetts is a comparatively wealthy state with a diversified economic base that includes health care, education, finance, insurance, telecommunications, computer technology, biotechnology, tourism, farming, and fishing. In 2003, the median family income was estimated at $67,527 compared with $52,273 for the nation; only 3 states (New Jersey, Connecticut, and Maryland) had higher median family incomes. The state had the second highest percentage of college-educated individuals (36%). The percent of children under 18 living in poverty in 2003 was estimated at 12.3 compared to the national average of 17.7; 9 states had lower poverty rates. Based on 10 key indicators measuring child well-being in 2001, the Annie E. Casey Foundation Kids Count 2004 rated Massachusetts equal or better than the national average for each of the 10 indicators, ranking ninth compared to all other states. A child born in 2003 in Massachusetts has a life expectancy of 78.5 years compared with 77.6 for the US.
Yet disparities between wealthy and poor, educated and not, persist. Massachusetts showed an improvement from 1996 to 2001 in only 4 of the Kids Count indicators. Poverty rates for families and for individuals, while lower than the national averages, have increased since the 1990 census. Significant disparities exist in poorer urban and rural areas with poverty rates for children. Although incomes are high, expenses are as well. Massachusetts has the fourth highest renter-occupied housing costs and the fifth highest owner-occupied housing costs.in the nation. A 2004 report by the Massachusetts Family Economic Self-Sufficiency Project documented financial stress for low-income working families, estimating that 25% of Massachusetts families and nearly 50% of urban families, earn less than the income needed to meet their basic needs without pubic or private supports. The report found that the real cost of living had increased from 17% to 35% depending on the region of the state between 1998 and 2003. To make ends meet, a family with one adult, one preschool child, and one school-age child, based on the report's estimates, needed to earn 228% to 336% of the federal poverty level.
Paralleling national trends, Massachusetts has experienced an increase in the number of homeless families and individuals since the 1980's. Families constitute about 58% of the homeless population in Massachusetts and about 20,000 children in the Commonwealth are homeless (51% of them under the age of 5). An upward trend on the Department of Transitional Assistance (DTA) expenditures on services for homeless families suggests an increased pressure on shelter use as well as in the number and needs of homeless families.
The three-person income limit for the DTA Emergency Assistance Program in FY 2003 was

$15,284. During this period, one-half of the sheltered population had an average annualized income of $4,584, all of which was cash assistance. Over 90% of all homeless families in shelters receive food stamps. The food stamps caseload in Massachusetts increased from 153,724 in March of 2004 to an estimated 165,969 in February 2005.
After financial problems and unemployment, substance abuse was the most common reason reported for homelessness among users of the shelter system in the state. Domestic violence is one of the main reasons that women seek shelter, and is a situation affecting many homeless families in the Commonwealth.

Health Insurance, Health Services, and Health Care Reform
/2008/ The following section presents an overview of the many changes taking place through the Massachusetts Health Care Reform process.
Health Care and Health Insurance Reform Efforts
On April 12, 2006, then Governor Romney signed into law a health reform bill to provide access to affordable health insurance coverage for all Massachusetts residents. The reform established that nearly universal coverage would be in place for all residents and that their care and coverage would be affordable and of high quality. It also assured that the process of expanding coverage would be open to transparency, accountability and improvement. Implementation began on July 1, 2006 and will be rolled in over the next two years. The reforms build on Massachusetts' previously approved 1115 Waiver extension and will form the basis for a new waiver to be submitted in FY08.

Key elements of the reform legislation include:
• Continuation and expansion of employer sponsored health insurance as the primary source of coverage
• New, lower-cost plans for individuals and small businesses
• Pre-tax treatment of health insurance premiums for employees
• Mechanism to make it easier for individuals and employers to participate in health care coverage
• Financial penalties for not participating which are included in state tax filing 2008
• Standards of adequacy and affordability for new state plans
• Expansion of public programs for people without access to employer sponsored health insurance
• New health care safety net for uninsured people who cannot afford and who are ineligible.
• Expansion of dependent coverage to age 25
• An expectation that employers (more than 10 employees) will offer pre-tax purchase of health insurance (10/1/07) and contribute at least $295 to subsidize insurance (10/1/06) or face a potential "free rider surcharge" as of 10/1/07.
• Creation of a new state body, the Commonwealth Health Insurance Connector Authority, that will manage the state plans.
• New plans for young adults 19-26 years old.
• Creation of four new councils: Health Care Quality and Cost, the Advisory Committee to Health Care Quality and Cost, MassHealth Payment Policy Advisory Board, and the Health Care Disparities Council

Implementation began in March 2006 with the expansion of coverage within MassHealth existing programs. This expansion included the following:
• Increase in eligibility for children (via SCHIP state plan amendment) up to 300% FPL as of 7/1/06
• Increase in the HIV waiver up to 200% FPL as of 7/1/06
• Increases in the enrollment caps for Essential, CommonHealth, and HIV waiver programs as of 3/9/06
• reinstatement of substance abuse treatment services, adult dental, vision, and chiropractic benefits as of 7/1/06
• addition of adult dental to the Essential benefit as of 7/1/06
• new tobacco cessation benefit for all MassHealth recipients

Since July 1, 2006 16,000 children have been enrolled in MassHealth. This includes 9,300 who "converted" from the state Children's Medical Security Program (CMSP) and 7,000 previously uninsured children. SCHIP premiums for 200-250% FPL were set at $20/child with a $60/family maximum; and at $28/child with an $84/family maximum for 250-300% FPL. It is required that a child be uninsured for six months prior to coverage, with certain exceptions such as special health needs, parent death, involuntary termination of prior coverage. The CMSP continues to provide preventive health coverage for children who are not eligible for MassHealth, with acute care covered through the uncompensated care pool.

MassHealth was also required to develop a Wellness Program tied to reduced premiums for Medicaid recipients if wellness goals are met. However, as the MassHealth Medicaid programs do not include premiums, the incentives related to this component are still being explored. Bureau of Family and Community Health staff have been actively involved with MassHealth staff in designing and developing the adult wellness program for recipients. This program will be implemented in FY08.

In addition, health care reform newly funded or increased funding for several initiatives in the BFCH. It provided $4M to tobacco control activities including cessation services, prevention targeting children and youth, local cessation programs including schools and community agencies, and better enforcement, including of sales to minors. Suicide prevention was funded at $750K and teen pregnancy prevention funding increased by $1M. One of the issues described in the Five-Year Needs Assessment was the need for pediatric palliative care. Health reform allocates $800,000 for MDPH to contract with hospices for this purpose. Also discussed was the importance of attending to the general health of women of reproductive age and prevention of chronic disease in this population. While not directed specifically to women of reproductive age, health reform funds breast cancer services ($4M), diabetes education and health interventions ($350K), ovarian cancer education, screening, and treatment ($200K), osteoporosis awareness, including materials for women 18-24 years old ($100K) and other programs. These funds will be continued into FY08 with suicide prevention increased by $2.5m, teen pregnancy by another $1M and pediatric palliative care funded through a separate line item. The other programs have been merged into a new Health Promotion and Disease Prevention account. A major focus of this new account will be on wellness, reduction of health disparities and chronic disease prevention

Implementation of the other components of health care reform has continued to move forward. Between July 1, 2006 and May 1, 2007, 122,330 adults have been enrolled either in MassHealth (53,000) or Commonwealth Care, a new publicly subsidized insurance program for low-income residents -- 53,770 with incomes at or below 100% FPL and 15,560 between 100 -- 300 % FPL. Concerns about the affordability of coverage resulted in a decision that a family will pay only one premium and individuals between 101-150% FPL would not pay a premium as of July 1, 2007. Individuals between 151% - 300% will pay a premium based on a sliding fee scale. Commonwealth Choice plans which offer unsubsidized coverage for individuals became available on May 1, 2007 with coverage beginning on July 1. 2007. Small businesses will be able to access these plans as of October 1, 2007. The Title V Director has participated as a member of the State Health Reform Implementation Team Steering Committee.

The Health Care Reform implementation will continue through out the next year. Outreach, education, promotion and public understanding of the law's mandate as well as employer requirements and continued enrollment in the new insurance programs will be the primary focus. The uncompensated care pool, which has continued to provide access to services for those individuals not eligible for one of the health reform products, is being redesigned into the Safety Net Pool. The exact provisions of the Pool will not be available until mid-late September. It is expected that the community health centers will continue to play a key role in the provision of services through the safety net pool.

The other major change which has occurred is the transfer of the majority of MassHealth

recipients from the PCC plan to an MCO plan. This shift has occurred during the past year and the Title V program will monitor whether it has affected access to services over the next year. It is expected that many families may move between MassHealth and Commonwealth Care. However as the same MCO's are providing services under both, there may be no significant changes in care. All children are covered through the MassHealth expansion of SCHIP.

The Deficit Reduction Act (DRA) requiring documentation of citizenship status has been implemented with minimal disruption in services. The state Healthy Start program had been merged with the SCHIP program; thus the enrollment of infants into MassHealth continued to occur automatically.

For young adults, the ability to extend dependent coverage to age 26 and the development of the 18-26 year old health insurance products should improve coverage for this group of individuals. The new young adult products are just becoming available and are not as comprehensive as the other packages.

For children who have medical needs beyond those covered by their insurance plan, the Catastrophic Illness in Children Relief Fund was expanded to age 21 beginning July 1, 2007. //2008//
/2009// Health Care reform has been successful in providing coverage to over xx residents. Options have been established for multiple plans and are expected to continue with only minor changes during this coming year. Coverage for young adults is in place. The individual mandate has resulted in individuals who failed to obtain insurance by January 1, 2008 receiving minimal fines. These fines will increase significantly for next year. Multiple employers have provided insurance although several small providers have elected to become part of the state plans. The system has been modified to facilitate enrollment and to provide assistance to those who need it in locating and enrolling in the appropriate plan. The Commonwealth is currently in the process of undertaking a "recertification process" for both Medicaid and all Connector subsidized health reform plans. It is not yet clear how many will no longer be eligible; will have moved from Medicaid to one of the Connector plans or vice versa. This process will be complete by late July. The state is also in the process of renegotiating with CMS the waiver which continues to be a critical component of the reform plan. A one month extension has been granted which expires on August 1. The state administration and legislature as well as providers, insurers and employers remain committed to continued implementation. //2009//
/2010/ Health Care reform continues to be successful and to have broad support among the public and the business community. As of June 2009, there are 428,000 more people enrolled in private or subsidized health plans in the Commonwealth since health care reform was initiated. Large declines in the percentage of uninsured working-age adults have been documented and these declines are evident across income categories, for those earning both above and below 300% of the FPL. The individual mandate fine for individuals who fail to obtain insurance now ranges between $210 and $912 annually, based on family income; the penalty is pegged to a percentage of the lowest priced comparable Commonwealth Choice plan. The tax penalty does not apply to individuals with income up to 150% of the FPL. Commonwealth Choice is the set of unsubsidized private health plans -- selected by competitive bidding and available through the Health Connector Authority to individuals, families, and some employers -- that have received the Connector's "Seal of Approval." They offer a range of benefit options and grouped by level of benefits and cost-sharing at the Bronze, Silver, and Gold levels. Of the 177,000 enrolled in Commonwealth Care (the subsidized program for adults who are not offered employer-sponsored insurance and do not qualify for Medicaid or Medicare which is the centerpiece of health care reform) as of June, 2009, more than 54,000 contribute something toward the monthly premiums and the remainder receive free coverage. Finally, there are now approximately 76,000 new members in MassHealth (Medicaid) since the inception of health care reform.

The economic crisis affecting the state is affecting health care reform. As plummeting

revenues have presented a budget crisis to state government, enrollment in subsidized programs has surged with the rise in the recently unemployed. The Health Connector Authority recently trimmed its budget by 12%. The state is currently considering the elimination of coverage for approximately 28,000 legal immigrants with special status in FY2010 since that population does not qualify for matching federal funds. The bulk of the savings will come from slowing enrollment, by not automatically assigning to a plan those who are eligible for full subsidies but forget to select one themselves. The option to eliminate dental coverage for adults has also been proposed but appears to be preserved in the final state budget. Discussions within the Health Connector Authority and throughout the Commonwealth will continue about how health care reform may need to be modified in these economic times.
At the same time, the Massachusetts model continues to be extensively studied and referenced in the invigorated health care reform debates and policy developments at the national level. //2010//

Massachusetts has been a leader in health care reform and is currently actively involved in developing strategies to expand coverage to the estimated 460,000 uninsured in the state. The current system provides access to health care across the state, with the highest quality ratings in the nation. The state has a strong network of high quality, not-for-profit hospital and community-based safety net services for the poor and disabled, as well as a generous culture of employer and public subsidized coverage. Thus the state has a low uninsured rate of 7%. The state has made a large commitment to supporting care for the uninsured primarily through the state's Uncompensated Care pool.

Nevertheless, several issues exist that challenge the current and future systems if they are not addressed. Health care costs are growing at unsustainable rates with state health care cost increases, primarily Medicaid crowding out other basic services. The cost of care for the uninsured is estimated to be more than $1 billion annually and must be recognized as everyone's problem. The regulatory environment has limited insurer innovation and there is a lack of transparency of both price and quality.
As in other states, the Massachusetts health delivery system has been impacted by many competing and related factors over the last decade. In its 2003 release, Massachusetts Health Care Trends: 1990-2001, the Massachusetts Division of Health Care Finance and Policy addressed six major paradigm shifts that have had and continue to have implications for services to infants, children, youth, and pregnant women:
State-initiated Increases in Access to Health Services: Interlocking state laws and programs have decreased the number of uninsured through Medicaid expansion, small group and individual insurance reform, and the Children's Health Insurance Program (CHIP). Massachusetts ranks 4th in the nation for health insurance coverage with just under 7% of the population uninsured in 2005.
Dilution of HMO Networks: Massachusetts HMOs started the decade with tightly controlled exclusive provider networks and lower premium costs to purchasers. It ended it with nearly identical universal panels of providers under pressure from consumers for greater choice, but left HMOs with deep discounts for volume and shrinking fiscal margins.
Health Care Role Blurring: Clear distinctions among providers, insurers, payers, purchasers and patients have become blurred as doctors began to share financial risks with insurers, insurers became providers who employed doctors and owned hospitals, employers became self-insured, and Medicaid moved from payer to purchaser as it expanded managed care, etc.
Changing Health Services Cosmology: Health care became less centralized around hospitals as managed care, enabled by technology and pharmaceuticals, reduced hospitalizations and inpatient days dramatically over the decade. This created a bulge in home health care and prescription drug use as well as a more fragmented health care landscape, presenting challenges to both professionals and patients.
Swings in Regulation. The decade saw a shift away from strict rate-setting to calls for a return to state involvement by patient advocates and industry experts. The cause of this is the dismal fiscal condition of many Massachusetts hospitals, nursing homes, and community health centers as

well as lack of oversight over provider closings, sales of institutions to for-profits, medical errors, etc.
Increased Consumerism: The long-standing paternalistic patient-physician relationship has been challenged as patients become clients and consumers and more information and options become available.
In response to these issues, the Governor is proposing a health care reform initiative that is a "comprehensive, market-based program which will focus on controlling health care costs and increasing access." The plan has four main elements:
-- Increased Medicaid enrollments (106,000 persons)
-- Affordable health insurance premium for individuals and small business through a new Commonwealth Care program for those with incomes up to 300% FPL (204,000 persons -- those who can afford insurance but don't buy it, short-term unemployed and new employees)
-- Safety Net Care managed care plan for those with incomes between 100-300% FPL to replace the Uncompensated Care Pool (150,000 persons)
-- Transitional coverage to new employees and the short-term unemployed (36,000 persons)
In addition, two proposals have been put forth in the Massachusetts Legislature. It is expected that the active discussion related to expanding access to health care coverage will continue over the next year. There are many building blocks in place to build from and the momentum is growing. Expansion of coverage will greatly benefit both children and families.

The Uninsured and Insurance Coverage in Massachusetts
Current estimates are that 93% of the Massachusetts population is insured either through employer, individual, Medicare, Medicaid or another public source and that there are approximately 460,000 uninsured persons. Approximately 12% of the uninsured are children, remaining at 3.2% of the total population statewide and an improvement from 4.5% in 1998. Hispanics tend to have the highest rate of uninsurance, followed by blacks and Asians, correlating with unemployment status. Although older adults age 25 and older are the majority of the uninsured, the highest proportion is in the transitioning young adult population aged 19 to 24, of whom 25% are uninsured. The northeastern part of Massachusetts had the highest proportion of uninsured residents (12%). 71% of children below 200% FPL are insured by MassHealth and 86% of children above 200% FPL are covered by their parents' employee insurance.
Massachusetts has one of the highest penetrations of managed care in the nation. The market continues to be dominated by locally based, not-for-profit organizations (there is one locally based for-profit health plan in the state), and these health plans consistently rank highly in national consumer satisfaction ratings and on HEDIS measurements.
The health plans, especially HMO-like plans, in Massachusetts (as well as throughout the country) have come under increasing pressure to expand services and reduce restrictions. Consumers and employers have demanded a broader choice of doctors and hospitals, resulting in a move away from tightly managed health benefit products, increased PPO and POS product offerings, and reduction in the number of procedures requiring prior authorizations. Consolidation among hospitals and physician groups has increased their bargaining clout. The Legislature also enacted laws mandating coverage of specific types of services and new measures for regulating health plans. These changes combined with the aging of the population, the accelerating introduction and use of new drugs and medical technologies, has led to higher health care costs. In response to the rising cost of health care and employers' desire for more choice in how they control their health care costs, health plans have continued to modify the insurance products available. This has included significant increases in deductibles and co-pays as well as tiered deductibles based on the site of care. Consumer-driven plans are currently being offered by more and more employers. Pediatricians have expressed concern that the consumer-driven plans may result in families delaying care, electing to not have follow-up care or make a choice on price only.

Medicaid and SCHIP
MassHealth, as the state Medicaid program is known, provides comprehensive services through Medicaid, SCHIP, Children's Medical Security Plan and CommonHealth. Currently 985,000 individuals are enrolled in MassHealth. Of this number, 416,500 are children up to the age of 18.

With identification of approximately 106,000 individuals as Medicaid eligible but unenrolled, steps are underway to increase outreach and facilitate enrollment of all who are eligible. The newly renewed Medicaid 1115 Waiver expands coverage to some selected special populations within the existing Medicaid populations and allows the state to establish a new program referred to as Safety Net Care. This program would provide coverage to eligible uninsured individuals within certain FPLs. Currently, multiple options are being considered to redesign the health care delivery system for MassHealth managed care members and other publicly assisted populations such as Safety Net Care.

MassHealth began moving toward managed care in 1991 with its first HCFA 1915b waiver and continued to expand this system with its 1115 waiver and SCHIP. Most children and pregnant women covered by MassHealth, including SSI recipients, were enrolled in a managed care program by 1998 with the exceptions of CommonHealth, for which managed care enrollment is optional, the MassHealth Family Premium Assistance Program (MHFPAP), and children and youth in state custody. A total of 603,373 or 62% of all 985,000 Massachusetts MassHealth enrollees are currently in managed care plans.

The Medicaid managed care program is very well integrated into the overall health care delivery system through two different managed care program types: a Primary Care Clinician (PCC) Program and a Managed Care Organization (MCO). The years 2000-05 saw a dramatic shift away from PCC plans to MCO plans.

In February 2005, the Commonwealth received a 3-year renewal of the 1115 waiver. The terms of this waiver extension are compatible with the Governor's health reform proposal. The major changes will be phased in over the next year. The changes have the potential to dramatically affect the existing safety net providers as well as two MCOs. The waiver allows more flexibility for a range of possible approaches especially for the Safety Net Care Pool. It is anticipated that over the next few months the Safety Net Care Pool Program design will be finalized. Services for mothers and children will be a key part of any solutions identified. Title V will stay at the table and be active in the design of the program as well as developing the implementation plan so as not to disrupt current services and decrease access. /2008/ The Commonwealth is beginning the development of the next waiver request.//2008//

/2009/ As of this writing, the Commonwealth remains in negotiations with CMS and OMB over our waiver request and the current waiver has been extended for one month. The successful completion of this process is crucial to the continued implementation of Health Care Reform.//2009//

/2010/ The Commonwealth did negotiate a revised waiver CMS and OMB, a crucial component to the continued implementation of Health Care Reform. Health care reform continues to assure that more children are insured through either public or private plans. The estimated rate of uninsured children is down to 1.2% as of Summer, 2008. To date, it does not appear that any proposed changes to health care reform options, range of benefits, or enrollment procedures will directly affect this amazing low rate of children without health insurance.

In March, 2009, the Robert Wood Johnson Foundation awarded $1 million to Massachusetts' Office of Medicaid, in partnership with the University of Massachusetts (UMass) Medical School, to help support enrollment of eligible children in the Children's Health Insurance Program (CHIP) over the next four years. One of only eight states to receive funding from a field of 28 applicants, Massachusetts was selected based on its proven success in and ongoing commitment to increasing children's health insurance enrollment. The state estimates that only 1.2% of children are uninsured and only 2-3% of likely CHIP-eligible children remain unenrolled. This is the lowest rate of uninsurance for children in the nation. With support from the Foundation, Massachusetts hopes to become the first state to achieve full participation for eligible children. //2010//

Health Services Delivery, Health Care Providers, and Shortages

Preventive and primary care services in Massachusetts are delivered almost exclusively in private practice or organized health care settings (for example, staff model HMOs, community health

centers and hospital outpatient departments). Massachusetts has an extensive and strong network of high quality, not for profit hospitals, and a community-based safety net system that provides primary and preventive health care services to MCH populations. Massachusetts also has a wealth of medical education and training programs, with four medical schools and three dental schools. There is no public delivery system of primary care for MCH populations. Title V and state resources have helped to support safety net providers at the community level for those unable to afford or otherwise access care.

The State continues to have a relatively large physician provider workforce, including primary care providers.
Despite the relatively large number of physicians both trained and currently registered within the State, as well as the extensive system of safety net health providers, localized health professional shortages remain in some urban and rural communities and for specific populations facing financial, linguistic or cultural barriers. Some of these disparities in the distribution of physicians and other health professionals are the result of a critical imbalance in the ability of community health centers (CHCs) and other safety net providers within these underserved areas to recruit and retain physicians. Physicians in Massachusetts continue to be negatively impacted by a high cost of living and malpractice insurance premiums. Massachusetts continues to lose obstetrical providers (including certified nurse midwives and family practitioners), with the greatest losses in Level I facilities and those in Western Massachusetts. In May of 2005, one of two in-state nurse midwifery programs also halted admissions. /2009/ Due to health care reform there are indications of a shortage of primary care providers in several areas of the state. Both the administration and legislature are involved in activities to identify the extent of the shortages and to develop plans to address them. Due to concerns in Western MA regarding a possible shortage in obstetrical providers and neurosurgeons, the Title V program has been involved in a study to determine the extent of the problem and to identify strategies to resolve it. //2009//
/2010/ A report on this issue was prepared and a final draft submitted to the state Secretary of Health and Human Services for review during FY09. It has not yet been released. //2010//

As in other parts of the country, health care employers are experiencing a severe shortage of nursing personnel. This shortage is affecting all aspects of the health system including hospitals, nursing homes, community health centers, home health agencies and schools. Additionally, there is a declining student body and an aging-out of nursing faculty and staff. The University of Massachusetts has a fast track nursing program for individuals shifting from non-health careers in order to address the shortage issues; however, the results of this program will not be seen for several years.

An estimated 5,100 dentists have clinical practices in over 6,000 office locations. The overall ratio of 1,429 residents for every one dentist is higher than the national average. Although there is not an overall shortage of dentists in Massachusetts, disparities exist in access. The distribution of dentists is uneven, with a significantly higher concentration of dentists in the eastern third of the state. An estimated eighty communities lack any dentist and additional communities do not have dentists who accept MassHealth. These communities are predominantly in the western and central parts of the state. Many of these are also the communities without community water fluoridation. A number of initiatives to increase access to dental screening and care have moved forward (see Safety Net Providers below).

The number of hospitals and hospital beds has been declining in Massachusetts for more than a decade. There are currently 61 hospitals with licensed maternity units and two freestanding birth centers. There are sufficient beds and proposed new perinatal hospital licensure requirements will clarify levels of care. Pediatric beds have also declined, in part due to the declining need for inpatient hospitalization among children. Sufficient availability and distribution of specialized and tertiary pediatric services remain. However, children's hospitals nationwide are suffering financial problems and this is true in Massachusetts also.

To assure access, rural hospital services have been a major focus of both MDPH and the Massachusetts Hospital Association (MHA). Three Massachusetts hospitals have converted to Critical Access Hospitals (CAHs). These include Fairview Hospital in Great Barrington and the sole hospitals on Nantucket and Martha's Vineyard Islands. Two other hospitals continue to undergo financial feasibility studies to assess the benefits of conversion to CAHs. The ability to qualify for this designation is essential because CAHs receive enhanced, cost-based, federal Medicare reimbursement to assist with maintaining the viability of local health care services in the more remote and less densely populated rural communities of the Commonwealth. /2008/ The Office of Rural Health continues to promote all possible options to assure continued access to and the viability of existing services. //2008//

Community Health Centers and Safety Net Programs. As Massachusetts does not have a county- or city-based health services system, Community Health Centers (CHCs) along with a few remaining hospital outpatient departments serve as the key safety net providers. Low-income uninsured and underinsured, high-risk Medicaid recipients and other individuals facing barriers are able to access health care through a statewide network of CHCs regardless of ability to pay. CHCs are non-profit, community-based organizations that serve approximately one out of every 10 patients in the state. CHCs have experienced financial pressure due to numerous changes in the health care reimbursement and support environment.
Currently in Massachusetts, there are 19 Primary Care HPSAs, 15 Dental HPSAs, 5 Mental Health HPSAs and 44 MUAs. FQHCs receive automatic HPSA status from the federal Designation Bureau. Within the last year alone, four applications for new HPSA designations have been submitted through the PCO and are awaiting federal review: 2 Primary Care, 1 Dental and 1 Mental Health.
There are currently 58 safety-net dental clinics in Massachusetts located in community health centers, hospitals, schools, dental and dental hygiene schools and other community locations. All are MassHealth dental providers and have a sliding fee scale, and some provide free care under the state's compensated free care pool.
As part of Health Care Reform, Massachusetts' statewide system of community health centers has been designated "essential community providers." An assessment is underway of the capacity of CHCs to absorb increased patient enrollment and a profile of provider types that are key to service delivery redesign. As these redesigns unfold, with a concomitant redesign of MassHealth and uncompensated care pool funding mechanisms, it is expected that more community patients will be directed and linked to CHCs and other community based providers, particularly those providing behavioral health services. It is also anticipated that these will form the foundation for the state's new Safety Net program.
Providers of family planning services (primarily the MDPH and Title X grantees) have been very interested in the development of a Family Planning Waiver. The waiver would allow the state to expand eligibility for Medicaid covered family planning services to individuals not otherwise eligible for Medicaid and thereby expand the availability of family planning services to low-income individuals, while supplementing (or supplanting) state-only funded programs. A positive CMS report found that Family Planning Waivers do avert births and are budget-neutral; they have been adopted in 19 other states. Currently, DPH and the Office of Medicaid are meeting regularly to discuss the development of a waiver and there is also legislation pending that would mandate one.
There are approximately 2,100 school nurses in the state. School nurses act as a safety net and provide entry into the health care system as needed.

/2008/ Six existing 330 community health centers have expanded services into new geographic areas, creating new full-service sites. A survey of CHC dental programs indicated that there is the opportunity to expand oral health capacity in the majority of sites. //2008//

/2009/ The Uncompensated Care Pool has been restructured and the Community Health Centers are the key providers of service to individuals who do not qualify for Medicaid or one of the Connector health plans.//2009//
Rural Health Issues While absolute distances in Massachusetts are relatively short compared to

many larger states, rural and small town culture, a lack of resources such as transportation, and family and work-life needs are such that it is difficult for many rural residents to travel to cities to receive services on a regular basis. Availability of primary care services in rural areas has improved in the past five years. Since 1997, three new CHCs have opened in rural areas and are currently opening satellite sites. Care for MCH populations is a significant component of the newly available services at each of these CHCs. The first free-standing federally certified and state licensed Rural Health Clinic (RHC) opened last summer in Dukes County to serve as a safety net provider for the uninsured and underinsured on Martha's Vineyard. Feasibility of expanding this model to other areas is being explored. /2008/ As a result of Health Care Reform, there are anecdotal reports of primary care provider shortages emerging, particularly in rural areas. //2008// Family planning clinics are located in some larger rural towns with only limited services in more remote areas. New family planning and women's health services models are being explored for rural communities that build on the positive assets and community programs in rural communities. Special Needs Services and Shortages. In programs for Children with Special Health Care Needs (CSHCN), families, care coordinators and other providers report shortages of in-home providers of nursing and personal care attendant services. Families of children with autism report long waits and shortages of neurologists willing to accept children for diagnosis.
Early Intervention (EI) staffing shortages of therapeutic and nursing personnel are the most severe that has occurred since the full implementation in MA of the Individuals with Disabilities Education Act in 1993. /2009/ Shortages continue in speech, physical and occupational therapy, as well as for skilled providers to provide services for autism spectrum EI clients. //2009//

/2010/ A proposed rate increase was not approved for EI services. Shortages in EI remain a significant issue regarding assuring an appropriate mix of all staff (i.e. therapeutic specialists versus developmental specialists).//2010//

Public-Private Partnerships
The Massachusetts health delivery system depends on public-private partnerships for the delivery of all services, including MCH services. The vast majority of community prevention, primary care and specialty services are delivered by private health care providers and community-based non-profit organizations. Within each city and town, local government is responsible for developing and enforcing environmental and sanitary codes. Some larger health departments also provide screenings, public health and school nursing services, and other traditional public health core functions. MDPH contracts with a wide range of these providers (both private and public), using a competitive bid process, for most of its community-based services. All vendors with MDPH contracts must report on uniform performance measures that assure a culturally competent, family-centered, community-based approach. All are required to participate in the health improvement processes of their local Community Health Network Area (CHNA). MDPH also actively collaborates with local health departments to improve their infrastructures and provide training and technical assistance.
MDPH contracts not only with CHCs, but with a wide variety of other community-based health and human service agencies that provide other MCH services such as early intervention, WIC, home visiting, teen pregnancy prevention, family planning, and health promotion. In addition, there is a broad network of HIV/AIDS and substance abuse services serving mothers, children and youth that MDPH also purchases. Title V purchased services are integrated into MDPH primary care, school health, substance abuse, HIV/AIDS, tobacco control, and other CHC programs to assure a multi-disciplinary, comprehensive, family-centered care model whenever possible. In areas of the state without CHCs, providing comprehensive, multi-disciplinary services becomes more difficult; the Bureau therefore works actively to support the development of additional CHCs or to promote access through networks of other community-based agencies and providers.
There are multiple instances of collaboration among insurers, private organizations, faith-based groups, and other state agencies such as public safety, education, and transportation. To be successful in maintaining and improving the health status of the residents of Massachusetts will depend on the continual enhancement of these relationships.

B. Agency Capacity

The Bureau of Family and Community Health (BFCH), in the Center for Community Health, in the Massachusetts Department of Public Health (MDPH) is the Title V Agency for the Commonwealth of Massachusetts. /2008/ As the result of a recent reorganization within MDPH, the Center for Community Health no longer exists and the Bureau of Family and Community Health is a free-standing unit reporting directly to the Commissioner of Public Health. BFCH remains the Title V agency for the Commonwealth. //2008// /2009/ As the result of further organizational changes with MDPH during FY08, BFCH was split into two separate Bureaus -- Bureau of Family Health and Nutrition (BFHN) and Bureau of Community Health Access and Promotion. The BFHN continues to be the primary Title V entity for the Commonwealth. See the next section for further details. //2009// MCH-related program areas within the Bureau are listed and briefly described in a Table organized by the MCH Population Groups that they primarily address. This table is part of a Word document that is the attachment to this Part III, Section B (Agency Capacity) The Table is called "BFCH MCH-Related Programs, Brief Descriptions, and Services Provided" and is the first 11 pages of the file. ***/2010/ This table is the first 11 pages of the file. //2010//***

The Bureau is committed to protecting and improving the health status, functional status, and quality of life of Massachusetts residents across the lifespan, with special focus on at-risk populations, low-income groups, and cultural and linguistic minorities. The programmatic divisions through which the Bureau carries out it mission are described in the next section, "Organizational Structure."

TITLE V IN MASSACHUSETTS

The philosophy of the Massachusetts Title V program is that in order to fully address the health needs of mothers and children, systems, programs and services need to consider the health of the entire family, including the community. In the Bureau of Family and Community Health, all systems and programs begin with this philosophical approach -- addressing the needs of women, children and youth, including those with special health needs, within the context of the family. The state's philosophy simply stated is: "Healthy families lead to healthy children."

An attached Figure displays BFCH programs and activities schematically in relation to the levels of the "MCH Pyramid." This Figure is in the Word document that is the attachment to this Part III, Section B (State Agency Capacity); it is called "The MCH Pyramid Core Public Health Services Delivered in Massachusetts by MCH" and is the last page of the file. The pyramid includes the core public health services delivered by MCH agencies hierarchically by levels of service from direct health care services (the tip of the pyramid) to infrastructure building services (the broad base of the pyramid). The Figure lists both generic functions and services carried out by MCH agencies that BFCH provides or assures, as well as specific Massachusetts programs and initiatives. Many programs carry out activities at more than one level of the Pyramid (e.g. primary care service providers also assist families with enrollment in WIC or offer other enabling services as well; population-based lead screening programs also provide direct client case management for children found to be lead poisoned). However, for this purpose, each program has been shown only at the level of the Pyramid that represents its primary or dominant focus based on the MCHB definitions for levels of services. Within MDPH, the BFCH MCH programs work closely with the other components of the Center for Community Health (CCH) on a daily basis; these include the Bureau of Substance Abuse Services, the HIV/AIDS Bureau, the Massachusetts Tobacco Control Program, the Office of Multicultural Health, and the Office for Healthy Communities. The CCH, including its MCH programs, is closely connected within MDPH with such units as vital statistics, health statistics and evaluation, immunization, communicable diseases, /2007/ emergency preparedness, //2007// and health care quality/licensing. The increasingly seamless integration of needs assessment, planning, program implementation, and evaluation can be seen throughout our 5-year needs assessment and the program activities and accomplishments described in this Application and Annual Report. /2008/Although the Center for Community Health no longer exists due to the recent MDPH reorganization, the Bureau of Family and Community Health continues to work closely with the other bureaus and offices referenced above. The Massachusetts Tobacco Control Program and the Office of Multicultural Health are

now part of the BFCH. //2008//

/2009/ During FY2008, further organizational changes were made that affected the Title V program. The Bureau of Family and Community Health was divided into two new Bureaus, the Bureau of Family Health and Nutrition and the Bureau of Community Health Access and Promotion, along division lines. At the same time, Tobacco Control Program was transferred to the Bureau of Substance Abuse Services and the Office of Multicultural Health (renamed the Office of Health Equity) was transferred to the Commissioner's Office.

The Bureau of Family Health and Nutrition (BFHN), which is led by Sally Fogerty, the state's Title V director, includes the Division of Perinatal, Early Childhood and Special Health Needs, the Nutrition Division (WIC, Growth & Nutrition, and other nutrition-related programs), and an Office of Data Translation (the portion of the staff of the previous Office of Statistics and Evaluation that work with the programs in BFHN). The Bureau of Community Health Access and Promotion (BCHAP), under Acting Director Stewart Landers, is now the home of the Division of Primary Care and Health Access, the Division of Violence and Injury Prevention, the Division of Health Promotion and Disease Prevention, a new Division of Wellness, and the remainder of the Office of Statistics and Evaluation. Administrative staff were also divided between the two new bureaus. Under this new organizational structure, a number of Maternal and Child Health and Title V programs and responsibilities reside in BCHAP, including a number of contracted services for women of reproductive age and adolescents, family planning services, the Office of Oral Health, and the Office of Adolescent and Youth Development (including teen pregnancy prevention services), childhood injury control programs, poison control center, a new shaken baby syndrome program, suicide prevention, youth violence prevention, and a number of domestic violence and sexual assault prevention programs, and some lifespan physical activity and nutrition efforts. For Block Grant purposes, all of these services and initiatives continue to be reported and staff and leadership of both Bureaus continue to work closely together to address common issues and cross-cutting initiatives. The BFHN retains overall responsibility for the Title V program and funds. //2009//

/2010/ The new organizational structure described in our 2009 update remains in place, with Ron Benham replacing Sally Fogerty as the Director of the Bureau of Family Health and Nutrition and as the state Title V Director. After many years of dedicated and innovative service to MCH at the local, state, and national levels, Sally retired from the Department in 2008. She did not retire from service to the MCH community however and is now the director of the national Children's Safety Network located at the Educational Development Center in Newton, Massachusetts. And she recently became a grandmother for the first time and is applying some of her skills and wisdom hands on!
Jewel Mullen, MD, MPH, has been hired as the Director for the Bureau of Community Health Access and Promotion.

A modest challenge since Sally's departure has been the inability to re-fill Ron's prior position due to a state employee hiring freeze through most of FY09. Federal funds are available to fill this and other critical positions. We anticipate that the freeze will be lifted early in FY10, and we will be able to move forward with recruiting and hiring. //2010//

MDPH also collaborates as a sister agency within the cabinet-level Executive Office of Health and Human Services (EOHHS) with other state agencies in regular meetings, cross-agency program development, workgroups and special taskforces. Other agencies within EOHHS include the Department of Transitional Assistance (welfare), the state Medicaid agency, the Department of Social Services (child welfare ***/2010/(now the Department of Children and Families)//2010//***, the Office of Child Care Services, the Department of Mental Health, the Department of Mental Retardation ***/2010/(renamed the Department of Developmental Services as of July 1, 2009)//2010//***, Department of Youth Services, Commission for the Blind, Commission for the Hard of Hearing, /2009/ Executive Office of Elder Affairs (which includes long-term care for children as well as adults and elders), //2009// and the Division of Health Care Finance and Policy. Agencies

outside EOHHS with which we actively collaborate include the Department of Education and the Executive Office of Public Safety, and the new (as of July 1, 2005) Department of Early Education and Care (DEEC). DEEC combines the functions of the Office of Child Care Services (OCCS) with those of the Early Learning Services Division at the Department of Education; the agency is to be responsible for the administration of all public and private early education and care programs and services in the state. Although no programs from MDPH were transferred to DEEC, MDPH staff have been involved in its establishment and expect to work in partnership to assure linkages and collaboration among birth to 5 services. The agency is supervised and guided by a new independent board. Massachusetts is trying to maximize systems building and minimize the potential confusion brought by multiple state plans, service networks, and community coalitions, by coordinating the development of these activities and structures across state programs. /2009/ In March, 2008, a new Secretariat of Education was created; it includes EEC and the renamed Department of Elementary and Secondary Education as well as Higher Education. BFHN will continue to work closely with our sister agencies and programs within the new Secretariat structure. //2009//
The Associate Commissioner, Director, Center for Community Health, who is the Title V administrator, holds a senior leadership position within MDPH and is integrally involved in collaborations and decision-making regarding both internal and cross-agency program development that affects MCH populations. The Associate Commissioner also collaborates with and seeks input from professional organizations, consumer representatives, advocacy groups, and community providers, as well as participating on multiple committees and taskforces addressing MCH issues in the state. /2008/ Under the new MDPH reorganization, Sally Fogerty remains as the Title V Administrator; her title is now Director, Bureau of Family and Community Health; the Center for Community Health no longer exists as an organizational unit. //2008// /2009/ Sally Fogerty remains as the Title V Administrator, with the revised title of Director, Bureau of Family Health and Nutrition. //2009//

/2010/ Ron Benham, who had previously been the Director of the Division for Perinatal, Early Childhood and Special Health Needs and the state Title V CSHCN Director, is now the Title V Administrator, with the title of Director, Bureau of Family Health and Nutrition. //2010//

Our MCH Priorities and State Performance Measures clearly reflect the systems development and partnership philosophies articulated above and have been developed with the Massachusetts health care system context in mind.
There are no statutes in Massachusetts directly related to the establishment or operation of a Title V program as defined by MCHB/HRSA. There are, however, a myriad of statutes and regulations that address issues related to MCH and CSHCN. Many of these have been referenced in the Needs Assessment section and in the NPM/SPM annual report narratives.
The Massachusetts Title V program has historically been a leader in the development of a statewide system of services that reflect the principles of comprehensive, community-based, family-centered care for CSHCN. An extensive review of where we stand on the MCHB-defined four constructs by which to assess the service system for CSHCN and state involvement with it is included in our Five-Year Needs Assessment (Section 2F3.4).
/2010/ Further updates for selected items in the full update in 2007 have been made for 2010. They are indicated within the 2007 text, along with those for 2008 and 2009. //2010//
/2009/ Further updates for selected items in the full update in 2007 have been made for 2009. They are indicated within the 2007 text, along with those for 2008. //2009// /2008/ Selected items in the full update in 2007 have been made for 2008. They are indicated within the 2007 text. //2008// /2007/ A stand-alone update to the constructs section is provided below

Four Constructs of a Service System for CYSHCN (From July 2005 MCH Needs Assessment with July 2006 updates)
The Maternal and Child Health Bureau has defined four constructs by which to assess the service system for CSHCN and state involvement with it. This capacity assessment responds to each of these four constructs in turn below.

Not counting short-term positions and service on task forces, the Bureau employs over 16 parents who represent approximately 12 full-time equivalent staff. Flexibility in both work hours and locations has enabled us to hire and retain this large group of committed and skilled people. Family TIES Coordinators work out of the regional offices and are the voices behind the statewide 1-800 number for families with children with special health care needs ***/2010/and their providers //2010//***. More information on our extensive parent involvement initiatives is provided through our reporting on Performance Measures.

Family members continue to report a strong commitment from the CSHCN program to create opportunities for involvement. Stipends for participation are always given. Families receive a high level of training and mentoring that facilitates participation. The CSHCN program encourages and supports family members to attend local, statewide and national conferences and meetings. Family members of CSHCN are valued and sought for their experience and expertise as parents. At the same time, families identified the need to increase diversity of families involved in Title V activities. Massachusetts has made improving its score on the family participation measure by increasing diversity one of its SSDI objectives. ***/2010/ As of FY08, family staff raised the score on Form 13, question six to a "2" and they expressed feeling increased confidence that we are on a path to meet the needs of families from diverse linguistic and cultural backgrounds. //2010//***

1. Collaboration with other state agencies and private organizations
MDPH continues to collaborate with other state agencies and private organizations, either through specific initiatives that we oversee or in which we participate. Key among these collaborative efforts have been:

* The Massachusetts Consortium for CSHCN
The Massachusetts Consortium for CSHCN is a working group of which MDPH is a key player. The Consortium offers a tremendous opportunity for collaboration. The Consortium, which was formed in 1999 to address continuing gaps in service and to promote improvement in the quality of the overall system of care for CYSHCN in MA, represents a broad array of over 180 members representing more than 70 organizations working on improving systems of care for CYSHCN in MA. Members include parents, direct care providers, parent organizations, state agencies (Departments of Mental Retardation, Mental Health, Education and Public Health; Division of Medical Assistance (MassHealth); Mass Rehabilitation Commission; and Mass Developmental Disabilities Council), health plans, academic institutions, hospitals and other health care settings. The CSHCN Director is a member of the Consortium Steering Committee, while other MDPH staff serve on Consortium work groups. The Director of Family Initiatives co-chairs the Consortium's Family Participation Work Group, the Director of Care Coordination and Medical Home Initiatives and MFT Director are on the Medical Home Work Group, the Care Coordination Supervisor is on the Care Coordination Work Group, and the Director of Special Projects, Transition Coordinator and MFT Director are on the Transition Work Group. Other MDPH staff also participate in the larger Consortium activities. MFT's Family-Professional Partnerships Institute, Transition Training, and medical home activities are being carried out through a contract between MDPH and the Consortium, and also include significant collaboration with the Massachusetts Chapter of the American Academy of Pediatrics Committee on Disabilities.

As an example of a Consortium project, in 2004-2005, the Consortium and MDPH conducted a pilot "Family Partners Initiative" which consisted of six pilot family-professional collaborations. Organizations such as health insurers, academic institutions and community-based practices were invited to apply to participate in the pilot, which was intended to model a variety of partnerships between families/consumers and professional organizations. The selected organizations were then partnered with a parent of a child with special health care needs to work with them on a particular project. The participants included three pediatric practice sites that wanted to develop Family Advisory Councils; one managed care organization interested in assessing need for and developing and implementing an orientation curriculum for its Member Services staff, aimed at helping the staff work more effectively with families of CSHCN; one

school of public health's MCH department, that was interested in making its faculty more aware of the need to model family involvement within the MCH curriculum; and one school for students with disabilities that wanted to develop an orientation for school staff. These pilots helped the Consortium and MDPH further identify the needs of professional organizations and families in facilitating meaningful family-professional partnerships.

In 2006, through MFT, MDPH and the Consortium developed a Family Professional Partners Institute, which expands on this initial pilot. Five new parent-professional partnerships have been established. These include: development of Family Advisory Councils at a community health center and at a managed care company overseeing behavioral health care; work to identify and ameliorate barriers to family centered care within a tertiary pediatric hospital ICU; development of recommendations to increase family engagement in managing childhood diabetes enrolled in one of the largest health plans in the state; and an initiative to better understand the role of health literacy for Spanish speaking families of CSHCN with a school of public health.
The Family Participation Working Group charge for FY06 was to build the diversity of the Consortium. This included conducting outreach to organizations serving diverse populations to participate in the Family Professional Partners Institute. Phone calls and visits from working group members have begun to build relationships.
The Consortium was involved in the 2005 needs assessment focus groups and analysis of National Survey of Children with Special Health Care Needs data.
/2008/ In FY07, the Consortium began the process of developing a plan for its future focus; the plan is expected to be completed in FY08. MDPH is an active participant in this process. //2008//
/2009/ Through a recently completed new competitive procurement, the Department will be contracting with the consortium to develop and maintain a broad-based and collaborative public-private partnership to build capacity to create and sustain effective community-based systems of care for children and youth with special health needs. The partnership will work with DPH to strengthen health care systems for CYSHCN and spread the Medical Home concept, to address Healthy People 2010 goals for CYSHCN, and to build a constituency of stakeholders committed to systems enhancement for CYSHCN and their families. //2009//
/2010/ The Consortium closed at the end of FY09 due to lack of sufficient funding to sustain its work. As a result, the contract begun in FY08 was not continued. MDPH remains committed to broad-based public-private collaborations and to the constituency-building efforts begun during the one year contract with the Consortium and is exploring other ways to achieve this. //2010//

* The Early Intervention Interagency Coordinating Committee.
The Early Intervention Interagency Coordinating Committee (ICC) has promoted strong interagency collaboration for the 0 to 3 population generally. Parents recruited through the ICC were involved in the needs assessment. Families involved continue to provide input and perspective to EI and CSHCN policies and programs.

* The Federation for Children with Special Needs
The Federation for Children with Special Needs is the state's parent training and information center. MDPH works with the Federation to help ensure an informed and empowered family constituency. MDPH has several contracts with the Federation. The Federation was involved in the needs assessment through focus groups and continues to provide guidance.

* The Alliance for Health Care Improvement
The Alliance for Health Care Improvement is a collaboration of the Medical Directors of the five MA-based not-for-profit health plans. Representatives from member organizations were involved in the needs assessment through the MassHealth MCH Quality Improvement task force.
MDPH has collaborated with the non-profit health insurance plans of the Alliance for Health Care Improvement (Blue Cross Blue Shield of MA, Fallon Community Health Plan, Harvard Pilgrim Health Care, Neighborhood Health Plan, and Tufts Health Plan), New England SERVE, and the Massachusetts Consortium for CSHCN, to create Directions: Resources for Your Child's Care, a health education tool for families of CSHCN. The purpose of Directions is: 1) to help families

organize health records and information; 2) to provide resources and specialized information about caring for a child with special health care needs; and 3) to improve communication among families, health care providers, and health insurance plans. Content includes forms for record-keeping; resource information and parent tips related to a child's medical team, everyday home care, health insurance, education planning, transition to adulthood, and connecting with other families; and a resource directory. 7,500 English and 2,500 Spanish copies were printed in 2005 and are being distributed to families and providers of CSHCN through a variety of methods, including physician practices and health plans. Two hundred fifty Portuguese copies were printed in 2006, as were another 1,200 English copies. Copies were sent to 1,800 members of the Massachusetts Chapter of the American Academy of Pediatrics. Another 1,200 English copies are being printed in 2006. All versions are available on the web. /2008/ In FY06, 1,359 copies (in English, Spanish, or Portuguese) were distributed. //2008// /2009/ Another 508 copies were distributed in FY07. //2009// ***/2010/ Another 566 copies were distributed in FY08. //2010//***

Other MDPH Collaborations
* Collaboration meetings with the MassHealth Community Case Management Program.
* Participation on an interagency working group, convened by the state Department of Mental Retardation, around state agencies' Family Support Plans.
* Participation in the Governor's Commission for Employment of People with Disabilities' Youth Leadership Forum for Students with Disabilities.
* Partnership in the New England Genetics and Newborn Screening Collaborative, which is engaged in efforts to enhance genetics literacy and newborn screening systems.
* Participation on the National Disability Mentoring Council, a project of Partners for Youth with Disabilities.
* The SSI/Public Benefits Specialist is an ex-officio member of the Statewide Special Education Advisory Council; a member of the Disability Determination Services Advisory Committee; and a participant in the SSI/Disability Coalition along with the Disability Law Center and statewide legal assistance programs.
* The BFCH also participates in the reforming long-term care initiative, Communities First. Communities First is a project to promote, encourage, and provide resources for children and adults to live within community settings.
/2010/ * The Director of Family Initiatives serves on the Advisory Boards of the Massachusetts Developmental Disabilities Council and the Institute of Community Inclusion.
**** The Bureau has several on-going collaborative activities with the Department of Early Education and Care (EEC). These include continuing collaboration around transition requirements for children leaving Early Intervention; collaboration between DPH, EEC, ACF/Head Start and other community agencies to expand training and support for inclusive community-based options for children; and participation on the Birth to Three Task Force formed by EEC. DPH staff sits on all Task Force committees to represent health issues.//2010//***
/2009/ The BFHN has been a major participant in the implementation of the Rosie D. class action suit which has been integrated into a broader Children's Behavioral Health Initiative. The initiative will result in a comprehensive redesign of the entire children's mental health delivery system for the Commonwealth. //2009//

2. State Support for Communities
State support for communities is provided through multiple programs, projects and initiatives. Specific programs of the Division for Perinatal, Early Childhood and Special Health Needs address the special needs of children with disabilities at the community level. Initiatives in this area include intensive efforts to promote provision of Early Intervention services in natural environments (aimed not only at improved services for individual children but also at increased community understanding of and capacity to meet special needs); the MASSTART program which provides consultation to schools and families about safe school placement of very medically involved children; the Family TIES program, which provides information and referral to

families of CSHCN and their providers, and also serves as the state Parent-to-Parent organization; the Flexible Family Support Fund and the Catastrophic Illness in Children Relief Fund, which provide financial support to eligible families with CSHCN; and practice-based MDPH care coordination in community-based medical practices, which helps increase the capacity to meet needs of CYSHCN at the community level.

In all meetings and focus groups with parents of CSHCN for the 2005 needs assessment, there was agreement when asked for the strengths of the Massachusetts system of care that the various forms of parent support and, in particular, parent-to-parent support came first. Education of parents to promote family participation and parent support occurs through the Family TIES program, the Massachusetts statewide information and referral network for families of CSHCN and their providers and the Parent-to-Parent Program; the Massachusetts Consortium for Children with Special Health Care Needs; the Federation for Children with Special Needs; Massachusetts Family Voices; and other family organizations such as those organized around specific conditions.

3. Coordination of health components of community-based systems:

Medicaid Managed Care

Medicaid managed care has enhanced opportunities for coordination of care at the community level in MA. Unlike states in which families experience Medicaid managed care as a de facto cut in benefits, Massachusetts has chosen to provide a choice for families between a traditional managed care and membership in Medicaid's own PCC gatekeeper manager care program. This shift has enhanced coordination for parents of CSHCN.

Families and the BFCH will be monitoring implementation of Health Reform.

/2008/ The shift from PCC to MCO plans in FY07 will be monitored closely to assure that the needs of families are still being met and that no decrease in services is occurring. //2008//

/2009 The majority of children within both Medicaid and SCHIP are now within one of 4 managed care plans which have expanded to provide statewide coverage, thus not requiring children to change practice sites. The Title V program participates in regular meetings between the MA Chapter of AAP and the Medicaid agency, as well as other major managed care providers in the Commonwealth. These meetings provide an opportunity for issues to be addressed between providers and insurers. //2009//

/2010/ Early Intervention benefits under Medicaid have been expanded effective 7/1/09 with the addition of Medicaid coverage for developmental specialists. All professional disciplines are now covered by MassHealth. This is a significant change; $14.7M previously in a retained revenue account for EI at MDPH has been transferred to MassHealth. //2010//

Care Coordination for CSHCN

The Division for Perinatal, Early Childhood and Special Health Needs' Care Coordination Program is designed to help families' coordination among multiple specialties and levels of care and to reduce fragmentation of care. Thirteen Care Coordinators are located in MDPH regional offices as well as 14 community-based pediatric primary care practices statewide. Care Coordinators help families navigate the health care system to better manage the medical, educational and social aspects of their children's needs. They may conduct home visits, attend IEP meetings, or train parents to be better advocates. They connect parents of CSHCN to other families facing similar challenges. Care Coordinators also help providers understand existing entitlements, services and benefits available to families of CSHCN and how to access them, and assist practices in developing systems to help them provide medical homes to families of CYSHCN. Staff were involved in the 2005 needs assessment and continue to provide input into CSHCN needs and Title V services. /2009/ Through a new procurement process in FY08, there are now 13 care coordination sites in pediatric practices (11 new and 2 continuing). //2009//

/2010/ In FY09, DPH contracted with an additional eight community-based pediatric practices statewide. Seven are Community Health Centers, one a private practice. DPH Care Coordinators are placed in these practices. //2010//

Universal Newborn Hearing Screening Program
The Universal Newborn Hearing Screening Program (UNHSP) employs a Parent Outreach Specialist -- who is also a parent -- who contacts all families with infants and young children diagnosed with hearing loss and provides parent-to-parent support. Educational materials are provided to all families with newborns and a Parent Information Kit is given to all families when an infant or young child is diagnosed with hearing loss. During 2004 and 2005 the UNHSP developed family surveys to measure satisfaction. Results became available in 2006: Overall, families expressed strong support for the universal newborn hearing screening initiative. Eighty-six percent of survey respondents reported being satisfied with screening services. Staff and a parent representative were involved in the needs assessment and their input continues. /2009/ The program is focusing on improving the screening for all infants who are transferred from NICUs to Level 2 hospitals prior to going home. //2009// ***/2010/ Our primary focus in FY09 has been on decreasing the number of families who are lost to follow-up and on expanding collaboration with the Massachusetts Commission for the Deaf and Hard of Hearing,(MCDHH), which will help families to get connected earlier.//2010//***

SSI/Public Benefits
The SSI/Public Benefits Specialist conducts statewide trainings for parent groups and organizations, state and local agencies serving families with CSHCN, and health care providers through community settings and hospitals serving CSHCN. Training and technical assistance is provided to help ensure CYSHCN are aware of benefits available to them and that they have adequate health insurance. The SSI/Public Benefits Specialist also co-trains parents and providers serving "transitional youth" along with Disability Law Center staff on topics related to children, youth and transition to adulthood. Staff continues to be involved in needs assessment activities.

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

MA Consortium for CSHCN
The collaborative relationships described above facilitate the coordination of health services with other services at the community level. Membership of and participation in the Massachusetts Consortium for CSHCN includes representatives from a variety of arenas, including early intervention, education, social services and family support services.
As part of a Champions for Progress grant awarded to New England SERVE and the Massachusetts Consortium for CSHCN, two pilot "regional affiliates" of the Consortium were developed in western and central MA. This enhances capacity to reach out to outlying parts of the state and develop greater linkages at the local and community level. ***/2010/ As noted above, the Consortium closed at the end of FY09 due to lack of funding //2010//***.

Care Coordination for CSHCN
As described above, the Division for Perinatal, Early Childhood and Special Health Needs' Care Coordination addresses a full range of services at the community level. Care Coordinators provide the ‘glue," in the form of information, advocacy and support, that can make systems that are not necessarily coordinated more coherent to families.

Community Support Line for CSHCN
The Division for Perinatal, Early Childhood and Special Health Needs' toll free Community Support Line provides families of CSHCN with information, referral and technical assistance. Assistance is available to families and providers statewide, including information on public benefits; family-to-family supports; funding programs; and referrals to care coordination, other MDPH CSHCN programs, and other state agencies and community-based resources.

Family TIES
The Family TIES program provides information and referral for families and providers as well as a parent-to-parent support network, which helps promote service coordination at the community level. Nevertheless, as noted in section 3.1.2.1, program staff have reported that lack of service

coordination continues to be a barrier for families. In addition, Family TIES is acting on the need to do targeted outreach to culturally and linguistically diverse families of CSHCN. Of the nearly 1,300 FY05 calls tallied for the needs assessment, 31 individuals identified something other than English as their primary language, with 26 of these callers requesting Spanish. Family TIES has secured the part-time services of staff who speak Spanish and Portuguese. These individuals respond to messages left on the toll free line in either of these languages. In addition, the training Let's Get Organized has been translated into Spanish and offered twice. For FY 2006, Family TIES has identified as a primary goal expanding capacity to effectively outreach to under-served populations by building community-based relationships at organizations, recreational and educational sites and places of worship where diverse families typically come together. Family TIES convened a focus group for the needs assessment.
In 2006, two new sections of statewide resources -- one in Spanish and one in Portuguese -- were added to the Resource Directory developed by Family TIES. This Directory reaches several thousand families and professionals either in hard copy or on-line and is in great demand.

Moving Forward Together: Partnerships to enhance integrated community systems for children and youth with special health care needs in MA
In 2005 MA was awarded an MCHB-funded state implementation grant for integrated community systems for CYSHCN. This project, Moving Forward Together: Partnerships to enhance integrated community systems for children and youth with special health care needs in MA, addresses all four constructs of a service system, and focuses on four of the six core outcomes for CYSHCN: medical home, family-professional partnerships, screening, and transition to adulthood. MFT-sponsored activities are currently underway, including developing a Family-Professional Partners Institute; Transition Training for care coordinators from a variety of settings statewide; creating linkages to ensure follow-up services for CSHCN identified through screening efforts; promoting medical home amongst pediatricians and physicians-in-training, in collaboration with the Massachusetts Chapter of the American Academy of Pediatrics; and developing a Youth Advisory Council (in collaboration with Partners for Youth with Disabilities) to advise both MDPH and the Massachusetts Consortium for CSHCN. A key strategy of MFT is significant collaboration with the Massachusetts Consortium for CSHCN. In fact, one objective of the project is to strengthen the capacity of the Consortium. This grant provides the state Title V CSHCN program in particular, and the state in general, with an enormous opportunity for improving community systems for CYSHCN and their families in the state. MDPH recognizes that no single organization or agency, on its own, can build a comprehensive system of services for CYSHCN and their families. We plan to use the opportunity offered by this grant to build upon existing collaborations and relationships with community, family and agency partners to expand and enhance a system of care for CYSHCN. //2007// /2008/ Our progress with the Moving Forward Together grant is reflected in the narrative sections for NPMs #02 - #06 elsewhere in the application. //2008// /2009/ Our continued progress with the Moving Forward Together grant, which is just ending, is reflected in the narrative sections for NPMs #02 - #06 elsewhere in the application. //2009// ***/2010/ Our continued progress with the Moving Forward Together grant, which ended during FY09, is reflected in the narrative sections for NPMs #02 - #06 elsewhere in the application. //2010//***

An attachment is included in this section.

C. Organizational Structure

The Bureau of Family and Community Health (BFCH) within the Center for Community Health in the Massachusetts Department of Public Health (MDPH) is the Title V Agency for the Commonwealth of Massachusetts. /2008/ As the result of a recent reorganization within MDPH, the Center for Community Health no longer exists and the Bureau of Family and Community Health is a free-standing unit reporting directly to the Commissioner of Public Health. BFCH remains the Title V agency for the Commonwealth. //2008// /2009/As the result of further reorganization within MDPH, the Bureau of Family and Community Health has been split into two

Bureaus, the Bureau of Family Health and Nutrition (BFHN) and the Bureau of Community Health Access and Promotion (BCHAP). The BFHN is a free-standing unit reporting directly to the Commissioner of Public Health. It remains the Title V agency for the Commonwealth. See Section III. B. (Agency Capacity) for additional information about this new organizational structure and its impact on the Title V program. //2009// The Department of Public Health is part of the Executive Office of Health and Human Services. (See the organizational charts in the attachment to this Part III, Section C. (Organization Structure)). As part of a larger re-organization of state government, Governor Romney has implemented a major restructuring of the cabinet-level Executive Office of Health and Human Services, with the goal of being more responsive to providers, clients and communities by improving organizational efficiency, using technology more effectively to achieve coordination of services, and building on the current strengths in the system. Administrative cost savings are being achieved by eliminating duplication. Central functions such as legal, human resources, and information technology have been centralized at the EOHHS level. Four "offices" have been created within the EOHHS of which the Office of Health Services now includes Public Health, Mental Health and Health Care Finance and Policy. Title V remains within Public Health. The other three offices are the Offices of Medicaid; Children, Youth and Family Services; and Disabilities and Community Services.

The Commissioner of Public Health (Christine Ferguson) resigned in March and the EOHHS Assistant Secretary, Office of Health, Paul Cote was named Acting Commissioner. A new deputy commissioner was appointed in May. It is expected that a new commissioner will be named before the end of 2005. The Secretary of EOHHS has also recently resigned and a new Secretary, Timothy R. Murphy, was just named in early July, 2005. Murphy is currently the Director of Policy in the Governor's Office and has been recently focused on the Governor's health care reform efforts. Further restructuring within EOHHS is being discussed. /2007/ Paul Cote was named Commissioner during FY2006. The deputy commissioner is Alda Rego-Weathers. Timothy Murphy continues as Secretary of EOHHS and his deputy is Fred Habib. There has been minimal reorganization in the last year with the exception of changes in top leadership and some Medicaid realignments (see Section E). The Center continues to work closely with these leadership teams and to serve on advisory committees for the Executive Office of Elder Affairs, the Disability Cluster, and the departments of Mental Retardation, Social Services, and Mental Health.

In early FY06, the Office of the Medical Director was created at EOHHS. This Office now functions to provide medical oversight, including dental services, for Medicaid and other EOHHS agencies. The Office is using a public health approach and has been instrumental in getting the family planning services waiver submitted to CMS and in initiating tobacco cessation benefits. //2007//

As a result of reorganization within the Department of Public Health, Sally Fogerty, Massachusetts Title V director, was promoted to Associate Commissioner level and has leadership responsibility for the Center for Community Health within MDPH that includes the Bureau of Substance Abuse Services, the HIV/AIDS Bureau, the Office of Healthy Communities, the Office of Multicultural Health, and the Office of Tobacco Control, as well as the Bureau of Family and Community Health.

The Bureau of Family and Community Health reports to the Associate Commissioner, Director, Center for Community Health. The Center for Community Health continues a process of realignment begun in FY05 to improve both functioning and program integration, including modifications to the BFCH organizational structure (see below). The Title V programs remains within the Center. Currently Sally Fogerty is continuing to serve as the Bureau Director, as well as Center Director. Ron Benham, Director of Division for Perinatal, Early Childhood, and Special Health Needs (DPECSHN), is the state's CSHCN contact person.

/2008/ With the election of a new Democratic governor in November, 2006, there have been a number of major changes in state government and within the Department of Public Health. Governor Duval Patrick named JudyAnn Bigby, M.D. as the new Secretary of Health and Human Services; she was previously an internist in active practice and a member of the Boston Public Health Commission, the governing body of the Boston public health department. In turn, John Auerbach was named Commissioner of Public Health; he was Health Commissioner for the City of Boston and had previously been with the MDPH 10 years ago. As part of his reorganization

efforts, the Center for Community Health (along with other centers) was eliminated and the previous Bureau structure has been reestablished. The Bureau of Family and Community is again a free-standing unit reporting directly to the Commissioner. Sally Fogerty remains as the head of the Bureau, with the title of Director; at the moment, there are no assistant or associate commissioner titles.
The organizational structure of the EOHHS has not been changed. New commissioners at other EOHHS agencies are being named or current ones are being reappointed.
Sally Fogerty and Ron Benham continue to serve as the Title V director and state CSHCN contact persons, respectively. //2008//
/2009/ EOHHS Commissioners and Assistant Secretaries are currently focusing on how to better integrate programs and services across the multiple health and human services agencies. For Children with Special Health Care Needs, there is a focus on those who have the most complex needs and how to better meets their needs across the life span to minimize transition issues. //2009//
/2010/ Ron Benham currently serves as both the Title V director and state CSHCN contact person. We are in the process of recruiting and hiring for a new CSHCN director management position. Karin Downs, Assistant DPECSHN Director for Clinical Affairs serves as the state Title V MCH contact person. //2010//
The Bureau of Family and Community Health is committed to protecting and improving the health status, functional status, and quality of life of Massachusetts residents across the lifespan, with special focus on at-risk populations, low-income groups, and cultural and linguistic minorities. After organization changes during FY05, the Bureau includes five programmatic divisions:

-- Division for Perinatal, Early Childhood, and Special Health Needs (DPECSHN)
-- Division of Primary Care and Health Access (DPCHA)
-- Nutrition Division (including WIC)
-- Division of Health Promotion and Disease Prevention (DHPDP)
-- Division of Violence and Injury Prevention (DVIP)
/2008/ After the recent reorganization affecting the Center for Community Health, the following programmatic units also remain within the Bureau:
-- Massachusetts Tobacco Control Program
-- Office of Multicultural Health //2008//

/2009/ After further reorganizations in FY08, the new Bureau of Family Health and Nutrition includes:
-- Division for Perinatal, Early Childhood, and Special Health Needs (DPECSHN)
-- Nutrition Division (including WIC)
The new Bureau of Community Health Access and Promotion includes:
-- Division of Primary Care and Health Access (DPCHA)
-- Division of Health Promotion and Disease Prevention (DHPDP)
-- Division of Violence and Injury Prevention (DVIP)
--Division of Wellness (new offshoot of DHPDP)
The following programmatic units are no longer in either Bureau:
-- Massachusetts Tobacco Control Program (now in the Bureau of Substance Abuse Services)
-- Office of Multicultural Health (now called the Office of Health Equity) //2009//
The Bureau also includes the following Internal Support Centers:
--Applied Statistics, Evaluation, and Technical Services (ASETS) /2007/ now renamed the Office of Statistics and Evaluation //2007// /2008/This office has been renamed again as Data Analytics and Decision Support //2008//
-- Administration and Finance
-- Policy and Planning

/2009/ After the reorganizations in FY08, each of the new Bureaus has separate internal support centers. Those for the Bureau of Family Health and Nutrition include an Office of Data Translation, and administration, policy, and planning. //2009//

/2010/ A possible reorganization within BFHN is under active consideration, but not finalized, as this is written. Under this plan, DPECSHN would be split into three smaller divisions: Maternal and Child Health, Early Intervention/Early Childhood, and Children and Youth with Special Health Needs. //2010//

In addition to its central office, the Bureau maintains staff in five regional offices. Many of these staff, such as FOR Families home visitors, and care coordinators for CSHCN provide direct services to individuals and families. Others work closely with BFCH programs, providing regional and local training and technical assistance, information and referral to services, coordination of services for families, performance monitoring, and other capacity building activities, such as the regional Early Intervention specialists. Among the staff are the Family TIES parent staff. Each regional office has a manager, under whose leadership staff work closely with communities to develop a system of care that is responsive to the diverse needs of community members. These staff facilitate the systems building activities in local communities for all Bureau programs and services. /2008/ The Department is considering moving back to maintaining six regional offices and is also working very actively to create and sustain more regional local health units. Without a functioning county system, individual local boards of health exist at the city/town level (351). //2008//
/2009/ The Department is moving forward to reestablishing an sixth regional office serving Southeastern Massachusetts and continues to work to create and sustain more regional local health units. Regional Offices now report through a new department level Office of Local Health Services and the functions of Regional Managers and general regional support staff are being redefined and focused. //2009//
/2010/ The Department has opened a regional office serving Southeastern Massachusetts (located in New Bedford) and continues to work to create and sustain more regional local health units. Due to cost considerations, the Boston Regional Office may be closed and most staff relocated to another regional office with available space.//2010//

An attachment is included in this section.

D. Other MCH Capacity

As of June, 2005, approximately 257 persons (244 full-time equivalents) employed throughout the Department work on Title V programs; of these 152 (144 FTEs) are paid from Title V Partnership funds. The rest are paid from MCH-related accounts. Approximately 46 of the total are usually based in the MDPH regional offices or other off-site locations (such as physician practices); the others work out of our central office in downtown Boston. Due to the combined impact of state budget reductions on some of the Partnership programs, a round of Early Retirement incentives in FY04, and the transfer of CMSP and Healthy Start outside the Department, the number of staff paid with Title V Partnership funds, particularly those in regional offices, has been reduced over the past three years. It is expected to remain stable during FY06.
/2007/ As of June, 2006, approximately 284 persons (252 full-time equivalents) employed throughout the Department work on Title V programs; of these 147 (129 FTEs) are paid from Title V Partnership funds (down from 152/144 FTEs in June 2005). The rest are paid from MCH-related accounts. Approximately 45 of the total are usually based in the MDPH regional offices or other off-site locations (such as physician practices); the others work out of our central office in downtown Boston. As expected, the workforce size has stabilized to a great extent. However, due to the combined impacts of a substantial reduction in the MCH Block Grant allocation and the cumulative costs of union settlements, cost-of-living raises, and a 4% increase in the fringe benefit rate for FY07, the number of FTE staff paid directly by the MCH Block Grant has been reduced, from approximately 107 to 93 for FY07, and they now represent approximately 37% of all FTEs and 72% of all Partnership FTEs (down from 44% and 75% in FY06). A higher percentage of staff working in MCH-related areas is being funded from either state or other federal grant sources. //2007//
/2008/ As of June, 2007, approximately 266 full-time equivalent (FTEs) are employed throughout

the Department work on Title V programs; of these 133 FTEs are paid from Title V Partnership funds (down from 144 FTEs in June 2005). The rest are paid from MCH-related accounts. Approximately 45 of the total are usually based in the MDPH regional offices or other off-site locations (such as physician practices); the others work out of our central office in downtown Boston. Due to the combined impacts of a substantial reduction in the MCH Block Grant allocation and the cumulative costs of union settlements, cost-of-living raises, and a 4% increase in the fringe benefit rate for FY07, the number of FTE staff paid directly by the MCH Block Grant has remained at 94 for FY08 (down from 107 in FY06), and they now represent approximately 35% of all FTEs and 70% of all Partnership FTEs (down from 44% and 75% in FY06). A higher percentage of staff working in MCH-related areas is being funded from either state or other federal grant sources. //2008//

/2009/ As of June, 2008, approximately 265 full-time equivalent (FTEs) are employed throughout the Department work on Title V programs; of these 132 FTEs are paid from Title V Partnership funds (down from 144 FTEs in June 2005). The rest are paid from MCH-related accounts. Approximately 31 of the total are usually based in the MDPH regional offices or other off-site locations (such as physician practices); the others work out of our central office in downtown Boston. Due to the combined impacts of a substantial reduction in the MCH Block Grant allocation and the cumulative costs of union settlements, cost-of-living raises, and an unexpected 31% increase in the fringe benefit rate for FY08, the number of FTE staff paid directly by the MCH Block Grant has remained at 94 for FY08 (down from 107 in FY06), and they now represent approximately 35% of all FTEs and 70% of all Partnership FTEs (down from 44% and 75% in FY06). A higher percentage of staff working in MCH-related areas are funded from either state or other federal grant sources. //2009//

/2010/ As of June, 2009, approximately 234 full-time equivalent (FTEs) employees throughout the Department work on Title V Partnership programs; of these 124 FTEs are paid from Title V Partnership funds. The rest are paid from MCH-related accounts. Approximately 25 of the total are usually based in the MDPH regional offices or other off-site locations (such as physician practices); the others work out of our central office in downtown Boston. The number of FTE staff paid directly by the MCH Block Grant is expected to be 90 for FY10 (down slightly from FY09), and they now represent approximately 38% of all FTEs and 73% of all Partnership FTEs. During FY09, state fiscal rules regarding payroll positions on MDPH state accounts were relaxed and a number of staff working on MCH-related programs were transferred from the MCH Block Grant (and other federal accounts) to various state accounts. This has reduced our reliance on federally-funded positions without affecting the total workforce. It also saves us money, as fringe benefits and indirect costs for state account positions are paid from a separate reserve rather than from the payroll account, as federal positions are charged. In addition, efforts to convert all consultant positions (which do not come with benefits) to regular payroll positions were reactivated during FY09, and we were able to transfer a number of consultants into newly created equivalent positions. This has provided better benefits and employment rights to the individuals and will help us in retaining these valuable staff. //2010//

Brief biographical sketches of the Title V senior management team are available in the Word document attached to this section. The biographies are the first section of the Attachment. Key data capacity elements are summarized in Health Systems Capacity Indicator #09. (See Form 19.)

Not counting short-term positions and service on task forces, the Bureau employs over 16 parents who represent approximately 12 full-time equivalent staff. /2008/ (The numbers have remained the same for FY07 and FY08.) //2008// /2009/ The numbers are expected to remain the same for FY09. //2009// ***/2010/ One part-time position remained vacant during FY09; it is uncertain if it can be filled during FY10. //2010//***
Flexibility in both work hours and locations has enabled us to hire and retain this large group of

committed and skilled people. Family TIES Coordinators work out of the regional offices and are the voices behind the statewide 1-800 number for families with children with special health care needs. More information on our extensive parent involvement initiatives is provided through our reporting on Performance Measures. The multiple types of roles that they carry out are also displayed visually in a Figure included in the Word document attached to this Section. The Figure is the last page of the document. /2008/ [More information on our extensive parent involvement initiatives is provided in Section II.B. above in our discussion of "Constructs of a Service System for CSYSHCN," as well as throughout our reporting on Performance Measures. The Figure displaying the various family roles has been updated for this application to reflect current roles and numbers and is again the last page of the Word document attached to this section. //2008// /2008/ In scoring Form 13 for this application, families reported satisfaction with the opportunities for involvement and partnership. A caution was raised, however, to remind the state Title V program that although we are doing an excellent job of involving families there are always ways to do even more. We will continue to expand opportunities to engage an ever more diverse group of families. //2008//

/2008/ Another aspect of capacity is the availability of communication mechanisms that are broad in their reach and can be used quickly and flexibly to address public health initiatives or planning (e.g. pandemic planning). The School Health Unit (SHU) has established a community-based infrastructure to enhance communication of updated information to the school health programs and to facilitate implementation of major public health initiatives. The 102 ESHS grantees are required to have a School Nurse Leader freed from direct care responsibilities. When there is a major public health initiative (e.g., preschool vision screening, pandemic planning, review of 911 calls from the school), these Nurse Leaders are the first to pilot its implementation. In addition, post 911, the SHU established a pyramid communication system. The SHU Director compiles a weekly e-mail for school nurses and school physicians. She sends this to the 102 Nurse Leaders. They in turn send it to their 1200 school nurses, the nonpublic schools in their communities, and nurse contacts in 2-3 other designated communities for whom whey are responsible. In this way updated information moves quickly to the 351 cities and towns. This system is used to communicate information on communicable disease outbreaks; updates form CDC, conference brochures from the hospitals, universities, and all DPH programs. In addition DPH programs provide ongoing information and resources to the SHU, and this is sent to the schools: injury prevention, substance abuse, suicide prevention, skin cancer prevention, healthy heart information, nutrition and physical activity, etc. More recently this system is used to provide information for the Department through brief questionnaires (e.g. compliance with preschool vision screening and numbers of AEDs in the schools). //2008//
/2010/ More information on our extensive parent involvement initiatives is provided in Section II.B. above in our discussion of "Constructs of a Service System for CSYSHCN," as well as throughout our reporting on Performance Measures. The Figure displaying the various family roles has been updated for this application to reflect current roles and numbers and is again the last page of the Word document attached to this section. //2010//

/2009/ In scoring Form 13 for this application, families reported satisfaction with the opportunities for involvement and partnership. They particularly noted improvement (after several years of effort) in attracting more bi-lingual, bi-cultural parents to work with us, as a result of their working more closely with a variety of community-based organizations (CBOs). As always, they remind the state Title V program that although we are doing an excellent job of involving families there are always ways to do even more. We will continue to work with them to take up this challenge in FY09. //2009//

/2010/ In scoring Form 13 for this application, families reported satisfaction with the opportunities for involvement and partnership; scoring remained the same as FY09 at 16 (of a total possible of 18). They noted continued improvement in attracting and involving more bi-lingual, bi-cultural parents to work with us, giving us a score of "2+." They expressed feeling increased confidence that we are on a path to meet the needs of families from diverse cultural backgrounds. As always, they remind the state Title V program that

although we are doing an excellent job of involving families there are always ways to do even more. //2010//

An attachment is included in this section.

E. State Agency Coordination

The BFCH views both intra-agency and interagency coordination as being essential to the achievement of its mission on behalf of improved maternal and child health. The Bureau maintains and promotes extensive networking and systems development relationships at the national, state, and local levels. These relationships include provider, non-profit, and other organizations; advocacy groups; coalitions, task forces, and community groups; other state agencies and governmental groups; universities and colleges; and internal MDPH working groups. Many of the activities carried out through these relationships are noted throughout the Annual Report and Annual Plan sections of this document as they related to specific performance measures or Title V priorities. The Bureau works with a broad base of constituency groups many of whom relate to specific populations or issues.
An extensive listing summarizing these relationships, categorizing them by type of agency/organization, is available in the Word document that is the Attachment to this Section. The following is a list of the major or key groups that the Bureau works with on MCH issues on a regular basis. See the attached file for details on relationships with public sector agencies, as well as a number of other private sector organizations and institutions. ***/2010/ The file has not been updated or attached for this application. It will be updated only periodically, as the bulk of the relationships do not change frequently. //2010//***

Adaptive Environments
Conference of Boston Teaching Hospitals
Delta Dental Foundation
Disability Law Center
Federation for Children with Special Needs
Health Care Alliance
Health Care for All
Independent Living Centers
Jane Doe, Inc. (Massachusetts Coalition Against Sexual Assault and Domestic Violence)
Latino Grocer Association
March of Dimes
Massachusetts Chapter of the American Academy of Pediatrics
Massachusetts Chapter of the American College of Obstetrics and Gynecology
Massachusetts Chapters of the American Heart Association and Cancer Society
Massachusetts Food Association
Massachusetts Hospital Association
Massachusetts Law Reform Institute
Massachusetts League of Community Health Centers
Massachusetts Medical Society
Massachusetts Nurses Association
Massachusetts Public Health Association
Massachusetts School Nurses Organization
Massachusetts Society for the Prevention of Cruelty to Children
New England Coalition for Health Promotion and Disease Prevention (NECON)
New England Consortium (the successor to Project SERVE)
Project Bread
School-Based Health Center Association

Collaboration with Medicaid
With the restructuring of Medicaid at the state level over the last two years, the Bureau has

established partnerships with the Office of Medicaid, Office of Acute and Ambulatory Care, Office of Long-term Care, MassHealth Operations, and the MMIS and Enrollment and Eligibility Components. In every Division and throughout a significant portion of its programs, the Bureau works with one or more of the offices or components within EOHHS that are responsible for a Medicaid activity. This continues to assure that there is a comprehensive and integrative approach in the outreach, enrollment and services provided to MassHealth, including CommonHealth, recipients. This includes involvement in waiver development, MMIS purchasing, enrollment functions and development of standards of care and quality initiatives. The Bureau strives to maximize Federal reimbursement mechanisms including FFP and municipal Medicaid opportunities.
/2007/ During the past year, the Office of Acute and Ambulatory Care has been realigned with the Office of Medicaid and Medicaid Behavioral Health has been transferred to the Department of Mental Health. Linkages and collaborations with the multiple Medicaid entities continue to be strong and regular. //2007//
/2008/ One new collaborative initiative worthy of note is the Massachusetts Special Commission on After School and Out of School Time. It is a legislative commission that is developing a comprehensive report on the need for these services, current programs, and a proposal for the Commonwealth to better address after school and extended learning needs. The Bureau of Family and Community Health is on the Commission and its three subcommittees. Release of the report is expected in early 2008. //2008//

/2009/ The BFHN is part of the steering committee for the implementation of the MassHealth -- Medicaid response to the Rosie D class action lawsuit. As a result of the settlement of the lawsuit, universal behavioral screening at each EPSDT visit was implemented in January, 2008, utilizing an approved screening tool. In addition the BFHN is in active discussions related to early intervention services and autism services for children birth to 3 and for children with significant medically complex health -- to explore the need for subacute and respite services. //2009//.

/2010/ One new collaboration of note is our active participation on Birth to Three Task Force formed by EEC. DPH staff sits on all Task Force committees to represent health issues. The Task Force itself is a subsection of the Governor's School Readiness Project, a major policy initiative. //2010//

F. Health Systems Capacity Indicators

Introduction

/2010/ The Health Systems Capacity Indicators are all actively used by Massachusetts to track the health of the Commonwealth and to inform public health policy and practice. These indicators are part of a much larger set of indicators that are routinely reviewed and that help shape efforts to reduce health disparities and target both programs and other systems capacity resources appropriately. Analyses by race, ethnicity, age, and other characteristics -- at both the state and local levels -- are key components of our approach. A particular emphasis is working with communities at greatest risk to develop their own capacity to use data to create, implement, and monitor strategic plans. These indicators are also among the risk indicators that we use for tracking and early identification and for needs assessments for procuring community-based services. Massachusetts has been a leader in the development of programs based on data analysis and on the development of innovative systems of care. We have dedicated epidemiology resources and provide leadership using surveillance data, expanding data utilization and applying data to public health policy. Our systems capacity is excellent in the areas of health care resources, Medicaid and other public benefits, and a national model universal health insurance system. We have a number of strong data system linkages that promote improvements in systems capacity, some of them unique (e.g. PELL).

Among our challenges are a better understanding of how systems capacity problems are

contributing to persistent health disparities and reconciling various -- and sometimes conflicting -- federal, state, and program-specific data sharing rules //2010//

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	63.8	60.4	69.6	72.0	72
Numerator	2525	2415	2699	2715	
Denominator	395662	400113	387863	376848	
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
Hospitalization data for 2008 are not yet available from the Massachusetts Uniform Hospital Discharge Data System (UHDDS), Division of Health Care Finance and Policy. We have estimated the same rate as that for 2007. See 2007 for the most recent actual data and see the Note for 2007 for data sources and other comments.

Notes - 2007
Hospitalization data are from Massachusetts Uniform Hospital Discharge Data System (UHDDS), Division of Health Care Finance and Policy, 2007. The 2007 denominator is from the most recent population estimates for Massachusetts, as provided by the Bureau of Health Information, Statistics, Research and Evaluation. The denominator -- and thus the rate -- have been updated. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere.

The numerator includes hospitalizations where asthma was either the primary diagnosis or a contributing cause.

Notes - 2006
Hospitalization data are from Massachusetts Uniform Hospital Discharge Data System (UHDDS), Division of Health Care Finance and Policy, 2006. The 2006 denominator is from population estimates for Massachusetts, as provided by the Bureau of Health Information, Statistics, Research and Evaluation. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere.

The numerator includes hospitalizations where asthma was either the primary diagnosis or a contributing cause.

Narrative:
Asthma is a significant public health challenge in Massachusetts and an area where we continue to explore methods to collect and analyze data more effectively. The hospital discharge database remains in continuous change and improvement, with Observation Discharges and Emergency Room visits being added in recent years, but not for every data year. The multiple possibilities for capturing ICD codes at various levels (primary diagnosis, secondary, etc.) make these data more

challenging to interpret over time than vital statistics. Our Asthma Planning grant is helping promote closer analyses. In addition, changes in medical care practice (and hospital/insurance policies) may create changes in where similar cases are recorded from year to year, making trend analysis complex.

The Massachusetts Asthma Advocacy Partnership (MAAP) is a primary mechanism to address asthma for all age groups, through a growing statewide organization. It replaces the previous Asthma Planning Collaborative Initiative (MAPCI) that has worked to expand the use of asthma action plans in the state, improve physician education around asthma diagnosis and treatment, and is designing a state plan in collaboration with healthcare providers, public health researchers, local Coalition members, and representatives of the business community. For example, in FY06, over 65,100 copies of the Asthma Action Plan (in seven languages) were distributed through the MA Health Promotion Clearinghouse to providers and others.

The School Health Unit continues to collaborate with the Bureau of Environmental Health to conduct annual asthma surveillance based on information reported to school nurses.

The Department has recently received a new CDC grant, "Addressing Asthma from a Public Health Perspective," which includes a number of strategies and initiatives to address childhood asthma. The MDPH and MAAP will jointly lead the statewide collaborative efforts to address unmet needs through: (1) Statewide regulatory, education and training interventions to reduce exposures in schools, homes and workplaces; (2) Improved disease management through interventions to increase the number of healthcare sites using evidence-based clinical guidelines and to increase the use of child and adult Asthma Action Plans; (3) Improved surveillance to better monitor asthma control indicators; and (4) A targeted regional approach to develop the capacity of regional asthma collaboratives in the five state health regions with the highest hospitalization rates.

/2009/Massachusetts is in the second year of the CDC asthma grant which includes children ages 0-4 among its four target populations, since they have the highest rates of hospitalization, observation stays, & ED visits of any age group. The goal of the grant, being carried out in close collaboration with the broad-based Massachusetts Asthma Advocacy Partnership, is to reduce the asthma hospitalization rates by 9% or more from the 2002 baseline by 2009. Among the interventions and activities specifically addressed asthma in young children are: analyzing the Massachusetts BRFSS Child Call-Back Survey for asthma severity, environmental and home conditions, demonstration of asthma control, and knowledge of asthma management; expanding capacity to analyze Massachusetts Inpatient Hospital Discharge, Outpatient Observation Stay, and Emergency Department Discharge databases for asthma severity across the lifespan (including improving the quality of the data by de-duplicating the databases); education & training interventions to reduce exposures in homes and licensed childcare centers; and promoting the use of Child Asthma Action Plans by health care professionals, child care providers, and families.//2009//

/2010/ Massachusetts is wrapping up the second year of the CDC asthma grant and has applied for competitive funding to begin in September 2009. Current interventions and activities specifically addressing asthma in young children are: release of an asthma burden document with comprehensive data about asthma in Massachusetts and analysis of the burden of asthma for young children; release of a 5-year Strategic Plan for Asthma 2009 -- 2014 that includes specific action steps to improve asthma for young children; Department of Early Education and Childcare regulations requiring all children with a chronic disease -- including asthma -- to have an individualized health plan; supporting the work of 3 asthma coalitions that have focused efforts on young children; funding 5 community health centers to conduct asthma self management education to people with asthma and their caretakers(several health centers have focused on children and their parents); and promoting the use of Child Asthma Action Plans by health care professionals, child care providers, and families.

In September 2009 Massachusetts received a 5 year 2.2 million award from the CDC to address asthma from a public health perspective. In the next year, Massachusetts will provide technical assistance documents to early education and child care settings to meet the requirements of the new regulation for children with asthma, to improve asthma management in these settings and to reduce or eliminate asthma triggers in them. In addition, at least 2 asthma coalitions and community health centers will be funded to reduce asthma disparities for Blacks and Hispanics in priority geographic regions with hospitalization rates above the state average. //2010//

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	100.0	100.0	100.0	100.0	100.0
Numerator	29582	33012	36022	37126	37458
Denominator	29582	33012	36022	37126	37458
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 Source: Massachusetts Division of Medical Assistance (state Medicaid agency), Medicaid Management Information System. Form HCFA 416: Annual EPSDT Participation Report for period October 1, 2007 to September 30, 2008.

Notes - 2007
Data Source: Massachusetts Division of Medical Assistance (state Medicaid agency), Medicaid Management Information System. Form HCFA 416: Annual EPSDT Participation Report for period October 1, 2006 to September 30, 2007.

Notes - 2006
Data Source: Massachusetts Division of Medical Assistance (state Medicaid agency), Medicaid Management Information System. Form HCFA 416: Annual EPSDT Participation Report for period October 1, 2005 to September 30, 2006.

The values have been adjusted to correct a typo in last year's submission; the rate of 100% remains the same.

Narrative:
Based on Medicaid EPSDT data, all enrolled infants are receiving some periodic screening. However, the consistency and quality of the screening, and the thoroughness of referrals, follow-up, and treatment are always of concern. A number of our programs (e.g. MCH home visiting programs, Early Intervention, WIC, etc.) work to assure that all infants, including those on Medicaid, receive comprehensive screening, assessment, and referrals.

The Title V program had been meeting with the state Medicaid (MassHealth) personnel and quality improvement staff from major MassHealth insurers on perinatal and early childhood

indicators until recently, when the group was dissolved. Title V continues to meet with MassHealth personnel. Health insurance reform may be a factor over the next few years as more children and families become eligible for MassHealth. Title V will continue in discussion with MassHealth about periodic screening.

/2009/Several major new initiatives are underway that should affect the quality of screening received by both infants and other children under EPSDT. The BFHN is part of the steering committee for the implementation of the MassHealth -- Medicaid response to the Rosie D class action lawsuit. As a result of the settlement of the lawsuit, universal behavioral screening at each EPSDT visit was implemented in January, 2008. All Primary Care Providers providing well child visits to MassHealth eligible children under EPSDT administer a behavioral health screening at each visit, using one tool from a specific menu of tools. //2009//

/2010/ This new undertaking by the MA Executive Office of Health and Human Services (EOHHS) to implement the court order in the Rosie D. lawsuit is called the Children's Behavioral Health Initiative (CBHI). The Title V Director has been appointed as the Commissioner's Representative on the EOHHS Children's Behavior Health Initiative (CBHI) Executive Committee and is a member of the CBHI Implementation Coordinating team. The major provisions of the order include: improved education and outreach to MassHealth members, providers, members of the public, and private and state agency staff who come into contact with MassHealth members about EPSDT services; implementation of standardized behavioral-health assessments as part of EPSDT "well-child" visits; improved and standardized behavioral-health assessments for eligible members who use behavioral-health services; the development of an information-technology system to track assessments, treatment planning, and treatment delivery; and a requirement to seek federal approval to cover several new or improved community-based services. CBHI now requires Managed Care Organizations and primary care providers under contract to MassHealth to offer to screen MassHealth-enrolled children and youth aged <21 years (including infants) with one of eight MassHealth-approved standardized behavioral health screening instruments during preventive care Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and Preventive Pediatric Healthcare Screening and Diagnosis (PPHSD) visits. According to MassHealth claims and encounter data, from October through December 2008, 22% of well-child visits for infants < 6 months and 53% of visits for children aged 6 months to 2 years included a behavioral health screen. During this period, the percentage of behavioral screens that identified a possible behavioral health condition were 2% for children aged < 6 months and 6% for children aged 6 months to 2 years. MassHealth continues to pursue quality improvement initiatives to increase member and provider awareness of, and provider compliance with, the screening requirement. //2010//

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	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1	1	1	1	1
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
Indicator is NOT APPLICABLE
All infants under 200% FPL are eligible for Medicaid rather than SCHIP.

Notes - 2007
Indicator is NOT APPLICABLE
All infants under 200% FPL are eligible for Medicaid rather than SCHIP.

Notes - 2006
Data Source: Massachusetts Division of Medical Assistance (state Medicaid agency). All infants under 200% FPL are eligible for Medicaid rather than SCHIP.

Narrative:
HSCI #03 is not specifically applicable to Massachusetts as all "SCHIP" infants are enrolled in Medicaid and are therefore reflected in HSCI #02. All infants under 200% FPL are eligible for Medicaid rather than SCHIP. See discussion under HSCI #02 for activities and issues.

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	83.3	83.0	82.1	81.6	82
Numerator	65178	63565	63568	63386	
Denominator	78232	76573	77391	77646	
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 birth data are not available. We have estimated the same rate as that for 2007. See 2007 for the most recent actual data and see the Note for 2007 for data sources and other comments.

Notes - 2007
Birth data are from MDPH, Vital Records for calendar year 2007 (the most recent year available). The Kotelchuck Index is calculated and reported routinely by the Department and is available in MassCHIP, which is the source for the 2007 data.

Notes - 2006
Birth data are from MDPH, Vital Records for calendar year 2006. The Kotelchuck Index is calculated and reported routinely by the Department and is available in MassCHIP, which is the source for the 2006 data.

Narrative:

This indicator is affected by women entering prenatal care after the first trimester. Although evidence is anecdotal only, reports are that some physicians counsel women not to come in for prenatal visits until after the 12th week, particularly if the woman has had a prior birth with good outcomes. Massachusetts is conducting further analysis of prenatal care data, and Title V primary care dollars will provide more focus on care of women of reproductive age, with one goal being early prenatal care.

See also NPM # 18 and SPM # 09 for additional information about numerous activities related to the improvement of this HSCI. See also NPM # 18 and SPM # 09 for additional information about numerous activities related to the improvement of this HSCI. Other related measures include SPM #01 and 03. Our recently awarded PRAMS grant, along with continuing use of PELL, will continue to provide increased information on risk factors and environmental contributors to inadequate prenatal care.

/2009/A number of new activities and data analyses are underway, as we continue to seek improvements in prenatal care. See also HSCI #05B and #05C and the multiple other sections of this application referenced above for more information. A few key items are listed below:

Birth data were presented to the Western MA Legislative Commission by mother's county of residence and birth hospital, as an initial step in assessing whether delayed prenatal care might relate to a provider shortage, if any, in Western MA.

In addition to a continuation of ongoing activities, prenatal enrollment in WIC in the 1st trimester will be incorporate as an outcome measure into WIC's Performance Management System. All local programs will establish individual goals for improvement in early prenatal enrollment as part of a larger system of performance management focused on improved health outcomes and quality services.

Further analysis of demographics and reasons for late entry to care within the limits of the one year of available PRAMS data will be conducted.

Analysis of PELL data on IPIs less than 6 months found that 5.5% of Hispanic women were identified as pregnant again within 6 months postpartum and this finding noted for further study. DPH will analyze this finding about Hispanic women with IPI less than 6 months in depth, examine 2006 data when available, and try to encourage programs to use IPI for quality improvement.

Title V will staff the activities of the expert panel on obstetrics with staff of the Betsy Lehman Center. The group will assess quality of patient care at birth hospitals including reviewing intrapartum management and criteria to develop an evidenced-based model of best-practice perinatal care in Massachusetts Hospitals.//2009//

/2010/ Massachusetts continues to conduct further analyses of prenatal care data. (See also HSCI # 05C.) Late entry into care usually results in inadequate care scores. PRAMS data show that over 10% of women reported not receiving prenatal care as soon as they had wanted. Among those not receiving care as early as desired, reasons related to the health care system were most often cited. Not being able to get an appointment sooner was the most common reason for not receiving timely care (6.9%) and not having a Medicaid card (5.5%) was the second most common cause of delay.
PRAMS data were also used for further analysis of demographics and reasons for late entry to care. While MA mothers demonstrated high levels of timely prenatal care utilization (85.0% overall), substantial differences were evident across socio-demographic groups. Beginning care in the first trimester was lowest among non-Hispanic black mothers (72.4%), youngest (62.3%), lowest educated (68.9%), and those living below or at 100% federal poverty level (72.0%). Those for whom Medicaid was a source of prenatal care payment were also less likely to enter care in the first trimester (76.1%). Argument

was made that women were not getting early into care because they may not know that they are pregnant until after the first trimester. However, PRAMS data show that only 5% of women were unaware of the pregnancy until after the first trimester. Women who said that they had not been trying to become pregnant were more likely to report starting prenatal care after the first trimester than women who said they had been trying to become pregnant (22% vs. 8 %). Women who said that they had wanted to become pregnant later or never were more likely to report starting prenatal care after the first trimester than women who said they had wanted to become pregnant then or sooner (24% vs. 9%). Adequacy of prenatal care as defined by the Kotelchuck Index also appeared to be associated with whether women reported trying to become pregnant. Those who reported that they had not been trying to become pregnant were more likely to have received inadequate or no care than those reporting that they had been trying to become pregnant (12% vs. 8%). Women who reported wanting their pregnancy later or never were more than twice as likely to have received inadequate or no care than those reporting wanting the pregnancy then or sooner (15% vs. 7%).//2010//

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	93.3	93.6	96.7	96.7	97.3
Numerator	407918	431448	457592		505517
Denominator	437296	460826	473158		519426
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 Sources: The numerator is the number of children aged 0 - 18 ever enrolled in Medicaid (MassHealth) during FY 2008; all children enrolled are assumed to have had at least one service paid for by the program. The denominator is made up of two components. The first is the total number of children aged 0 - 18 enrolled in MassHealth during that period. The second is an estimate of children not enrolled in Medicaid who might be eligible for it, defined as the estimated number of children at or below 200% FPL (26% of 1,621,137) who are reported as uninsured through state surveys (3.3% of those under 150%, used as closest and conservative proxy). These calculations yield an estimate of 13,909 children possibly eligible for Medicaid but not enrolled during FY2008.Medicaid enrollment data: HHS, CMS, “FY2008 Medicaid Children Annual Enrollment Report.” Data are the unduplicated number of children (defined as under age 19) ever enrolled in the Medicaid program in FY 2008, as reported by the state into the CHIP Statistical Enrollment Data System (SEDS). www.cms.hhs.gov/NationalCHIPPolicy/CHIPER.
% of children Uninsured estimate: Massachusetts Division of Health Care Finance and Policy, “Health Insurance Coverage in Massachusetts: Estimates from the 2008 Massachusetts Health Insurance Survey.” Updated March 2009.
Estimate of % of children below 200% of poverty: Annie E. Casey Foundation. KidsCount Data Center. Analysis of data from the 2007 American Community Survey.

Notes - 2007
Updated 2007 enrollment data for Medicaid are not available. We have estimated a similar rate as for 2006, which is probably an underestimate given the aggressive outreach and enrollment activities tied to Health Care Reform that began during FY07.

Notes - 2006
Service data are provided by the Division of Medical Assistance. The numerator is the number of children aged 0 - 18 who received a service paid by MassHealth (Medicaid) during the state fiscal year. All children enrolled are assumed to have had at least one service paid for by the program. The denominator is made up of two components. The first is the total number of children aged 0 - 18 enrolled in MassHealth during the same period. The second is an estimate of children not enrolled in Medicaid who might be eligible for it, defined as the estimated number of children at or below 200% FPL (the Massachusetts cut-off for Medicaid for children) who are reported as uninsured through state surveys.

For FY06, the denominator is the sum of 457,592 children enrolled in MassHealth and an estimate of 15,566 children unenrolled eligibles under age 19. [See previous years' notes for more details on methodology.]

The percent of eligibles enrolled in MassHealth rose in FY06, as the impact of Health Care Reform and the expansion of Medicaid and SCHIP eligibility began to take effect, leaving fewer low income children potentially eligible but not enrolled.

Narrative:
See Notes to HSCI for details about data sources and calculation of estimated rates.

The coverage rate had remained at just over 93% for some years but rose in FY06 to over 96%, with the expansions under health care reform of Medicaid eligibility for children up to 300% of the FPL. Children have been enrolled primarily in MCO plans and health care resources have been adequate to absorb this increase. In addition, there has been increased public information to inform families both to the benefits they are now eligible for and to their responsibilities under the new law (e.g. purchasing insurance under various subsidies).

It is expected that as a result of Health Care Reform implementation, the rate of Medicaid-eligible children actually using the program should be close to 100%. (I.e. there will be very few if any children under 200% of poverty that are neither on Medicaid nor without one of the new insurance coverage options in place.) The HCFP survey has become an annual one and should provide even more information about who is uninsured and how various aspects of health care reform affect children and their health care utilization in particular.

/2009/ The majority of children within both Medicaid and SCHIP are now within one of 4 managed care plans which have expanded to provide statewide coverage, thus not requiring children to change practice sites. The Title V program participates in regular meetings between the MA Chapter of AAP and the Medicaid agency, as well as other major managed care providers in the Commonwealth. These meetings provide an opportunity for issues to be addressed between providers and insurers.

BFHN will continue to work with MassHealth and the Health Connector to assure children and families are enrolled in appropriate health coverage plans and to monitor effects of recertification and possible disenrollment due to premium nonpayments. Effects on the current programs, such as EI, will continue to be reviewed and programs modified as indicated.

EIPP negotiated with 3 of 4 Massachusetts Managed Care Organizations (MCOs) to provide reimbursement for home visits and groups. MCOs have identified CPT codes and reimbursement rates for home visiting services to ensure that low-income women, and women living in

communities with poorer birth outcomes are connected with healthcare providers early in pregnancy.

In April the Governor directed MassHealth to waive premium payments for children in the State Children's Health Insurance Program (SCHIP) when they have parents with Commonwealth Care coverage who are paying individual premiums. This will impact MCHB families and others, and will save families with children receiving coverage through the MassHealth program monthly premiums of $12-$28 per child.//2009//

/2010/ BFHN continues to work with MassHealth and the Health Connector to assure children and families are enrolled in appropriate health coverage plans and to monitor effects of recertification and possible disenrollment due to premium nonpayments. Effects on the current programs, such as EI, continue to be reviewed and programs modified as indicated.

Early Intervention benefits under Medicaid have been significantly expanded effective 7/1/09 with the addition of Medicaid coverage for developmental specialists. All professional disciplines are now covered by MassHealth.

Two of the four MCOs are regularly reimbursing for home-based nursing and social work interventions for high risk pregnant and parenting families in selected communities. A third MCO is still considering whether to agree to pay for home-based services, and a fourth MCO has declined to participate in this program (since they have very few members in the communities served by EIPP). The two MCOs are currently negotiating to pay for group services to be provided by EIPP which would specifically focus on addressing maternal depression by decreasing isolation, and improve parenting skills. One of these MCOs has identified addressing maternal depression a priority for their members, and actively collaborates with bureau staff to support legislation that will mandate screening in multiple settings across the lifespan. //2010//

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	48.9	50.3	51.9	56.4	61.0
Numerator	43549	45318	49648	54817	60452
Denominator	89055	90075	95723	97160	99037
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 Source: Massachusetts Division of Medical Assistance (state Medicaid agency), Medicaid Management Information System. Form HCFA 416: Annual EPSDT Participation Report for period October 1, 2007 to September 30, 2008.

Notes - 2007

Data Source: Massachusetts Division of Medical Assistance (state Medicaid agency), Medicaid Management Information System. Form HCFA 416: Annual EPSDT Participation Report for period October 1, 2006 to September 30, 2007.

The calculations used DMA changed in 2003, resulting in a new baseline level. Since then, there has been a modest but steady increase each year in the percentage of children receiving preventive dental services. Improvements in MassHealth dental care reimbursement rates for services to children and other systems improvements are expected to cause continued improvement in this indicator. Massachusetts has a related State Performance Measure that addresses the use of preventive Medicaid dental services for children ages 3 – 18; See SPM # 04 for more information on changes in the MassHealth system and our involvement in them.

Notes - 2006
Data Source: Massachusetts Division of Medical Assistance (state Medicaid agency), Medicaid Management Information System. Form HCFA 416: Annual EPSDT Participation Report for period October 1, 2005 to September 30, 2006.

The calculations used DMA changed in 2003, resulting in a new baseline level. Since then, there has been a modest increase each year in the percentage of children receiving preventive dental services. Improvements in MassHealth dental care reimbursement rates for services to children and other systems improvements are expected to cause continued improvement in this indicator. Massachusetts has a related State Performance Measure that addresses the use of preventive Medicaid dental services for children ages 3 – 18; See SPM # 04 for more information on changes in the MassHealth system and our involvement in them.

Narrative:
MassHealth benefits include dental care for children. It is expected that the rates will now continue to increase due to number of positive changes that have occurred in the past two years: improved payment rates, increased recruitment of dentists, increased pediatric dental services available at community health centers, and increased promotion of the importance of dental care through a number of initiatives. An on-going issue for children on MassHealth is availability given the number of dentists who accept MassHealth and the uneven geographic distribution of dentists across the state.

In July 2005, a judge determined that MassHealth program practices and procedures for the dental program violated several federal statutes. The Commonwealth reached an agreement on a proposed remedial program in January 2006. This judgment only related to children's oral health services. Key agreements included ability of MassHealth dental providers to limit the number of members they treat, expand preventive and oral evaluation services to twice yearly, expand reimbursement for sealants, restorative, endodontic and prosthodontic services, eliminate prior authorization and require a Third Party Administrator to be hired. These changes are now in place. In addition, several items were referred to a joint committee with representatives from various state agencies and programs to develop recommendations on how to proceed. The Title V Director sits on the joint committee, which presented recommendations to the court in January, 2007. The recommendations addressed expansion of school-based services, capacity at community health centers, expansion of services to children in Head Start and other day care settings, integration of a dental component into pediatric well-child exams, expansion of EPSDT schedule to include first exam at age one, expansion in the role of dental hygienists, and allowing pediatric providers to apply fluoride varnish. The Court ordered that the Joint Committee continue to work on these items and develop more detailed work plans. The Committee has been expanded with work on each item continuing. It is expected that the work will be complete by early fall and submitted for approval in early winter.

See also NPM # 09 and SPM # 04 for additional information about activities related to the improvement of this HSCI. We work closely with Medicaid, dental professionals, schools,

community-based health care providers, and advocates in a variety of ways to improve oral health services and preventive oral health measures (including fluoridation) for all children. Efforts include direct care and enabling services, population-based activities, and a great deal of infrastructure and capacity building. A focus in FY08 will be on the expansion of school-based services. These efforts will be enhanced through two competitively awarded HRSA/MCHB grants targeted at oral health workforce development and at improved systems for oral healthcare access for children.

/2009/We continue to have a SPM (#04) that specifically addresses this HSCI; see that SPM for more detailed information. A few highlights of progress this year and future plans are listed below:
The increase to the MassHealth reimbursement fee for dental sealants is resulting in more programs providing this service in school-based and school-linked preventive dental programs.

The Office of Oral Health (OOH) will be working with MassHealth to develop a statewide oral health prevention plan to increase the number of underserved and unserved children receiving preventive services in school settings and is collaborating with interested dental and health professionals in developing school-based oral health programs (education, screenings, sealants and fluoride) and increasing the number of MassHealth children served in them. In one such 7th grade site, more than 50% of participants were on MassHealth.

OOH is also working with Mass Health and the MCAAP to implement the recommendation of each child having an oral health assessment at 1 year. Beginning in the fall of 2008, pediatricians will be reimbursed by MassHealth for fluoride varnish applications at well-child visits.

A proposed oral health workforce bill (similar to one in several other states) would allow licensed dental hygienists to work in public settings without the supervision of a dentist and would also allow dental hygienists to bill MassHealth for their services directly. If passed it could assist in increasing the number of children receiving preventive oral health services, including dental sealants.//2009//

/2010/ See SPM (#04) for more detailed information.
In October '08, MassHealth began reimbursing pediatric health providers to apply fluoride varnish during well-child visits. OOH developed a tool kit and is conducting trainings of medical providers focusing on community health centers. New legislation has created a public health dental hygienist category to work without the supervision of a dentist. Dental hygienists can now bill MassHealth directly, increasing the number of low income children receiving sealants and fluoride.

In FY10, the OOH will begin implementing its statewide plan for the expansion of school-based oral health prevention (sealant) programs statewide focusing on schools with greater than 50% free and reduced school lunch participation and in communities with greater than 10,000 MassHealth children.//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	100.0	100.0	100.0	100.0	100.0

Numerator	17270	18150	19129	20247	20895
Denominator	17270	18150	19129	20247	20895
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
All SSI beneficiaries in Massachusetts are automatically enrolled in Medicaid. The breadth of the Medicaid benefit package in the state leaves Title V with no residual responsibilities because "the extent medical assistance for such services is not provided by Medicaid" is zero. To indicate the degree to which such services are available to the SSI population, the numerator is the same as the number of children on SSI.

The data are from the Social Security Administration, Supplemental Security Record (Characteristic Extract Record format) and include children under age 18 and are for children receiving benefits as of December 2008.

Notes - 2007
All SSI beneficiaries in Massachusetts are automatically enrolled in Medicaid. The breadth of the Medicaid benefit package in the state leaves Title V with no residual responsibilities because "the extent medical assistance for such services is not provided by Medicaid" is zero. To indicate the degree to which such services are available to the SSI population, the numerator is the same as the number of children on SSI.

The data are from the Social Security Administration, Supplemental Security Record (Characteristic Extract Record format) and include children under age 18 and are for children receiving benefits as of December 2007.

Notes - 2006
All SSI beneficiaries in Massachusetts are automatically enrolled in Medicaid. The breadth of the Medicaid benefit package in the state leaves Title V with no residual responsibilities because "the extent medical assistance for such services is not provided by Medicaid" is zero. To indicate the degree to which such services are available to the SSI population, the numerator is the same as the number of children on SSI.

The data are from the Social Security Administration and include children under age 18 (not 16) and are for children receiving benefits as of December 2005.
http://www.ssa.gov/policy/docs/statcomps/ssi_children/2005/table05.pdf

Narrative:
All state SSI beneficiaries under 16 years old receive rehabilitative services through MassHealth, as all are automatically enrolled in Medicaid. All are also referred to the state Children with Special Health Care Needs program for additional services as needed.

The breadth of the Medicaid benefit package in the state leaves Title V with no residual responsibilities because "the extent medical assistance for such services is not provided by Medicaid" is zero. To indicate the degree to which such services are available to the SSI population, the numerator is the same as the number of children on SSI.

See extensive discussions in Agency Capacity (Part III, Section B. of the Narrative) and under NPMs 2 -- 6 for details about the services and systems that are in place and in development to

better meet the needs of SSI beneficiaries, along with all children with special health care needs. The Title V program works very closely with MassHealth (Medicaid), the Massachusetts Rehabilitation Commission, our other sister human services agencies, the Department of Education, health care providers, and a number of other organizations, as well as with parents and families to assure that these children and their families receive the services and supports to which they are entitled.

/2009/ BFHN will continue to work with MassHealth and the Health Connector to assure children and families are enrolled in appropriate health coverage plans and to monitor effects of recertification and possible disenrollment due to premium nonpayments. Effects on the current programs, such as EI, will continue to be reviewed and programs modified as indicated.

EOHHS Commissioners and Assistant Secretaries are currently focusing on how to better integrate programs and services across the multiple health and human services agencies. For Children with Special Health Care Needs, there is a focus on those who have the most complex needs and how to better meets their needs across the life span to minimize transition issues.

The Title V Director has been appointed as the Commissioner's Representative on the EOHHS Children's Behavior Health Initiative (CBHI) Executive Committee and is a member of the CBHI Implementation Coordinating team. The CBHI an interagency initiative whose mission is to strengthen, expand and integrate Massachusetts services into a comprehensive system of community-based, culturally competent behavioral health and complementary services for all children with serious emotional disturbance and other emotional and behavioral health needs, along with their families.
A key objective of this initiative is to: develop and implement integrated policies regarding early identification, access to behavioral health, assessment of behavioral health needs, service delivery and measurement of outcomes. This group will over see the implementation of the assessment component of the Court Order and begin the process to put in place an enhanced emergency response system and services for severely mentally ill children/adolescents. //2009//

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	payment source from birth certificate	8.9	7.5	7.9

Notes - 2010
Birth data are from MDPH, Vital Records for calendar year 2007 (the most recent year available). The percentages shown differ from those published elsewhere, due to how missing data are handled. The MCHB definition of the denominator is specified as all resident births during the referenced year. In MassCHIP and most Massachusetts publications (such as Massachusetts Births), percentages are reported only for cases where information is known (i.e. the denominator excludes births for which data on the variable are missing). Using the MCHB definition reduces the calculated percentage slightly.

Narrative:

Our SPM # 9 (Systems to address perinatal health disparities at the state and local levels, collaboratively with stakeholders and community partners) is designed, in part, to help us reduce the differences between Medicaid births and the rest of the population, thereby improving overall perinatal indicators for the Commonwealth. Our increasing capacity to analyze perinatal risk factors and outcomes in a comprehensive and timely manner through such mechanisms as PELL and PRAMS will add to our ability to develop effective, targeted interventions, both at the state level and in concert with local areas at particular risk.

Until recently, Title V program staff met with the state Medicaid (MassHealth) personnel and quality improvement staff from major MassHealth insurers on perinatal and early childhood indicators. However, this group no longer meets. Health insurance reform may be a factor over the next few years as more children and families become eligible for MassHealth. Title V will continue in discussion with MassHealth about the issues reflected in this indicator.

The BFCH has developed capacity as of FY07 to annually update Perinatal Periods of Risk (PPOR) analyses. It distributes packets of related birth data to communities with the highest IMRs.

In addition to SPM #9, activities under the following NPMs and SPMs are relevant to HSCIs #05A, B, C, and D: NPMs # 1, 8, 10, 13, 15, 17, and 18; SPMs # 1, 2, 3, and 6.

/2009/See discussion under HSCIs #05B and #05C for updates related to perinatal care and outcomes. Also see the updated information in the NPMs and SPMs referenced above.//2009//

/2010/See discussion under HSCIs #05B and #05C for updates related to perinatal care and outcomes. Also see the updated information in the NPMs and SPMs referenced above.//2010//

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	payment source from birth certificate	6.5	4.3	4.9

Notes - 2010
Data are from MDPH, Vital Records, Births and Linked Birth / Infant Death files. Data are for 2007, the most recent year available. Note that the linked file for 2007 only includes 376 infant deaths, while there were a total of 380 infant deaths in 2007. The calculated rates shown here may therefore differ from those published elsewhere.

Narrative:
Our SPM # 9 (Systems to address perinatal health disparities at the state and local levels, collaboratively with stakeholders and community partners) is designed, in part, to help us reduce the differences between Medicaid births and the rest of the population, thereby improving overall perinatal indicators for the Commonwealth. Our increasing capacity to analyze perinatal risk factors and outcomes in a comprehensive and timely manner through such mechanisms as PELL and PRAMS will add to our ability to develop effective, targeted interventions, both at the state level and in concert with local areas at particular risk.

Until recently, Title V program staff met with the state Medicaid (MassHealth) personnel and quality improvement staff from major MassHealth insurers on perinatal and early childhood indicators. However, this group no longer meets. Health insurance reform may be a factor over the next few years as more children and families become eligible for MassHealth. Title V will continue in discussion with MassHealth about the issues reflected in this indicator.

The BFCH has developed capacity as of FY07 to annually update Perinatal Periods of Risk (PPOR) analyses. It distributes packets of related birth data to communities with the highest IMRs.

In addition to SPM #9, activities under the following NPMs and SPMs are relevant to HSCIs #05A, B, C, and D: NPMs # 1, 8, 10, 13, 15, 17, and 18; SPMs # 1, 2, 3, and 6.

/2009/A new the perinatal data review project currently awaiting approval is to 1) monitor outcomes of mothers and infants over time to measure the success of the revised maternal and newborn hospital licensure regulations in assuring all mothers and infants receive care at a hospital licensed at the appropriate level for their needs and 2) to measure whether the regulations help reduce maternal, fetal and infant morbidity and mortality.

Perinatal Periods of Risk (PPOR) analyses are being used for both the state and the city of Springfield as part the Perinatal Disparity Project activities. At the state level, excess feto-infant mortality rates have remained relatively stable over the last 5 years. The opportunity gap between black and white has decreased, but black mothers are still 5 times more likely to experience fetal or infant death compared to white mothers. In Springfield the overall excess feto-infant mortality rate and the gap between excess rates among black and white have increased. The increase in feto-infant mortality in Springfield was mainly due to maternal health/prematurity factors and maternal care among black mothers. For white mothers, the increase was mainly due to maternal health/prematurity, newborn care and infant health factors. This increase among white mothers should be further explored in the coming year to determine whether this is due to yearly fluctuations.

See also updated information in the NPMs and SPMs referenced above.//2009//

/2010/ The Perinatal Periods of Risk (PPOR) analyses were updated with 2007 birth and death data for the state and Springfield as part the Perinatal Disparity Project activities. Community packets related to teen birth and infant death were prepared and disseminated to communities with highest infant mortality and teen birth rates. At the state level, excess feto-infant mortality rates continue to be relatively stable. The opportunity gap between black and white has decreased, but black mothers are now 6 times more likely to experience fetal or infant death compared to white mothers. An analysis plan has been developed by the perinatal data review project working group which includes members of the medical community and BFHN staff.

The Perinatal Data Committee has now received 24AB approval (IRB approval) to begin analyzing specific maternal and infant outcomes including transfers between birth hospitals to assess the impact of the perinatal regulations on whether women are giving birth at a hospital level appropriate for their care needs and the needs of their newborn. The committee has agreed upon data needed, and is establishing a baseline from birth data gathered prior to the promulgation of the regulations. //2010//

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

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 infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	payment source from birth certificate	71.2	84.8	81.4

Notes - 2010
Birth data are from MDPH, Vital Records for calendar year 2007 (the most recent year available). The percentages shown differ from those published elsewhere, due to how missing data are handled. The MCHB definition of the denominator is specified as all resident births during the referenced year. In MassCHIP and most Massachusetts publications (such as Massachusetts Births), percentages are reported only for cases where information is known (i.e. the denominator excludes births for which data on the variable are missing). Using the MCHB definition reduces the calculated percentage slightly.

Narrative:
Our SPM # 9 (Systems to address perinatal health disparities at the state and local levels, collaboratively with stakeholders and community partners) is designed, in part, to help us reduce the differences between Medicaid births and the rest of the population, thereby improving overall perinatal indicators for the Commonwealth. Our increasing capacity to analyze perinatal risk factors and outcomes in a comprehensive and timely manner through such mechanisms as PELL and PRAMS will add to our ability to develop effective, targeted interventions, both at the state level and in concert with local areas at particular risk.

Until recently, Title V program staff met with the state Medicaid (MassHealth) personnel and quality improvement staff from major MassHealth insurers on perinatal and early childhood indicators. However, this group no longer meets. Health insurance reform may be a factor over the next few years as more children and families become eligible for MassHealth. Title V will continue in discussion with MassHealth about the issues reflected in this indicator.

The BFCH has developed capacity as of FY07 to annually update Perinatal Periods of Risk (PPOR) analyses. It distributes packets of related birth data to communities with the highest IMRs.

In addition to SPM #9, activities under the following NPMs and SPMs are relevant to HSCIs #05A, B, C, and D: NPMs # 1, 8, 10, 13, 15, 17, and 18; SPMs # 1, 2, 3, and 6.

/2009/ Maternal risk factors such as substance use, domestic violence, and depression can affect both prenatal care utilization and perinatal outcomes; these risk factors are often overrepresented in Medicaid populations. In order to better address and reduce these risks, the Women of Reproductive Age and Adolescents program model is funding 32 Community Health Centers (with both MCH and Substance Abuse funds) to provide alcohol and other drug screening, brief intervention, and referral to treatment (SBIRT) for women of childbearing age and adolescents. Staff at the Health Centers have been trained in using screening tools, providing brief interventions for those that were found to be positive, and in referring patients that needed treatment. The screening tool also screened for tobacco, domestic violence, and depression.

Again to better understand the nature of disparities in care and outcomes, BFHN ODT staff conducted a comprehensive evaluation of EIPP (a program serving very high risk women, many of them on Medicaid). EIPP data were linked with PELL data to conduct a population-based

analysis comparing perinatal outcomes for EIPP participants with outcomes for a socio-demographically and geographically similar comparison group.

See also HSCI #05B and updated information in the NPMs and SPMs referenced above.//2009//

/2010/ In addition to SPM #9, activities under the following NPMs and SPMs are relevant to HSCIs #05A, B, C, and D: NPMs # 1, 8, 10, 13, 15, 17, and 18; SPMs # 1, 2, 3, and 6. See HSCI # 04 and #05B for updates on the uses of data to analyze timely prenatal care and Periods of Perinatal Risk (PPOR).

The PRAMS team developed a fact sheet entitled "Prenatal care entry among Massachusetts women, 2007." The Healthy People 2010 goal is the 90% of pregnant women enter prenatal care during their first trimester of pregnancy. According to PRAMS data, 86% of women entered prenatal care during the first trimester. Women who were white, non-Hispanic, married, had private insurance, or more than 12 years education were the only groups to reach the HP2010 target for early initiation of prenatal care. The most common barriers reported by mothers were: having no transportation, not being able to get a doctor's appointment, and having a doctor or health plan that would not start care as early as the mother wanted. Overall, one out of five women reported experiencing at least one barrier to receiving PNC during pregnancy. Women experiencing at least one barrier to receiving PNC were almost 3 times as likely to receive late or no PNC compared to those experiencing no barriers. //2010//

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	payment source from birth certificate	73.5	84.4	81.6

Notes - 2010

Birth data are from MDPH, Vital Records for calendar year 2007 (the most recent year available). The percentages shown differ from those published elsewhere, due to how missing data are handled. The MCHB definition of the denominator is specified as all resident births during the referenced year. In MassCHIP and most Massachusetts publications (such as Massachusetts Births), percentages are reported only for cases where information is known (i.e. the denominator excludes births for which data on the variable are missing). Using the MCHB definition reduces the calculated percentage slightly.

The Kotelchuck Index is calculated and reported routinely by the Department and is available in MassCHIP, which is the source for the 2007 data.

Narrative:

Our SPM # 9 (Systems to address perinatal health disparities at the state and local levels, collaboratively with stakeholders and community partners) is designed, in part, to help us reduce the differences between Medicaid births and the rest of the population, thereby improving overall perinatal indicators for the Commonwealth. Our increasing capacity to analyze perinatal risk factors and outcomes in a comprehensive and timely manner through such mechanisms as PELL and PRAMS will add to our ability to develop effective, targeted interventions, both at the state level and in concert with local areas at particular risk.

Until recently, Title V program staff met with the state Medicaid (MassHealth) personnel and quality improvement staff from major MassHealth insurers on perinatal and early childhood indicators. However, this group no longer meets. Health insurance reform may be a factor over the next few years as more children and families become eligible for MassHealth. Title V will continue in discussion with MassHealth about the issues reflected in this indicator.

The BFCH has developed capacity as of FY07 to annually update Perinatal Periods of Risk (PPOR) analyses. It distributes packets of related birth data to communities with the highest IMRs.

In addition to SPM #9, activities under the following NPMs and SPMs are relevant to HSCIs #05A, B, C, and D: NPMs # 1, 8, 10, 13, 15, 17, and 18; SPMs # 1, 2, 3, and 6.

/2009/See discussion under HSCIs #05B and #05C for updates related to perinatal care and outcomes. Also see the updated information in the NPMs and SPMs referenced above.//2009//

/2010/See discussion under HSCIs #05B and #05C for updates related to perinatal care and outcomes. Also see the updated information in the NPMs and SPMs referenced above.//2010//

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	300

Notes - 2010
All infants under 200% FPL are eligible for Medicaid rather than SCHIP; between 200 to 300% FPL they are eligible for SCHIP.

Narrative:
All infants under 200% FPL are eligible for Medicaid rather than SCHIP. Under 150% FPL, children are eligible for Medicaid rather than SCHIP. Between 150% and 300% FPL, children are eligible for the non-Medicaid portion of SCHIP -- assistance with the payment of insurance premiums; this includes Family Assistance/Direct Coverage and Family Assistance/Premium Assistance.

SCHIP has expanded by about 16,000 enrollees, including 9,300 who "convert" from the state Children's Medical Security Program and 7,000 previously uninsured children. SCHIP premiums for 200-250% FPL will be $20/child; $60/family maximum; for 250-300% FPL, $28/child; $84/family maximum. It is required that a child be uninsured for six months prior to coverage, with certain exceptions such as special health needs, parent death, involuntary termination of prior coverage. The CMSP continues to provide preventive health coverage for children who are not eligible for MassHealth, with acute care covered through the uncompensated care pool.

Please see our State Overview (Part III, Section A.) for updated information about Medicaid and other public insurance programs in the Commonwealth and the broader topic of Health Care Reform.

/2009/ Eligibility standards have not changed from last year. Again see our State Overview (Part III, Section A.) for 2009 updated information about Medicaid and other public insurance programs in the Commonwealth and the broader topic of Health Care Reform. If proposed federal changes to SCHIP eligibility are enacted, Massachusetts will be one of the states severely affected. In addition, if federal approval is not granted for a continuation of our current Medicaid Waiver, eligibility standards may also be affected.

The majority of children within both Medicaid and SCHIP are now within one of 4 managed care plans which have expanded to provide statewide coverage, thus not requiring children to change practice sites. The Title V program participates in regular meetings between the MA Chapter of AAP and the Medicaid agency, as well as other major managed care providers in the Commonwealth. These meetings provide an opportunity for issues to be addressed between providers and insurers.//2009//

/2010/ Federal changes to SCHIP eligibility were not implemented and Massachusetts did receive approval for the continuation of our Medicaid Waiver. Therefore eligibility standards have not changed. The majority of children continue to be served within managed care plans and the Title V program continues to participate in discussions on these issues. //2010//

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 18) (Age range to) (Age range to)	2008	150
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 18) (Age range to) (Age range to)	2008	300

Notes - 2010

Under 150% FPL, children are eligible for Medicaid rather than SCHIP. Between 150% and 300% FPL, children are eligible for the non-Medicaid portion of SCHIP – assistance with the payment of

insurance premiums; this includes Family Assistance/Direct Coverage and Family Assistance/Premium Assistance.

Narrative:
Under 150% FPL, children are eligible for Medicaid rather than SCHIP. Between 150% and 300% FPL, children are eligible for the non-Medicaid portion of SCHIP -- assistance with the payment of insurance premiums; this includes Family Assistance/Direct Coverage and Family Assistance/Premium Assistance.

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Please see our State Overview (Part III, Section A.) for updated information about Medicaid and other public insurance programs in the Commonwealth and the broader topic of Health Care Reform.

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/2010/ Federal changes to SCHIP eligibility were not implemented and Massachusetts did receive approval for the continuation of our Medicaid Waiver. Therefore eligibility standards have not changed. The majority of children continue to be served within managed care plans and the Title V program continues to participate in discussions on these issues. //2010//

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**	**YEAR**	**PERCENT OF POVERTY LEVEL**

programs for infants (0 to 1), children, Medicaid and pregnant women.		SCHIP
Pregnant Women	2008	200

Notes - 2010
Technically, pregnant women are not eligible for SCHIP, but remain eligible based on age or income for Medicaid. If they are ineligible for Medicaid but are at or below 225% FPL, they are eligible for Healthy Start pregnancy-related services through SCHIP as coverage for the unborn child.

Narrative:
Technically, pregnant women are not eligible for SCHIP, but remain eligible for Medicaid based on age or income. If they are ineligible for Medicaid and are at or below 225% FPL, they are eligible for Healthy Start pregnancy-related services through SCHIP as coverage for the unborn child.

Massachusetts provides regular Medicaid (MassHealth) coverage for women up to 200% of the FPL and also has the Healthy Start program. We work very closely with MassHealth to assure access for pregnant women to comprehensive health benefits.

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	2	No
Annual linkage of birth certificates and WIC eligibility files	2	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	3	Yes
Annual birth defects surveillance system	3	Yes

Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:
These Health Systems Capacity Indicators reflect the breadth and scope of the Commonwealth's historic commitment to MCH data capacity. We have extensive and highly skilled internal staff and systems, including a number of MCH epidemiologists and an Office of Data Analytics and Decision Support, that enable us to carry out most of the capacity items listed in this Indicator. Over the years, the number of areas where the Title V staff have direct access to or in fact manage these data systems has increased.

The score for PRAMS increased to "3" this year because Massachusetts has received its first PRAMS implementation grant from CDC and has recently put its first survey into the field. Data will be fully available to us as the project continues. SSDI supports PRAMS by funding an MCH epidemiologist who serves part-time as the PRAMS Project Director. A second key SSDI project is to link WIC data to births using Massachusetts' Pregnancy to Early Life Longitudinal data system. Massachusetts has focused its SSDI proposal this year on increasing scores in areas where they are less than "3."

The areas where we do not yet have complete scores are primarily in areas dealing with direct linkages with birth files and with Medicaid. These have historically been complex areas in Massachusetts where major progress is now being made, although it is not all reflected in the scores yet.

The initial deployment of a DPH ESM/EIM pilot began in April, 2006, with deployment to production now well underway. It is expected that rollout will continue throughout FY07 and will be complete for the majority of DPH, DMH, and DMR programs by July, 2008. Planning is now beginning to develop the linkage to Vital Records and the integration of existing surveillance systems such as birth defects and of new surveillance systems as they develop. Current plans call for data to move to a secure data warehouse at the Secretariat level. This will allow for cross-linkages with Medicaid, Food Stamps, etc. The warehouse is expected to be available in mid to late FY08.

Linkage of births with Medicaid (including SCHIP, Healthy Start, and other programs) will require a longer timeframe. Given federal regulations, MassHealth may share identifiable data only to support MassHealth purposes. Therefore, discussions with MassHealth have focused on common purposes of the MCH and MassHealth programs. MDPH has been meeting with MassHealth about the value of linkage with births to inform a request for a Medicaid waiver. MassHealth has been very interested in related analysis from PELL longitudinally linked birth and hospital discharge data performed over the last two years of the SSDI project concerning interpregnancy intervals. Specifications for a new MassHealth information system include linkage with births as part of eligibility determination, and Title V is represented in systems planning. Without federal rule changes, MCH access to these data will likely depend on a common purpose.

Among the national and state performance measures affected by or involved in these MCH data capacity areas are NPMs # 01, 08, and 12; and SPMs # 01, 02, 03, 06, 09, and 10. See the narrative sections for further information on how data systems and infrastructure are used. Also relevant is the discussion in the Attachment to Part IV, Section F for our Priority Need #4 related to the integration of systems and data and the use of data to inform practice.

/2009/ A few key efforts at improving the weaker areas of data linkages include:
-- PRAMS became fully operational and has already produced the first preliminary data for NPM #

15 ahead of schedule; it is our only source of population-based data for this measure.
-- Progress with linkages to WIC included the signing of a contract that formally provides funding from WIC to PELL and gives the programmers status as WIC consultants, easing access concerns.
-- MDPH legal staff assisted in negotiating a breakthrough regarding PELL linkage to special education data to better understand EI services and outcomes related to autism. The Department of Elementary and Secondary Education determined that MDPH is an educational agency for the purpose of providing EI services under the Federal Education Rights and Privacy Act.
-- MAPCP is exploring an Interagency Service Agreement with the data owners of MassHealth (Medicaid) claims data. Asthma-specific data, as identified by the needs of MAPCP and other key partners, would be analyzed by MassHealth staff and submitted to MAPCP. The MAPCP could examine asthma controller medication use/asthma control outcomes among children served by MassHealth. Use of pharmaceutical data would improve pediatric asthma surveillance in Massachusetts with the goal of increasing asthma self-management.//2009//

/2010/ See Priority #4 in the Attachment to Section IV F for new data improvement projects. Our MCH data capacity is now led by the BFHN Office of Data Translation.

2007 PRAMS data were used to measure third trimester smoking (NPM 15) and first-trimester prenatal care and to develop topic-specific fact sheets. PRAMS data have been linked with PELL.

MDPH revised and resubmitted a proposal to the Dept. of Elementary and Secondary Education in accordance new FERPA regulations amended in Dec. 2008. The goal of the project is to obtain information that will enable both MDPH and DESE to improve instruction for children with ASD with timely and appropriate developmental and educational services. //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)	3	Yes
Youth Health Survey	3	Yes

Notes - 2010

Narrative:
Data on youth smoking are available from both the Youth Risk Behavior Survey (YRBS) and the Massachusetts Youth Health Survey (MYHS). These two surveys were combined in FY07 and are administered on a bi-annual basis. We will continue to have full access to the data from the new survey methodology. The consolidation will result in a more efficient use of limited resources, more consistent data, and better continued cooperation from school districts in allowing the surveys to be administered regularly.

Data on youth smoking are actively used to guide and evaluate the programs and initiatives of the Massachusetts Tobacco Control Program. State funded initiatives have been very successful in reducing or controlling teen smoking and access to tobacco products; the use of accurate and timely data has been critical in targeting programs and documenting change. Examples of these programs include the following:

- 22 Boards of Health Programs enforce youth access and secondhand smoke laws in 180 municipalities; they serve 4,568,085 residents.
- 5 Youth Access Prevention Programs (serving 93 municipalities) conduct compliance

checks and provide tobacco retailer education, parent education and community education in municipalities without funded boards of health.

- A statewide youth tobacco prevention program includes 50 mini-grants, advisory group, youth summit and a short-film contest. (www.makesmokinghistory.org)

These youth survey data are also used to identify health disparities and to guide the development of programs and targeting of resources in multiple areas in addition to tobacco use; these include suicide prevention, substance use, healthy weight and physical activity, violence, and other risk behaviors.

Also relevant is the discussion in the Attachment to Part IV, Section F for our Priority Need #4 related to the integration of systems and data and the use of data to inform practice.

/2010/ Statewide surveillance data as well as local program data continue to be used to guide and evaluate the programs and initiatives of the Massachusetts Tobacco Control Program. Findings show that state funded initiatives have reduced teen smoking and limited minors' access to tobacco products. Examples of youth prevention programs funded in FY2009 include the following:

- ***23 Boards of Health Programs enforce youth access and secondhand smoke laws in 195 municipalities; they serve 4,688,893 residents.***
- ***5 Youth Access Prevention Programs (serving 94 municipalities) conduct compliance checks and provide tobacco retailer education, parent education and community education in municipalities without funded boards of health.***
- ***A statewide youth tobacco prevention program includes 22 mini-grants to Massachusetts youth groups, a youth summit, and a short-film contest. (www.makesmokinghistory.org)***

Youth surveillance data are also used to identify health disparities and to guide the development of programs and targeting of resources in multiple areas in addition to tobacco use. These areas include suicide prevention, substance use, healthy weight and physical activity, violence, and other risk behaviors.

The 2009 joint administration of the MYHS and MYRBS in collaboration with the MA Department of Elementary and Secondary Education is underway. Survey administration to the sampled middle and high schools is almost complete. Data are expected to be available for analysis in July 2009. The data will provide updated estimates of the prevalence of health conditions, risk and protective factors that can be used to inform the upcoming five year needs assessment.

In FY 2010, surveillance data will be used to develop a mathematical model to predict local prevalence of smoking and identify geographic areas of high need. When available, local youth survey data will be compared to estimated figures. The hope is that starts a conversation with local schools and key stakeholders about the need for local youth programs. //2010//

IV. Priorities, Performance and Program Activities

A. Background and Overview

The overall health status and access to health care services of the MCH population in Massachusetts continues to improve. At the same time, there are some areas in which this generally positive progress has reached a plateau, or in which poorer outcomes have persisted. While improving overall, there continue to be significant disparities in outcomes and measures for some population groups. There are also some concerning trends to address: continued persistent health disparities, both geographic and population-based; increases in childhood obesity and asthma; the growing number of very low birth weight births; and the perinatal mortality rate. These trends require further analysis to better identify underlying contributing factors and develop strategies for improvement. Because of wide and growing coverage of health services through MassHealth and CMSP, relatively little Title V funding is expended on direct medical services. Rather, BFCH efforts are primarily focused on non-medical direct services, enabling, infrastructure and population-based services to further improve accessibility and coordination of services.

Direct health care and enabling services: The health care delivery system in Massachusetts can be characterized by four major trends that had implications for providing accessible, quality services to infants, children, youth, and pregnant women:

- increased health care costs
- increased cost of the uninsured (estimated currently at $1B annually)
- limits on insurer innovation due to the regulatory environment
- lack of transparency regarding both price and quality.

Financial access, however, is only the first step in assuring quality preventive services for mothers and children and children with special health care needs. Resources continue to be directed toward assuring the availability of comprehensive, community based, culturally competent services, with a strong network of safety net providers in the Community Health Centers and School Based Health Centers. This safety net does continue to be stretched severely due to inconsistent funding over the past several years. However, the FY06 state budget contains sufficient funding for Medicaid and safety net insurance programs. After an hiatus, collaborative outreach efforts by MDPH and Medicaid are being reactivated. Such major new initiatives as the EOHHS Virtual Gateway are also expanding information about and access to services for potentially eligible populations.

Through the medical home initiative, restructuring of care coordination services, and increasing work with private payers, a statewide system of care coordination, especially for CSHCN, is being developed. This system is a private-public partnership building on a broad range of services, agencies and programs that are resources to families. Other barriers to access to health care and related services continue to be cited by parents and other consumers, including flexibility in hours services are offered, lack of transportation, lack of providers who speak a language other than English (especially in mental health), and often a lack of knowledge of available resources. A lack of accessible providers continues to be an issue in oral health; reducing barriers to care is being discussed with growing interest as revenues improve.

Population based services: Over 99% of all newborns are screened for metabolic disorders, and parents are offered screening for 19 additional disorders and cystic fibrosis. Similarly, over 99% of all newborns receive newborn hearing screenings prior to discharge from a birth center or hospital. School based health centers and enhanced school services are two other mechanisms for delivering population based services that expanded through the early 2000's. Since 2003, they have experienced multiple state funding changes with a destabilization of the services. However, with more steady funding levels (while less than in the past), the system is regaining a new equilibrium.

Infrastructure building services: Collaboration and partnerships on the state and local levels have

been historical and consistent priorities. The establishment and growth of the Community Health Network Area Coalitions brought new dimensions to this emphasis on partnerships. Numerous initiatives, programs, and new approaches to health and health systems issues have been successful as a result. The coordination and integration of the services system for at risk children from birth to age 5, for example, has made great progress since our last needs assessment. Challenges remain, in particular with the successful transition of youth with special health needs to adult services, and improvements and strengthening of IT systems and data linkages to support efforts in all levels of the pyramid.

/2010/ Status of Progress on Measures for FY08 Annual Report
The status of Annual Performance Objectives for Massachusetts is summarized below. Similar summaries from our FY2007, FY2008, and FY2009 Applications (for FY05, FY06, and FY07 performance respectively) have been omitted due to space constraints.
National Performance Measures (18 total):
8 Annual Performance Objectives Met or Exceeded (# 09, 10, 11, 13, 14, 15, 16, and 17)
5 Annual Performance Objectives -- No new data for FY08 (# 02, 03, 04, 05, 06) - those related to CSHCN with data from the National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006 conducted as part of NCHS/SLAITS. Of these, we had met our targets for 2 last year and had not met them for 3.
5 Annual Performance Objectives Not Met (#01, 07, 08, 12, 15, and 18). In all cases, the differences from the objective were small.
For #01 (newborn screening follow-up), we did not achieve 100% (slipping to 99%), due to one infant whose family left the United States for Haiti and could not be verified as being under treatment.
For #07 (immunization rates), while we did not hit our target, the rate is among the five best in the country. Based on trend data, we have readjusted target objectives for future years as parental resistance to some immunizations (as opposed to lack of program outreach and service availability) is an increasing problem that affects overall results.
For #12 (newborn hearing screening), the actual rate of 98.3% (versus a target of 98.8%) is based on an improved data system that now allows us to get accurate unduplicated counts for both numerators and denominators -- but a year later, when the birth file is closed and final. Therefore, this very close rate is provisional and may still be adjusted up or down in next year's report.

State Negotiated Measures (9 total):
6 Annual Performance Objective Met or Exceeded (#01, 04, 06, 09, 10, and 11)
1 Annual Performance Objective -- No new data for FY06: #08 (child care consultants; survey put on hold pending new data system)
2 Annual Performance Objective Not Met (#02 and 03) - The difference from the objective in both cases was small (92.3% actual versus a target of 92.5% and 13.8% versus a target of 13.5%)
SPM #07 (Pediatric sexual assault nurse examiners) has been dropped as its objectives were essentially met by the end of FY08.
A new measure (SPM #11) was added for FY09, related to implementation of a new regulation on informing new parents about shaken baby syndrome before hospital discharge. The FY08 score for it represents our baseline rate and it is now projected to have been completely met early -- by the end of FY09. //2010//

B. State Priorities

From its analysis of the Needs Assessment findings, Massachusetts selected the following 10 Priority Needs. These priorities are not listed in any "ranked" order; all are considered to be equivalent priority needs. The attachment to this section is a chart that summarizes the multi-faceted relationships among the new Priority Needs, National Performance and Outcome Measures, and the 10 new State Performance Measures (SPMs) that we are proposing.

/2010/This chart is not included in this year's Application.//2010// The new Priority Needs and Performance Measures address all MCH population groups and all levels of the MCH Pyramid. Most of the Priority Needs and many of the SPMs address issues that relate to all MCH populations and involve proposed actions at more than one level of the pyramid. As with our current set of SPMs, a number of the SPMs (4 out of 10) are composite measures, scored by unique scales. The Checklists for each of those four SPMs are also attached to this section, following the relationships chart. /2008/SPM #05 has been dropped. The Checklists for the remaining three composite SPMs are in the file attached to this section. //2008// /2009/SPM #07 is being dropped going forward, as its objectives have been met. It is being replaced with a new SPM (#11) related to shaken baby syndrome; the new measure is not a composite score. //2009//

We should also note here that one SPM (#08 for Massachusetts) is a "placeholder" for a childhood health and development asset-based measure to be finalized during FY06. Massachusetts and the five other states in Region I have been working with the National Center for Infant and Early Childhood Health Policy to develop an asset indicator framework and have agreed to develop an indicator that reflects the collective assets of their early childhood health and development systems. The Region has chosen to focus on their collective assets regarding child care health consultants (CCHC). [More details on this process and the rationale behind the approach may be found on the Detail Sheet for SPM # 08.]
/2007/ The placeholder has been replaced by a defined measure (SPM #08) with a revised Detail Sheet. //2007//

/2010/Please note that additional information on activities that address Priority Needs but that are not covered by NPMs or SPMs is provided in the annual Attachment to Part IV, Section F. For 2010, this attachment includes Priority Needs # 1, 2, 4, 6, 7, 8, 9, and 10. //2010//

Priority Need #1: Improve the health and well being of women in their childbearing years.
A majority of overall pregnancy outcomes in the state continue to improve and are lower than the U.S. rates in many instances. However, the continuing racial and ethnic disparities in perinatal outcomes, and the rising LBW and perinatal mortality rates are cause for concern and continuation of vigilant efforts in this area. BFCH recognizes that a woman's health status prior to becoming pregnant /2008/ and between pregnancies //2008// is a key variable in her pregnancy outcome. Health promotion activities, freedom from domestic violence, food security and good nutrition, access to primary care and family planning /2008/, screening and interventions for risk-taking behaviors, oral health services, and good mental health //2008// are all necessary components to overall good health to ensure a healthy family. A number of new state performance measures have also been selected to better target our approach and evaluate progress.
/2009/Emphasis has increased on the adult "medical home" model to assure access to and use of primary care services.//2009//
/2010/ The Title V Director participates in these discussions and brings the MCH experience with the medical home model to the table. //2010//

Priority Need #2: Improve adolescent health through coordinated youth development and risk reduction.
Adolescent health risks have been well documented in the Needs Assessment. The majority of high school students engage in some risk behaviors that pose serious threats to their health and safety. Risk factors are similar for many behaviors. Students who engage in one high-risk or health-compromising behavior are often likely to engage in other risk behaviors as well; strong relationships have been documented between various adolescent risk factors and risk behaviors. This clustering of both factors and behaviors reveals the important interrelationships between one risk behavior (e.g. drinking) and other health consequences (e.g. automobile injuries, dating violence). On the other hand, factors often identified as "assets" or "resiliency factors" such as perceived adult support in and out of school, volunteer work, and other extra-curricular activities, are associated with lower levels of one or more risk behaviors.

Reducing risk behaviors and promoting youth development through all settings in which public health programs come in contact with teens are a major priority of the Department and the Center. A new, multi-pronged approach is being embraced through a new state performance measure.
/2008/Our state performance measure (SPM #5) is being dropped. See Part IV, Section A above for further discussion of reasons.//2008//

Priority #3: Improve supports for the successful transition of youth with special health needs to adulthood.
Over 60,000 youth aged 14 to 17 in Massachusetts may need transition supports. Compared with other NSCSHCN-measured outcomes, transition stands out as problematic. Health professionals can play a critical role but nationally only 15% of respondents said their doctors provided guidance and support on transition. Massachusetts is in the same range, suggesting substantial room for improvement. The stakes for youth are substantial, given the relationships between disabilities, poor adult health, lower income, and other disparities.
The Massachusetts Consortium for CSHCN's Transition Task Force Background Brief summarizes needs, the current organization of services, strengths, and recommends next steps, noting the insufficiency and fragmentation of transition-related initiatives. Preparation for transition is complex because it is as varied and unique as the youth themselves. The adult health and human service system is ill equipped to "take on" young people with SHCN and lacks mandates. Pilot projects related to transition have taken place in MA and elsewhere and best practices are still being identified. A new 3-year MCHB grant will provide resources for a system-wide approach to the Priority Need.
/2009/A major priority for CYSHCN is the development of a comprehensive plan for successful transitions, building on experiences from the Moving Forward grant. Transition is a FY09 priority also for the EOHHS Undersecretary for Disabilities.//2009//

Priority Need #4: Integrate service systems and data, and use data to inform practice.
BFCH has developed its capacity for electronic data collection and dissemination to a sophisticated level. To develop the most effective and properly targeted program services, time-sensitive, accurate information is essential. Much work still needs to be done to create truly comprehensive, timely, and flexible data systems and we continue with on-going innovation in this area.
Over the last several years, BFCH and MDPH began efforts to move to internet-based systems that would allow for the integration of data while assuring privacy for clients. More recently, EOHHS began a similar initiative and the MDPH and EOHHS efforts are now being fully integrated. The first stage of this system (known as the Virtual Gateway) began a year ago with the Information, Enrollment, and Referral component that uses a common application allowing an eligible individual to be enrolled in any state insurance program and referred to food stamps, child care, and WIC. Deployment of the more expansive DPH components -- including enrollment for other programs, service tracking, and electronic payments -- is expected to begin in January 2006. Other planned data initiatives include implementation of PRAMS, improved youth health surveys, and Center-wide use of logic models for programs.
/2007/ The initial deployment of a DPH ESM/EIM pilot began in April, 2006, with deployment to production currently scheduled for October, 2006. It is expected that rollout will continue throughout FY07 and will be complete for the majority of DPH, DMH, and DMR programs by July, 2007. Planning is now beginning to develop the linkage to Vital Records and the integration of existing surveillance systems such as birth defects and of new surveillance systems as they develop. Current plans call for data to move to a secure data warehouse at the Secretariat level. This will allow for cross-linkages with Medicaid, Food Stamps, etc. The warehouse is expected to be available in mid to late FY08. //2007//
/2008/Rollout for EIM continued throughout FY07. ESM was rolled out for SBHCs and substance abuse programs; rollout will continue to rollout for BFCH and other DPH bureaus throughout FY08. In addition, it is expected that Common Intake will be expanded to include public enrollment in late fall. EOS, the new WIC data system, will be pilot tested in FY08 and fully implemented by 7/1/08.//2008//

/2009/ Systems assessments are being completed for our birth defects surveillance system, newborn hearing screening and other CSHCN programs for 2009 implementation. EOS will begin roll-out in late fall/early winter. Discussions are underway with the new Secretariat of Education to link EI and education special needs data initially in relation to autism.//2009//
/2010/ Eos pilot testing will be completed in FY10, with full roll out now scheduled by 7/1/2010. //2010//

Priority # 5: Increase capacity to promote healthy weight.
The rationale for addressing healthy weight as a Priority Need is self-evident. Massachusetts is very much a part of the national epidemic of overweight, obesity, unhealthy diets (low intake of fruits and vegetables), and inadequate levels of physical activity -- across the lifespan. The magnitude of the issue draws attention as do the potential health consequences, including diabetes, heart disease, and other chronic diseases, particularly with overweight starting early in life.
The Needs Assessment presents many statistics addressing the scope and seriousness issues related to healthy weight, including health disparities. Many programs and opportunities for intervention are in place, and policy/environmental interventions are also underway. They require ongoing support. The larger issue is system-wide capacity building, consistent messages, and approaches that continue to support local activities such as those articulated in our state plan. The roles of both health care settings and schools are particularly critical in promoting change. At the same time, improvements in key surveillance systems, could address major data and information gaps for the three priority MCH populations, allowing more timely and targeted interventions. A new, multi-pronged approach is being embraced through a new state performance measure.
/2009/Promoting healthy weight is a MDPH priority, with enhanced activities and new initiatives. A major area of focus is on employers, including promoting breastfeeding.//2009//

/2010/Promoting healthy weight and reducing childhood obesity are expected to be a major focus as our 5-Year Needs Assessment and priority setting processes continue in FY10.//2010//

Priority Need # 6: Develop and implement initiatives that address violence against women, children, and youth.
The adverse physical and mental health outcomes associated with exposure to violence, as either victim, witness, or perpetrator, underscore the need to integrate violence prevention into the range of maternal and child health initiatives. Gender-based violence (domestic violence and sexual assault), are particular risks for the MCH population. Domestic violence occurs in at least 25% of families in the U.S., and one in three female trauma patients is a victim of abuse. Approximately 20% of female public high school students in Massachusetts report being physically and/or sexually hurt by a dating partner. Adolescent girls who experience dating violence are at risk for other health risk behaviors including substance use, high-risk sexual behavior and suicidality. Studies dating back to the early 1990s have correlated domestic and sexual violence with chronic pain, HIV infection, gastrointestinal disorders, delayed entry into prenatal care, unintended pregnancy, smoking during pregnancy, and more. An increasing body of literature is detailing serious consequences for children who live in homes where there is violence. Data from the Adverse Childhood Experiences (ACE) study is demonstrating links between child abuse, domestic violence and sexual abuse and range of negative health outcomes as adults, including smoking, alcohol and other drug use, suicide attempt, chronic obstructive pulmonary disease, diabetes, and more.
MCH programs and providers are in an excellent position to identify victims of violence and to refer to appropriate resources. Education about domestic and sexual violence can assist providers in addressing these issues as part of routine service provision and can insure their awareness of community resources to provide linkages for clients. MCH can also play a critical part in such infrastructure roles as data analysis, policy development, public awareness and education, and capacity building.
/2008/ A state plan has been developed related to youth violence and will be used as the basis

for the development of a Youth Violence Initiative that has received $2M in the FY08 state budget. //2008//
/2009/The Youth Violence state plan is being implemented with increased cross-program effects.//2009//

Priority # 7: Increase the integration of unintentional injury prevention into relevant MCH programs.
Injury is the leading cause of death and disability for children and adults, ages 1-44. Every day in Massachusetts approximately 7 people die, 129 are admitted to a hospital and 1,918 seek hospital emergency department treatment because of an injury. Massachusetts children aged 0 to 17 experienced 187,323 injury-related Emergency Department (ED) visits in 2003 and total charges for these visits exceeded $122 million. Injuries were also responsible for over 4,030 hospitalizations among Massachusetts' children, costing over $15 million. Among women aged 18-44 in Massachusetts, injuries were responsible for 148,135 ED visits and 5,052 in-patient hospitalizations costing a total of $102 million and $16 million respectively. Significantly for the MCH population, in Massachusetts from 1990-2003 injuries cause 1/3 of all pregnancy-associated deaths and one in 7 pregnant women experienced a "pregnancy-associated injury." Given that most injuries are highly preventable, these statistics underscore the need to intensify prevention efforts throughout the Commonwealth. Maternal and child health providers are in an excellent position to provide clients with injury prevention messages and strategies. Such messages can be routinely integrated into the work of providers with educational materials and appropriate referrals to resources. The recently developed DPH plan for injury prevention will help prioritize areas of unintentional injury and those strategies that have been proven most effective for prevention.
/2008/ The FY08 State Budget includes new funding for the Regional Poison Control Center and a Shaken Baby Syndrome Program that will be developed in collaboration with the Children's Trust Fund and the Department of Social Services. //2008//
/2009/The maternal mortality committee has developed a sub-committee to focus on both intentional and unintentional deaths.//2009//

Priority # 8: Improve oral health.
Improvements in prevention and access to oral health care are critical needs for children and youth. Access to care for children covered through MassHealth continues to be a problem due to declining numbers of Medicaid-participating dentists. The state is currently considering an increase in rates and allowing dentists to limit the number of Medicaid recipients seen in order to increase participation rate. The availability of other safety net providers providing care to low income uninsured children is being developed primarily through community health centers. Children with special health care needs, particularly the large number covered by MassHealth, have even more restricted access to care. A major concern is the lack of access for adults, especially pregnant women, since Medicaid eliminated all but emergency dental care for adults. Medicaid is involved in a class action suit related to access.
Prevention services such as fluoride mouthrinse programs for children in non-fluoridated communities and sealants are not available statewide, although they are growing. Fluoridation efforts in several communities continue to face major challenges from anti-fluoridation groups.
/2007/As the result of class action lawsuit, major efforts are currently underway to redesign how services are delivered and to provide improved access.//2007//
/2008/The state has increased rates for children's dental services and is allowing dentists to limit Medicaid recipients. Adult dental services were reinstated in June, 2006 but rates had not been increased. The expanded Joint Committee on Dental Remediation is developing implementation plans for expanding services related to fluoride varnish, childcare/Head Start programs, school programs, and guidelines/standards for portable oral health programs.//2008//

Priority Need # 9: Develop and implement public health programs, policies, and collaborations that promote positive mental health.
Across many diverse BFCH programs, mental health needs among the MCH population and a lack of mental health service capacity have been identified as critical issues.

Over the past several years a Governor's Commission has been meeting to identify the major issues, barriers, and gaps in services and to develop a plan for addressing the complex issues related to providing access to services and decreasing the number of children who remain stuck in residential services or hospitals due to lack of resources. It is expected that the recommendations will be finalized by September 2005.
The Medicaid Behavioral Health Program was transferred to the Department of Mental Health (DMH) in 2004. Recognizing the need to develop a more accessible and responsive system, including services for children and youth, the DMH is just completing a strategic plan. The Title V program will be working with DMH to continue to identify joint areas of focus and how public health programs can support and enhance mental health services.
/2007/ This transfer was completed in 2006 with both entities now co-located and jointly purchasing services from the same third party -- the Massachusetts Behavioral Health Partnership. Discussions continue as to whether or not the mental health carve-out will remain or whether Medicaid Mental Health will be integrated into the Medicaid medical component. The Governor's Commission was transferred to the Department of Mental Health in the summer of 2005 and now operates as part of an advisory committee. DPH and Title V continue to be active in multiple groups to improve access and will be involved in the implementation of the Class Action Lawsuit Remediation Plan. //2007//
/2008/The Commonwealth's plan for the Rosie D. lawsuit remediation has been accepted; a court monitor and implementation monitor have been hired. Title V staff are involved in working on the components related to early childhood and school services. SBHC mental health pilot projects will continue and may be increased. Suicide prevention efforts will be expanded due to additional state funds available in FY08.//2008//
/2009/Title V is active in the interagency workgroup that is revamping the system for children with mental health problems and their families, including universal screening, intensive case management and increased services for children with significant mental health problems.//2009//

Priority Need # 10: Reduce health disparities.
/2009/This had been a Center-wide priority since the 2005 Needs Assessment. With 2008 organizational changes, Title V has included it as an MCH priority to highlight this focus.//2009//
An attachment is included in this section.

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	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	99.2
Numerator	100	131	102	115	119
Denominator	100	131	102	115	120
Data Source					New Eng Regional Newborn Screening 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	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
Data on Newborn Screening from the New England Newborn Screening Program (NENSP) at the University of Massachusetts Medical School. The data are for Calendar Year 2008. The NENSP provides all these newborn screening services and furnishes these data. See Form 06 and its Notes also. In 2008, Massachusetts screened every newborn for ten disorders: Phenylketonuria (PKU), Congenital Hypothyroidism (primary), Galactosemia, Hemoglobin Disorders (including sickle cell anemia), “Maple Syrup” Urine Disease (MSUD), Homocystinuria, Congenital Toxoplasmosis, Congenital Adrenal Hyperplasia, Biotinidase Deficiency, and Medium-chain acyl Co-A dehydrogenase deficiency (MCAD).

Every newborn with abnormal results is tracked to a normal result or appropriate clinical care. In 2008, the total of 120 confirmed cases from mandated screening receiving treatment included 6 with PKU, 65 with Congenital Hypothyroidism, 1 with Galactosemia, 35 with Sickling Disorders, 3 with Congenital Toxoplamosis, 4 with Biotinidase Deficiency, 5 with Congenital Adrenal Hyperplasia, and 1 with MCAD.

Due to unusual circumstances in 2008, one baby with sickling disease is not counted as being under treatment. This baby was lost to follow-up. We believe the family moved back to Haiti but could not track the family and infant to determine if proper follow-up is occurring.

Notes - 2007
Data on Newborn Screening from the New England Newborn Screening Program (NENSP) at the University of Massachusetts Medical School. The data are for Calendar Year 2007. The NENSP provides all these newborn screening services and furnishes these data. See Form 06 and its Notes also. Massachusetts screens every newborn for ten disorders: Phenylketonuria (PKU), Congenital Hypothyroidism (primary), Galactosemia, Hemoglobin Disorders (including sickle cell anemia), “Maple Syrup” Urine Disease (MSUD), Homocystinuria, Congenital Toxoplasmosis, Congenital Adrenal Hyperplasia, Biotinidase Deficiency, and Medium-chain acyl Co-A dehydrogenase deficiency (MCAD).

Every newborn with abnormal results is tracked to a normal result or appropriate clinical care. In 2007, the total of 115 confirmed cases from mandated screening receiving treatment included 2 with PKU, 52 with Congenital Hypothyroidism, 1 with Galactosemia, 48 with Sickling Disorders, 2 with Congenital Toxoplamosis, 3 with Biotinidase Deficiency, 6 with Congenital Adrenal Hyperplasia, and 1 with MCAD.

Notes - 2006
Data on Newborn Screening from the New England Newborn Screening Program (NENSP) at the University of Massachusetts Medical School. The data are for Calendar Year 2006. The NENSP provides all these newborn screening services and furnishes these data. See Form 06 and its Notes also. Massachusetts screens every newborn for ten disorders: Phenylketonuria (PKU), Congenital Hypothyroidism (primary), Galactosemia, Hemoglobin Disorders (including sickle cell anemia), “Maple Syrup” Urine Disease (MSUD), Homocystinuria, Congenital Toxoplasmosis, Congenital Adrenal Hyperplasia, Biotinidase Deficiency, and Medium-chain acyl Co-A dehydrogenase deficiency (MCAD).

Every newborn with abnormal results is tracked to a normal result or appropriate clinical care. In 2006, the total of 102 confirmed cases from mandated screening receiving treatment included 10 with PKU, 36 with Congenital Hypothyroidism, 2 Galactosemia, 35 with Hemoglobin Disorders, 1 with Congenital Toxoplamosis, 6 with Biotinidase Deficiency, 8 with Congenital Adrenal Hyperplasia, and 4 with MCAD.

a. Last Year's Accomplishments
See also NPM #12.

Two approaches were (and are) used to assure that all babies born in MA had blood specimens collected for newborn screening.
--A statewide check made by NENSP staff using a series of data set algorithms comparing electronic birth certificate data with specimens received, finding babies over 2 weeks old with no specimens and following up to receive specimens.
--Provider-focused checks. Electronic files are submitted to the NENSP from selected hospital NICUs, Community Health Center, and pediatric practices with data on all babies either in their nursery or being seen in their pediatric practice. These files are electronically matched to specimens received: non-matched babies are reported back to get specimens

Comprehensive fact sheets are distributed to parents and providers for all the optional disorders (cystic fibrosis and the panel of metabolic disorders detectable by tandem mass spectrometry).

With NENSP, the NE Public Health Genetics Education Collaborative's newborn blood screening brochure was printed in 5 languages and disseminated to families, providers, and DPH programs.

DPH materials about its special health needs programs were distributed through NENSP.

Individual paper reports of all newborn blood screening results (normal as well as out-of-range) are now mailed to each of the following: 1) the birth hospital, 2) the pediatrician listed on the submitted form, and 3) the submitter (if checkmark-indicated on the submitted form and different from both 1 and 2 above).

Through the New England Genetics Collaborative (NEGC) grant, intensive in-state long term follow-up (LTFU) planning continued, along with a regional component to coordinate data on affected infants across New England, including work on an interstate data-sharing agreement. Meetings were held with state public health privacy officers to determine legalities of data sharing. In addition, the NENSP is leading an inter-regional analysis to improve the quality of tandem mass spectrometry results interpretation and reporting.

Newborn Hearing Screening Director and NENSP continued collaborations and regional meetings.

The Director of the Newborn Hearing Screening Program serves as liaison to the NENSP to ensure families are connected to DPH services and to participate in NENSP planning and annual meetings. The Director also participated in NERC, NERC's LTFU workgroup, New England Public Health Genetics Educational Collaborative, and New England Regional Genetics Group (NERGG).

The NENSP began offering primary succinylacetone screening, expanded use of compound blood marker indices, further developed SCID screening capabilities, enhanced its disaster preparedness through agreements with other competent newborn screening programs and participation in national workshops on emergency preparedness, and incorporated the above-noted newborn screening brochure into prenatal distribution packets at hospitals not distributing an existing lengthier brochure.

Under leadership of the Title V Director, the DPH Newborn Screening Advisory Committee evaluated the 19 pilot conditions and cystic fibrosis and voted to recommend that screening become mandatory for all but 2 of the current pilot conditions and that certain conditions identified as byproducts of screening for listed conditions be reported to physicians (including 2 current pilot conditions). New pilots were also recommended. Proposed Amendments to Licensure Regulations Governing the Testing of Newborns for Treatable Diseases (105 CMR 270.000) were

developed collaboratively by the DPH Newborn Screening Advisory Committee, DPH Legal Office, NENSP and BFHN. Two public hearings were held to solicit comments on the amendments.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assure collection of blood specimens from all MA births by identifying any missing specimens through electronic matching of received specimens with (1) provider-submitted birth records and (2) statewide electronic birth certificates.			X	
2. Screen all newborns (mandated) for 10 treatable disorders, through the New England Newborn Screening Program.			X	
3. Optionally screen for 19 additional metabolic disorders and cystic fibrosis and monitor over time to recommend any additional mandated screenings.			X	
4. Track every newborn with abnormal results to a normal result or appropriate clinical care and, with other New England states, plan to carry out Long Term Follow-Up (LTFU) project for continued access to care.			X	X
5. Perform regular quality improvement activities to assure all babies are screened and that affected infants and children have continued access to care (LTFU activities).				X
6. Continue Bureau of Family Health and Nutrition (BFHN) and NENSP collaboration to assure ongoing linkages of families to comprehensive services.		X		X
7. Work toward improved integration of genetics and newborn screening.				X
8. Regularly convene and maintain staffing for the DPH Newborn Screening Advisory Committee meetings and special forums to promote high quality newborn screening and followup and continuous improvement in the state system.				X
9. Through regional collaboration, address newborn blood (and hearing) screening issues for “border babies” residing in MA but born in neighboring states, and vice versa.				X
10. Increase consumer and provider knowledge and access to newborn screening and genetics information and services, including workshops, phone consultation and distribution of printed materials for mandated and optional screenings.				X

b. Current Activities

The amended Regulations were approved by the MA Public Health Council, submitted to the Secretary of State for final approval, and took effect on 2/12009. 30 routine screenings are now performed on all newborns and screening for these 30 disorders may show information about 23 additional disorders/conditions (by-products of mandatory screening). There are 2 optional screenings (pilot studies) that require consent from parents (Severe Combined Immune Deficiency (SCID) and a panel of an additional five metabolic disorders).

New materials describing the revised screening panel were developed and disseminated to hospitals and other providers. The parent brochure that describes the newborn blood screening and serves as the source of information upon which parents base their consent for the optional testing is available in eight languages.

In addition to the addition of SCID and certain metabolic disorders to the laboratory testing, the laboratory has improved some testing algorithms to increase sensitivity and improve the quality of the screen interpretation to the medical home.

BFHN, NENSP and DPH Legal Office collaborate on issues related to long-term follow-up, including developing systems to share "border babies."

Active BFHN participation continues in activities related to the New England Regional Genetics Collaborative, including medical home and educational subcommittees, and the New England Regional Genetics Board.

c. Plan for the Coming Year
See also NPM #12. Continue ongoing activities.

Screenings will occur for all Massachusetts births in accordance with the newly established regulations. The NENSP manages systems that ensure prompt follow-up occurs and diagnosis is achieved for infants that screens positive or needs repeat screens.

The Newborn Screening Advisory Committee will meet to review implementation of the revised screening panel and make further recommendations.

The NENSP expects to have the infrastructure in place during 2010 to have the capacity to electronically transmit newborn screening results using standardized HIE formats. Implementation will depend on capacities of clients (hospitals, for example) to receive such transmissions, and implementation of electronic interfaces.

The Newborn Hearing Screening Program Director will continue to work in collaboration with the NENSP and DPH Legal Office on issues related to long-term follow-up, including developing systems to share "border babies" (infants being born or receiving care in a state other than the one they reside in) data. Goals of the regional Long-Term Follow-up Committee include ensuring that there is adequate scientific data to support screening and that disparities in care, regional or otherwise, can be identified. Newborn Hearing is included in this effort.

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	65	70	70	72	59
Annual Indicator	64.4	57.1	57.1	57.1	57.1
Numerator					
Denominator					
Data Source					NS-CSHCN, 2005-2006 (part of NCHS/SLAITS)
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	60	61	63	65	65

Notes - 2008
There are no updated state-level data for 2008. Data are from the National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006 conducted as part of NCHS/SLAITS. See note for 2006.

Notes - 2007
There are no updated state-level data for 2007. Data are from the National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006 conducted as part of NCHS/SLAITS. See note for 2006.

Notes - 2006
Data are from the National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006 conducted as part of NCHS/SLAITS. The 95% Confidence Intervals (CI) for the 2005-2006 and 2001 survey, from which the earlier data come, overlap (2005-2006 CI: 52.8-61.3; 2001 CI: 56.4-72.5). The overlap suggests that the figures do not differ statistically (change may be due to random survey variation). Massachusetts is also comparable to the nation. The national figure is 57.4 (CI: 56.5-58.2) for 2005-2006, and the comparable national figure for earlier years is 57.5 (CI: 56.0-59.0).

a. Last Year's Accomplishments
See NPMs #3, 4, 5, 6, and 12.

The Family Initiatives Director and Family TIES recruited 125 Family Advisors who took part in 4 RFR reviews, participated on working groups reviewing EI competencies, and accessed several skill building opportunities. Family members received stipends and mentoring to support their involvement.

Over 200 family members, including Spanish, Haitian Creole and Eritrean speaking parents provided input through focus groups and surveys around ongoing needs assessment and offered substantial consultation to develop a state mandated "Family Support Plan" to provide flexible supports and enhance community participation.

Over 750 parents attended the Family TIES co-sponsored statewide parent/professional conference and 75 parents gave feedback to a survey asking about unmet and under met public health needs. Families reported a need for easier access to information and resources, broader understanding of health related transition issues and readily available help with unexpected life crises.

The Early Intervention Parent Leadership Project (EIPLP) received 122 calls on its toll free line, 385 calls to project staff, 50,744 website hits, and distributed 6 editions of its newsletter to over 4200 parents and professionals.

EI Family Survey was fully implemented across the state at 59 EI programs. Of 14, 000 disseminated in FY 08, 2239 surveys were returned. Of families completing the survey, 85.6% reported that EI helped family help their children develop and learn, 74.6% reported that EI

helped the family effectively communicate their child's needs, and 77.6% reported that EI helped the family know their rights

Family TIES offered in-person training and outreach to 5000 families and professionals, with close to 500 participating Spanish and 150 Chinese speakers. The Parent-to-Parent program received 115 match requests and was able to complete 47 new matches. Parent-to Parent program coordinator worked with Family TIES Spanish interpreter to translate the Listen and learn training program for mentor parents into Spanish and delivered the training to 2 parent groups.

Contacts and collaborations were established with 20 CBOs including presentations at Health Fairs, Parent groups and local public health groups.

Family TIES program developed and deliver of "The Ladder of Success" Transition Training for Youth with Special Health Care Needs to 2 groups of young adults.

DFI worked with staff from New England Serve to complete "Structure and Spark" a training manual for establishing and Institute to broker and coordinate partnerships between families and health care organizations.

A strong parent participation focus was included in the CSHN chapter of the School Health Manual released this year.

Parents and consumers participated in 100% of the UNHSP Advisory Committee meetings. See NPM 12A.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Division for Perinatal, Early Childhood and Special Health Needs (DPECSHN) and its Family Initiatives (FI) Director provide leadership for DPECSHN, BFHN, and other state agency programs to enhance and extend consumer and family participation.				X
2. Increase diversity of family participants, in particular through two FI programs: Family TIES and Early Intervention Parent Leadership Projects (EIPLP).				X
3. Hire family members and consumers as paid staff/consultants to the state CYSHCN programs.				X
4. Support parents' active participation in advisory groups, including EI, Universal Newborn Hearing Screening, Family and Professional Partners Institute (FPPI, to FY09), MassCARE and New England Regional Genetics Group (NERGG).				X
5. In collaboration with Family Voices, the Director of Family Initiatives presents information about the MCH Block to family leaders and obtains family input through multiple avenues.				X
6. Provide parent support and training, including stipends, and collaborate with the Federation for CSN, NE SERVE and Consortium to develop parent participation and leadership. Offer parents opportunities to participate in all Family Initiatives.				X
7. Through the Care Coordination Program for CSHCN, increase opportunities in pediatric practices for parent-professional partnering, including development of parent advisory groups and				X

other systems for family participation.				
8. Require parent participation in School Health Advisory Committees in Essential School Health Services (ESHS) program sites.				X
9. DPECSHN updates, posts on the web and distributes, a resource and recordkeeping tool, “Directions: Resources for Your Child’s Care” to families of CYSHCN and providers, in English, Spanish and Portuguese.				X
10. Survey families and youth accessing DPH-funded services and supports, including Community Support, Family TIES, School Based Health Centers, Essential School Health Services, EI, and MASSTART to assess satisfaction and impact.				X

b. Current Activities
See Summary Sheet and NPMs #3, 4, 5, 6, and 12.

On-going collaboration with MA Family to Family Health and Information Center - DFI serves on the Advisory Board of the Project and helps support F2F annual conference.

Care Coordinators working in medical practices have identified and supported 6 Family Consultants to serve as part of the practice improvement teams.

DFI participates in UNHSP Advisory Board, the Institute for Community Inclusion Board, MA UCEDD, MA Developmental Disabilities Council and EOHHS activities to promote medical home.

Outreach to under-served populations promotes cultural competence, with the goal of reaching at least 12 new CBOS this year.

DFI and staff from New England SERVE work to identify a new base for the FPPI - discussions continue with both MA LEND programs. DPH continues to support opportunities for networking, skill building and continuation of established partnerships among families and organizational partners.

Hired 1 FTE Parent Outreach Specialist to annually support > 200 families whose infants have hearing loss through personal contact and Parent Information Kits.

Newborn Hearing Screening Program and Newborn Blood Screening Advisory Committees have parents and consumers actively participating in program planning and oversight.

Community Support Line issued a satisfaction survey for parents/caregivers utilizing its services in spring 09.

c. Plan for the Coming Year
See Summary Sheet and NPMs #3, 4, 5, 6, and 12. Continue ongoing activities.

Build EI Parent Contact network, offer skill building in-person and through alternative options such as conference calls and webinars, develop a list serv for information sharing.

Grow Advisor network and develop additional interactive communication mechanisms including a list-serv and an electronic newsletter to disseminate information about DPH policies, services and supports, obtain feedback from families about unmet/under-met public health needs and to help identify additional opportunities for family involvement.

Work with internal and external partners to increase opportunities for family input into 2010 needs

assessment.

Care Coordination and Family TIES staff will continue to collaborate with community programs to sponsor "Navigating the Maze" regionally to share information about resources and systems of care with families and providers.

Develop and implement marketing strategy for referral to PPCN based on revised eligibility criteria in order to ensure families receive needed services.

An "MDPH Annual Family Support Plan for FY 2010" will be finalized and distributed to the legislature and public, as part of a composite report filed by EOHHS. This plan is in compliance with state Chapter 171 of the Acts of 2002: An Act Providing Support to Individuals with Disabilities and Their Families. The final draft of the MDPH plan, prepared by DPECSHN, is attached to this section.

Make information and support for transition to adult health services such as timelines and checklists available to families.

Revise and distribute Pediatric Palliative Care family satisfaction survey.

Continue ongoing ESHS client satisfaction survey on schedule to survey one-third of districts annually.

The SBHC program will recommend to sites that they survey parent and school staff satisfaction, as well as client satisfaction.

Change the Family Initiatives Director to a Bureau-level position reporting directly to Bureau Director, to affirm the importance of consumer input for all Bureau efforts.

An attachment is included in this section.

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	65	65	65	67	47
Annual Indicator	61	45.7	45.7	45.7	45.7
Numerator					
Denominator					
Data Source					NS-CSHCN, 2005-2006 (part of NCHS/SLAITS)
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	49	51	53	53	55

Notes - 2008
There are no updated state-level data for 2008. Data are from the National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006 conducted as part of NCHS/SLAITS. See note for 2006 re non-comparability to pre-2005 data.

Notes - 2007
There are no updated state-level data for 2007. Data are from the National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006 conducted as part of NCHS/SLAITS. See note for 2006 re non-comparability to pre-2005 data.

Notes - 2006
Data are from the National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006 conducted as part of NCHS/SLAITS. Questions used for the 2005-2006 survey changed substantially and results cannot be compared to 2004 or earlier. The comparable national figure is 47.1% (CI: 46.3-48.0) for 2005-2006. The CI for Massachusetts for 2005-06 is 41.4-50.0, suggesting no statistical difference between Massachusetts and the nation.

a. Last Year's Accomplishments
After a competitive RFR process, Care Coordinators were located in 11 pediatric primary care practices across the state (including 9 new ones) as part of its Medical Home Project, to promote the medical home model. A new position was developed for the Program: the Medical Home Practice Facilitator, who provides support to practice teams and Care Coordinators, and also technical assistance and ongoing support to practices where the Project has exited. Three of the Practices that the Project exited themselves identified funding and hired Care Coordinators as staff. DPH Care Coordinators provided training and continue to offer support. Care coordinators for CSHCN provided care coordination services to 1,227 families of CYSHCN statewide in FY07. Care coordinators help physicians provide family-centered care, develop care plans and establish office systems to improve quality of care. They identified and referred CSHCN; helped families optimize insurance coverage, access public benefits, find parent to parent support, and become better advocates; attend school meetings; assist with transition activities.

Through the HRSA-funded Moving Forward Together (MFT) grant's CSHCN Medical Education Project, completed a qualitative study to look at pediatric residency training in topics related to the care of CSHCN. Faculty and residents at the state's 5 pediatric residency programs were interviewed to find out what and how residents are being taught about family-centered care; communicating with families; medical home; coordinating care; and advocacy and financing. Reported findings and recommendations in a publication, "Preparing for Practice: Addressing Special Health Care Needs in Pediatric Residency Programs." Purpose is to enhance future provider capacity for providing medical homes to CYSHCN.

The MFT CSHCN Medical Education Project was presented at the Pediatric Academic Societies Annual Meeting in May 2008.

As part of MFT, conducted outreach to members of the MA Chapter of the American Academy of Pediatrics focusing on CYSHCN. A statewide mailing with resources and information related to CYSHCN was sent from the MCAAP president to all members. Articles focusing on CYSHCN and medical home were included in quarterly newsletters.

Jane Stewart, M.D., worked in collaboration with MA Newborn Hearing Screening staff to publish and article in the MA AAP newsletter the Forum on the recently published Joint Committee on Infant Hearing Position Statement

Staff from the Care Coordination Program sit on the MA Consortium for Children with Special health Needs Medical Home Working Group.

The revised Comprehensive School Health Manual was issued to all schools with information on the school physician as a liaison with the community PCPs and care of CSHCN.

School nurses (ESHS) arranged 126,117 primary care appointments for students during the school year; about 6.9% of referrals were for students who did not yet have providers.

The MA School Nurse Research Network implemented studies: (a) the use of hand held computers for students to document their 24 hour asthma symptoms (accepted for publication) and (b) school nurse interventions to ensure that adolescents with life threatening allergies will carry their Epi-Pens. They will expand studies in FY09.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. DPECSHN Care Coordinators for CSHCN, housed in primary care practices and DPH Regional Offices, respond to referrals from the practices and community sources and help practices develop components of a medical home model.		X		X
2. DPECSHN collaborates with MA Consortium for CSHCN and MA Chapter American Academy of Pediatrics (AAP) to promote the concept of medical home as the standard of care for CYSHCN.				X
3. All BFHN programs serving children screen/refer for a regular primary care provider.		X		
4. DPECSHN programs (including EI, MASSTART, Medical Review Team, CICRF, Pediatric Palliative Care, and Community Support) assess and link CYSHCN with care coordination and medical homes, if needed.		X		X
5. DPECSHN programs and others in BFHN are charged to maintain effective coordination and collaboration with child's existing medical home.				X
6. DPECSHN collaborates with Managed Care Organizations, including Medicaid, to promote medical home concept.		X		X
7. MassCARE Program offers care coordination services and links to primary and specialty care to all enrolled HIV-infected children and youth statewide through 7 community-based settings.				X
8. DPECSHN distributes a resource and recordkeeping tool, “Directions: Resources for Your Child’s Care” to families of CYSHCN and providers, in English, Spanish and Portuguese, which helps parents build and use a medical home for their child.				X
9. DPECSHN staff participate in the New England Regional Genetics Group (NERGG) medical home workgroup.				X
10. UNHSP staff verify that children referred through newborn hearing screening are linked to a PCP and staff work with the PCPs when families are at risk of not getting to follow-up audiological services.		X		X

b. Current Activities
See Summary Sheet and NPMs #1, 2, 4, 5, 6 and 12.

Care coordinators for CSHCN, are located in 11 pediatric primary care practices across the state.

Parent Consultants to support the medical home model were identified and supported through stipends and training at 6 practices. They developed tools to support care coordination activities. The Care Coordination Medical Home Project hosted a meeting for new Practice teams' physicians and parents, entitled "Conversations in Medical Home Best Practices.

The Title V Director and staff are active in the Consortium, including the Medical Home work groups.

Medical Home Fact Sheets were developed for families and providers and are distributed.

The Title V, Care Coordination, and FI Directors participated in MA EHS planning (and grant submission) to develop medical home in community health centers in MA for all populations.

DPH and EHS staff, providers, and parents participated in the Medical Home/Life Course Perspective training as part of the Title V Knowledge to Practice Technical Assistance by BU.

A Family Partner continues to work with a 17-member, community-based pediatric practice, to implement family involvement, care coordination and support around transition as part of FPPI.

Family TIES coordinators support community pediatric practices with information and referral and provide training as requested around family participation and transition.

Staff member from the EI PLP serves on Baystate's Medical Home group.

c. Plan for the Coming Year

See NPMs #1, 2, 4, 5, 6 and 12.. Continue ongoing activities.

As the BFHN/DPECSHN strategic planning initiative re systems for CSHCN continues, BFHN/DPECSHN will review the components contributing to the NS/CSHCN score on this measure to assess whether they provide information useful for directing improvement efforts.

BFHN will continue to actively participate with EOHHS and MassHealth in developing a state plan and policy for implementing the medical home concept for all age groups. New funding has been awarded to Massachusetts by the Commonwealth Fund. Additiona fiscal and human resources will be dedicated to this work, which will complement the MassHealth/EOHHS effort.

Collaboration among Division programs serving CYSHCN will continue with practice staff to enhance the role of care coordination, levels of service, and build the components of medical home in practices.

An annual training meeting will be held for former and new (Care Coordination Program) medical home practice providers to share successes, best practices and strategies for integrating and sustaining the model.

SBHC program staff will conduct at least 10 site visits to thoroughly review medical charts and individualized care plans for patients with special health care needs. Medical chart abstraction criteria include: 1) documentation of collaboration among specialty care providers 2) evidence of appropriate referrals and 3) communication between PCP and specialists demonstrating continuity of care without service duplication. Charts sampled at each site will include 2 documenting chronic care services (e.g. asthma, diabetes) and 2 documenting mental health services (including screening, identification, treatment, referral, and care coordination services).

The SHU and MASNRN will expand its studies of school nurse involvement in mental health and complete the study of school nurse interventions to ensure that adolescents with food allergies are carrying their Epi-pens. Additionally, focus groups of school nurses and physicians will explore best practices for collaboration between these two groups on behalf of children.

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	65	65	70	70	64
Annual Indicator	65.1	63.1	63.1	63.1	63.1
Numerator					
Denominator					
Data Source					NS-CSHCN, 2005-2006 (part of NCHS/SLAITS)
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	65	66	68	70	75

Notes - 2008
There are no updated state-level data for 2008. Data are from the National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006 conducted as part of NCHS/SLAITS. See note for 2006 for additional information.

Based on assumptions of the continued progress of health care reform in Massachusetts and nationally, we are projecting a larger improvement by 2013.

Notes - 2007
There are no updated state-level data for 2007. Data are from the National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006 conducted as part of NCHS/SLAITS. See note for 2006 for additional information.

Notes - 2006
UPDATED.
Data are from the National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006 conducted as part of NCHS/SLAITS. The 95% Confidence Intervals (CI) for the 2005-2006 and 2001 survey, from which the earlier data come, overlap (2005-2006 CI: 59.0-67.2; 2001 CI: 60.1-70.1). The overlap suggests that the figures do not differ statistically (change may be due to random survey variation). Massachusetts is also comparable to the nation. The national

figure is 62.0 (CI: 61.2-62.8) for 2005-2006, and the comparable national figure for earlier years is 59.6 (CI: 58.7-60.5).

a. Last Year's Accomplishments
See also NPMs #1 and 13.

The SSI/Public Benefits Program provided 14 training programs to 201 participants statewide of which 34% were parents. Others trained included community health providers, nurses, Early Intervention staff, case managers, pediatricians, graduate students/fellows, occupational and physical therapists and child state agency staff. Most technical assistance calls related to SSI/Public Benefits were by the Community Support 800#. Nevertheless, the Public Benefits specialist responded to 136 calls for technical assistance, 29% of which were from parents.

By phone or email, the Community Support 800# responded to 1,827 technical assistance requests, of which 55% were from parents. Community Support staff sent mailings to the families upon request with information and applications for public insurance programs.

The CICRF provided approximately $1.7 million in financial assistance to 211 families of CSHCN with extraordinarily high out-of-pocket medical or related expenses in relation to family income (expenses exceed 10% of family income). As a payor of last resort, CICRF assisted families with payment for needed items and services not covered by insurance, including home and vehicle modifications. CICRF also negotiated with insurers or located alternate resources for additional families, obviating the need for CICRF funding and assisting families who did not meet the 10% of income requirement.

During FY07, 75 uninsured or underinsured clients received special foods assistance through PKU Special Medical Foods Program.

DPH Care Coordinators assisted 322 families through the Flexible Family Support Fund to reimburse costs of goods and services. Eligible expenses relate to raising a child with special health care needs. These expenses tend not to be medical in nature and are therefore not covered by regular health insurance.

Of children in EI, 97% have private or public insurance. The remaining 3% receive state-funded EI services, and assistance is provided by EI staff to assess, as appropriate, public health insurance benefits.

The Pediatric Palliative Care Network (PPCN) contracted with 10 hospices in FY08 to provide palliative care services statewide for children with life-limiting illness and their families, covering services not otherwise covered by insurance. Unlike public benefits for hospice care, PPCN funding does not require that treatment toward a cure be suspended, that the child have a 6-month prognosis, or that child no longer receive care by his/her current medical caregivers. A total of 231 children were referred, 190 were served (and others referred to appropriate services). An additional 385 members of the families of these children (parents, siblings, and others) also received services.

DPH, in collaboration with the MCAAP and the Consortium, mailed to all 1,800 members of the MCAAP "Making the Case for Coverage: Tips for Helping Children and Families Get the Benefits They Need from Their Health Plans." This guide for clinicians and advocates outlines the process health plans use when approving or denying medical coverage for patients, and provides helpful tips for physicians trying to navigate the process. It was developed by the Consortium and New England SERVE as part of Moving Forward Together, a HRSA-funded CYSHCN state implementation grant.

In response to families' reports that the system for acquiring durable medical equipment overburdens and under-serves families, the MA Consortium for CSHCN designed and obtained

private grant funding for the DME Access Project to study the issue. Research and data analysis were completed in FY08, and the findings were used in FY09 to draft proposed legislation that has been filed in state legislature.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All BFHN and other DPH programs with direct family contact are required to screen for health care access and insurance, make referrals and assist with enrollment and access.		X		
2. The SSI/Public Benefits Coordinator trains providers and families of CYSHCN on eligibility, application processes and appeals for SSI, CommonHealth, Kaileigh Mulligan and MassHealth, and participates in related state-level coalitions/groups.		X		X
3. DPH Family Support Fund helps families of CYSHCN pay for expenses related to their child's special health care needs that are not covered by health insurance or public benefits.		X		
4. The Catastrophic Illness in Children Relief Fund (CICRF) serves as a payor of last resort for eligible families of CYSHCN with extraordinary out-of-pocket medical and related expenses not covered by insurance or other sources.	X	X		
5. The CICRF refers and provides technical assistance to access other resources (such as MassHealth; CommonHealth; MA Assistive Technology Loan Program; Home Modification Loan Program), assisting families eligible and not eligible for CICRF funding.		X		
6. The Pediatric Palliative Care Network provides services not covered by insurance to reduce pain and other symptoms, improve quality of life, and provide end-of-life care for children with life-limiting illness and their families.	X	X		
7. DPH Care Coordination for CSHCN provides families with assistance with accessing and optimizing health insurance benefits. Care Coordinators provide trainings on benefits and services regionally and in pediatric practice sites.		X		X
8. State law mandates health care plans to cover newborn hearing screening and diagnostic follow-up and the state funds hearing aids for low income, uninsured or underinsured children.				X
9. Participate in the Children's Health Access and the Covering Kids & Families coalitions, which assess the percent of the population receiving adequate health coverage and actively monitor the effect of health reform on children, especially CYSHCN.				X
10. The Community Support 800# provides information and technical assistance about insurance programs for which families may be eligible and about programs that offset health costs not covered by insurance.		X		X

b. Current Activities

See also Summary Sheet and NPMs #1and 13.

SSI and Public Benefits and Training, Care Coordination, EI, EIPP, school health and school-based health centers, FOR Families, Pediatric Palliative Care and community health center

based programs are key venues for health insurance access for CSHCN.

PPCN is reviewing its standards of operation for contracted providers (in collaboration with experts and the Hospice & Palliative Care Federation of MA) based on first two years of program implementation.

An FY09 amendment to the CICRF statute allows for more staff to review applications to the Fund.

The CICRF Commission is exploring ways in which to use CICRF dollars to address certain systemic unmet needs related to CSHCN.

The Title V Director represents DPH on the EOHHS Children's Behavioral Health Initiative (CBHI) to provide increase coverage for behavioral health services.

The MA Consortium for CSHCN worked with state legislators to craft and submit a bill to explore why the process of obtaining durable medical equipment is so often problematic for families. Bill would establish a commission to recommend guidelines for private health insurers, MassHealth and vendors to promptly process prescriptions for durable medical equipment for children.

c. Plan for the Coming Year
See also NPMs #1 and 13. Continue ongoing activities.

Monitor impact of state Health Care Reform on insurance coverage for CYSHCN and continue to assure current levels of and identify gaps in coverage.

If funding and staffing allow, CICRF will undertake an expanded outreach campaign in FY10, in order to increase awareness of the Fund as a resource for families with extraordinary medical and related expenses uncovered by any other private or public source.

See Summary Sheet items 4, 5, and 6 (related to CICRF and PPCN).

The Title V Director will actively participate at Executive and Implementation levels in the EOHHS Children's Behavioral Health Initiative (CBHI) to promote increased coverage for developmental and behavioral services by all insurers.

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	80	80	81	81	87.6
Annual Indicator	79	87.6	87.6	87.6	87.6
Numerator					
Denominator					
Data Source					NS-CSHCN, 2005-2006 (part of NCHS/SLAITS)

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	89.2	89.2	90	90	91

Notes - 2008
There are no updated state-level data for 2008. Data are from the National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006 conducted as part of NCHS/SLAITS. See note for 2006 re noncomparability of data to 2004 and earlier.

Notes - 2007
There are no updated state-level data for 2007. Data are from the National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006 conducted as part of NCHS/SLAITS. See note for 2006 re noncomparability of data to 2004 and earlier.

Notes - 2006
UPDATED.
Data are from the National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006 conducted as part of NCHS/SLAITS. Data for 2004 and earlier are from the NS-CSHCN conducted in 2001. The wording, placement, and ordering or questions changed substantially in the 2005-2006 administration of the survey, and the results are not comparable across survey years. The 95% Confidence Intervals (CI) for the 2005-2006 for Massachusetts is 84.7-90.5; for the nation, it is 88.6-89.6 (point estimate 89.1). The CI's overlap; there is no statistical difference between Massachusetts and the nation (differences may be due to random survey variation).

a. Last Year's Accomplishments
See also NPMs #1, 2, 3, 4, 6, and 12.

DPECSHN's centralized Community Resource Program fielded information and referral calls, provided 800# service to 1,827 callers of whom 1,005 were parents in FY08. The 800# staff helps families determine and connect with appropriate and available DPH and community-based services.

Family TIES received 1,743 calls, had a total of 9,612 contacts with families and professionals and 646,598 hits on its website. Staff distributed 6,000 brochures in English, Spanish and Portuguese, 2,000 Resource Directories and a variety of tip sheets on topics such as autism, mental health, medical home and transition.

DFI and staff of Family TIES participated in the CYSHCN strategic planning process offering insights and "reality checks" about family needs.

Multiple presentations statewide and nationally to promote Family-Professional Partners Institute. Development and dissemination of materials to support other Title V programs to implement similar systems building activities.

Staff at the Community Resource Program 800# serve as a resource statewide to direct families and providers to DPECSHN, other DPH and state and community agency programs.

DPH EI and FI leaders, continued to work with the Department of Early Education and Care (EEC) to disseminate a guide for parents and providers called "Best Practices to Transition" both as hard copy and on-line. On-going collaboration to improve transition, and support inclusion occurs.

Care Coordination and Family TIES staff collaborate with community programs to sponsor "Navigating the Maze" in each state region to share information about resources and systems of care with families and providers.

School-based Health Centers, which serve many CSHCN, have program standards that address continuity of care, access, consent policies, and parent participation. Additional sub-categories of standards include the requirement to accommodate working parents.

School nurses reported to ESHS providing CYSHCN substantial services at school, including, per month, about 6,303 scheduled (vs. "as needed") doses of medication and over 64,100 SHN-related treatments (highest being blood glucose testing delivered at a rate of 5.85 procedures per month per 100 students). These figures greatly underestimate services, notably for asthma, for which nurses gave nearly 17,510 "as needed" doses per month of prescription medications, and for conditions requiring epinephrine, which nurses administered an average of 8,215 times per month "as needed." For FY08, ESHS schools reported over 5.29 million student-nurse encounters and about 24% of students reported to the school nurse as CYSHCN.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. All DPECSHN programs support families to more easily access resources, develop external collaborations for this purpose, and assess barriers in conjunction with consumers, parents, and providers. Telephonic interpreters and TTY are available.		X		X
2. FI programs (Family TIES and EIPLP) provide information, support families and partner with community-based services and health care organizations to improve access.		X		X
3. The Community Resource Program provides I&R and technical assistance to families and providers using its 800# and, through this centralized service, coordinates access to multiple CYSHCN programs for CYSHCN and their families.		X		X
4. DPH Care Coordinators are based in several large pediatric primary care practices across the state with additional Care Coordinators in regional offices serving CYSHCN who are outside the designated practices.		X		X
5. Disseminate printed and electronic resources (e.g., Family TIES directory, Directions) and increase resources in multiple languages (e.g., Spanish and Portuguese sections of directory and 2 articles in Spanish in each issue of the EIPP newsletter).		X		X
6. Technical assistance to families and schools, in particular through MASSTART, allows medically complex CYSHCN to attend public school.				X
7. DPECSHN staff participates actively in the MA Consortium for CSHCN and its Steering Committee, Massachusetts AAP, community-based coalitions, and other forums to encourage ease of access.				X
8. MassCARE offers a community-based system of care for		X		X

infants, children, and adolescents with HIV and their families to enable families to access care from local providers and not only major pediatric hospitals.				
9. FI and other DPECSHN programs conduct periodic focus groups and surveys to gather current information from parents about barriers and facilitators of access.				X
10. DPH Care Coordinators facilitate regional trainings on benefits and services for CYSHCN for parents and providers.				X

b. Current Activities
See also Summary Sheet and NPMs #1, 2, 3, 4, 6, and 12.

Title V CYSHCN program strategic planning process includes an action team working to enhance continuum of services and supports for families.

Opportunities for family involvement across the Division including family members serving on task forces to update perinatal regulations and review hospital policies and procedures re: obstetrical services.

Participation on EMSC Advisory Board and on-going work with EMSC program director to identify and implement training resources for EMT/paramedics around CYSHCN and families.

Family Initiatives works with the Consortium for Children with Special Health Needs to support better access to durable medical equipment and to create opportunities for family input to identify ways to improve access across a variety of health care organizations.

MOU and data sharing agreement in place to facilitate transition of children from EI to the Commission for Deaf and Hard of Hearing.

DPH and the MA Consortium for CSHCN co-hosted an invitational meeting of 33 child health leaders in MA to identify top priorities for investment to improve system of care for CYSHCN and their families, and solicit ideas and guidance about where DPH and the Consortium can most effectively focus their efforts. Medical home, family support programs and constituency-building were among the highest priorities identified.

Active participation on the EEC Birth to 3 Task Force and key subcommittees.

c. Plan for the Coming Year
See also NPMs #1, 2, 3, 4, 6, and 12. Continue ongoing activities.

Continued active participation on the EEC Birth to 3 Task Force, including its Strong Families and Good Health subcommittees. The focus is on inclusive settings serving all children, including those with special health needs.

Collaboration with U Mass Boston LEND program to develop and disseminate leadership training for family members working in partnership with DPH and other health care organizations.

Collaboration with Shriver LEND faculty to support families with emergency preparedness.

Work with internal and external partners to promote medical home with an emphasis on family involvement, satisfaction and ease of access.

Joint training activities with care coordination program for family members taking on roles within primary care practices aimed at systems change.

Continue to strengthen existing linkages among all programs for CYSHCN and streamline referral processes to improve ease of access to programs for families.

Print and widely distribute CYSHCN Program brochures to families, providers and other referral sources promoting the Community Support Line 800# as entry point of services. Identify and implement additional tools for marketing the Program and clarifying processes for families.

Increase opportunities for family involvement and input in Pediatric Palliative Care Program including development of a Family Advisory Committee.

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	10	10	15	46.6
Annual Indicator	5.8	46.6	46.6	46.6	46.6
Numerator					
Denominator					
Data Source					NS-CSHCN, 2005-2006 (part of NCHS/SLAITS)
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	47	48	49	50	50

Notes - 2008
There are no updated state-level data for 2008. Data are from the National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006 conducted as part of NCHS/SLAITS. See note for 2006 re noncomparability of data to 2004 and earlier.

Improving transitions to adulthood - and the adult health care system - is a priority for MDPH for all children.

Notes - 2007
There are no updated state-level data for 2007. Data are from the National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006 conducted as part of NCHS/SLAITS. See note for 2005-2006. See note for 2006 re noncomparability of data to 2004 and earlier.

Notes - 2006

UPDATED.
Data are from the National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006 conducted as part of NCHS/SLAITS. Data for 2004 and earlier are from the NS-CSHCN conducted in 2001. The wording, placement, and ordering or questions changed substantially in the 2005-2006 administration of the survey, and the results are not comparable across survey years. The 95% Confidence Intervals (CI) for the 2005-2006 for Massachusetts is 39.8-53.4; for the nation, it is 40.0-42.5 (point estimate 41.2). The CI's overlap, indicating no statistical difference between Massachusetts and the nation (differences may be due to random survey variation).

a. Last Year's Accomplishments
See also NPMs #2, 3, 4, and 5.

The Care Coordination working group on Transition developed standards for their roles with the transition process for enrolled youth ages 14-22, an assessment tool, and materials to aid youth and families to work more effectively with their health care providers.

As part of Moving Forward Together (MFT), the HRSA-funded state implementation grant for CYSHCN, DPH contracted with Partners for Youth with Disabilities to run the Young Adult Advisory Council (YAAC). The YAAC, comprised of 20 young adults with SHCN, had two branches, one in western and one in eastern MA, ensuring geographic diversity. Each group met 8 times.

The YAAC completed and held a premiere of "We Are Able: Perspectives of Transitioning Young Adults with Disabilities," an awareness/educational DVD for health care providers and policymakers.

As part of MFT, the "Make Things Happen!" transition training was held for 25 care coordinators/case managers and parent-professionals and the "Make Things Happen!" transition training curriculum was completed.

DPH staff participated in MA Consortium for CSHCN's Transition Work Group, which also served as advisory group for MFT transition training above.

The SSI/Public Benefits Coordinator provided information and referral resources and training for agencies serving transitional youth. She participated on the state Advisory Council for Special Education and the Special Education Steering Committee regarding Federal compliance issues, which monitors and addresses issues regarding transition planning for students to post-secondary education or work.

Held workshop on health transition for parents during the 6th Youth Leadership Forum (YLF) for high school juniors and seniors with disabilities in March 2008. Twenty youth with disabilities and special health care needs and 12 peer leaders attended YLF, which was sponsored by the Governor's Commission on Employment of People with Disabilities, Harvard University and Partners for Youth with Disabilities, and co-sponsored by DPH.

The Youth Violence Prevention Program identified the need to support youth development programs that specifically address youth with disabilities as a priority area for FY09.

DPECSHN, Healthy Aging and Disability Unit (HADU), Violence Prevention Program and Office of Adolescent Health and Youth Development (OAHYD) revised and updated three brochures with tips for parents and caregivers of youth with disabilities to discuss sexuality and recommendations to prevent sexual exploitation of youth with disabilities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Coordinator of Youth Transition Initiatives promotes the concept of "health transition" and DPH as a focal point for health transition.				X
2. Build external linkages and collaborations with agencies and organizations serving youth, including youth with special health care needs, to ensure health-related transition issues are incorporated into other transition planning efforts.				X
3. Include focus on youth with disabilities and chronic conditions in DPH youth initiatives, e.g. school-based health centers, violence prevention, tobacco, health promotion, suicide prevention and healthy weight.				X
4. Young Adult Advisory Council (YAAC), which meets 5-6 times/year, provides input into services and programs for CYSHCN and addresses issues related to transition. YAAC members speak at Transition Trainings and other events.				X
5. As part of HRSA-funded Moving Forward Together grant, contract with MA Consortium for CSHCN to develop and implement transition training for care coordinators, case managers and parent-professionals, with emphasis on health.				X
6. Multiple DPH staff participates in MA Consortium for CSHCN's Transition Work Group, which also serves as advisory group for MFT transition training above.				X
7. DPH Care Coordinators work with parents, youth and other agencies to promote smooth health transition, including transition to adult medical care, and maximize youth autonomy in relation to self-management of health.		X		X
8. SSI/Public Benefits Coordinator and Community Support Program staff provide resources, technical assistance and training for agencies serving transition-age youth.		X		X
9. DPH Care Coordinators, Family Initiatives staff, and Community Support Program staff offer formal and informal training and technical assistance on transition to families and providers (English and Spanish).				X
10. School-Based Health Center (SBHC) programs for teens with chronic health problems and Essential School Health Services (ESHS) nurses foster responsibility and self-care and promote transition activities.		X		

b. Current Activities

See Summary Sheet and NPMs #2, 3, 4, and 5.

Included an indicator in the Planet Health (Healthy Choices) and Eat Well-Keep Moving progress and year-end reports for 5 middle schools and 12 elementary schools, to identify teachers who work with youth with disabilities participating in the program.

BFHN works with the EOHHS Assistant Secretary for Disabilities to strengthen activities across multiple state agencies providing services to individuals with disabilities to facilitate transition between agencies.

Due to staffing and funding limitations, the role of Coordinator of Youth Transition Initiatives has been discontinued.

Due to staffing and funding limitations the YAAC no longer meets in person. Former YAAC members continue to engage in activities to distribute and promote their DVD, and have participated in conferences and local access television. Copies of the DVD are being sent to pediatricians statewide and it is available via the web. It is being used for training medical and public health professionals.

Conducted healthy sexuality education needs and resource assessment for youth with disabilities. Findings will be used for program planning and policy development, as part of DPH Sexual Violence Prevention Plan.

The Healthy Lifestyles Workgroup involving HADU, NPAU, DDS and UMASS-CDDER identified adaptable curricula with evidence-based content for health promotion of nutrition and physical activity for youth and adults with intellectual disabilities.

c. Plan for the Coming Year
See also NPMs #2, 3, 4, and 5.

Continue activities on Summary Sheet with exception of #1, 4, 5 and 6. As explained above, the role of Coordinator of Youth Transition Initiatives has been discontinued. Moving Forward Together grant ended in FY09. Contract with Consortium MA Consortium for CSHCN is closing at end of FY09 due to insufficient funding.

Implement method for incorporating youth input without regular in-person YAAC meetings.

HADU in collaboration with NPAU will identify how to expand existing DPH Healthy Choices/Eat Well-Keep Moving Programs to youth with disabilities and to increase the number of teachers working with youth with disabilities participating in the Healthy Choices Program.

The Healthy Lifestyles Workgroup will incorporate evidence based programs using train-the-trainer models [i.e. Healthy Lifestyles (Oregon), Living Well with a Disability (Montana)] with DDS staff to increase nutrition and physical activity among DDS clients in MA.

YAAC members will continue to distribute and promote its DVD, "We Are Able: Perspectives of Transitioning Young Adults with Disabilities" and will continue to be available for speaking engagements along with DVD viewings.

With additional funds, we plan to re-energize and expand the YAAC and reestablish regular in-person meetings.

The Sexual Assault Survivor Services (SAPSS) program will work with DDS to develop plans to increase knowledge of healthy sexuality/healthy sexual behavior among people with developmental disabilities; increase knowledge of healthy sexuality/healthy sexual behavior among DDS staff and parents/guardians of DDS clients to ensure that the environments in which people with developmental disabilities live, work, and recreate are safe and support healthy sexual behavior; and establish new DMR policies that will improve the sexual health and safety of DDS clients.

Develop resource guide for youth with disabilities, parents and providers regarding healthy relationships and sexuality for CYSHCN. Resource guide will be designed to provide information and offer a list of supports, services and organizations to help answer questions regarding sexuality for youth with disabilities, in order to promote healthy and safe attitudes and beliefs about sexuality and help youth with disabilities enjoy healthy and fulfilling lives.

The PPCN will establish a protocol as part of the standards of operation to identify adult services

for youth who will 'age out' of the program on their 19th birthday. This protocol will ensure appropriate health services and facilitate continued support of young adults and their families.

For all 45 SBHCs, efforts will be made to develop partnerships and augment access to community-based resources for youth with special health care needs.

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	83	88.1	91.3	90	89
Annual Indicator	86.5	91.3	89.2	88.3	84.1
Numerator					
Denominator					
Data Source					CDC, 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	84.1	85	85	86	86

Notes - 2008
Fully immunized corresponds to the CDC definition of 4:3:1:3:3 (4 or more doses of DTP, 3 or more of poliovirus, 1 or more of any MMR, 3 or more of Hib, and 3 or more of HepB) by age 19-35 months (age 3). [Note that definition of measure in Detail Sheet differs from the label on the measure which suggests immunization status among children 19-35 months of age. That age range is what we report here.] Data are from the National Immunization Survey, as reported by the CDC at http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_0708.htm. Because the percentage rates are generated by the NIP from surveys, no numerators and denominators are presented in Form 11.

Our fully immunized rate dropped again in 2007-2008. Although Massachusetts continues to have a very high rate well above the national average of 79.8%, it is now only ranked #5 , down from second in the country last year. Future year Objectives have been adjusted downward to reflect the intensified work needed to improve follow-up and completion rates.

Notes - 2007
Fully immunized corresponds to the CDC definition of 4:3:1:3:3 (4 or more doses of DTP, 3 or more of poliovirus, 1 or more of any MMR, 3 or more of Hib, and 3 or more of HepB) by age 19-35 months (age 3). [Note that definition of measure in Detail Sheet differs from the label on the measure which suggests immunization status among children 19-35 months of age. That age range is what we report here.] Data are from the National Immunization Survey, as reported by the CDC at http://www.cdc.gov/nip/coverage/default.htm; Table 09. Because the percentage rates are generated by the NIP from surveys, no numerators and denominators are presented in Form 11.

Although our fully immunized rate dropped slightly in 2007, Massachusetts continues to have a very high rate (second best in the country after New Hampshire) and well above the national average. However, increased parental resistance to some immunizations has led us to adjust our future year Objectives slightly downward to more realistic levels.

Notes - 2006
Fully immunized corresponds to the CDC definition of 4:3:1:3:3 (4 or more doses of DTP, 3 or more of poliovirus, 1 or more of any MMR, 3 or more of Hib, and 3 or more of HepB) by age 19-35 months (age 3). [Note that definition of measure in Detail Sheet differs from the label on the measure which suggests immunization status among children 19-35 months of age. That age range is what we report here.] Data are from the National Immunization Survey, as reported by the CDC at http://www.cdc.gov/nip/coverage/default.htm; Table 09. Because the percentage rates are generated by the NIP from surveys, no numerators and denominators are presented in Form 11.
Although our fully immunized rate dropped slightly in 2006, Massachusetts continues to have the highest rate in the country.

a. Last Year's Accomplishments
According to the latest U.S. National Immunization Survey (NIS) Q3/2007-Q2/2008 by CDC's National Immunization Survey, Massachusetts continues to rank among the top five states in the nation for the 4:3:1:3:3 series with 84.1% compared to the national average of 79.8% and ranks # 3 in the nation for the 4:3:1:3:3:1:4 series with 75.3% compared to the national average of 68.1%.

The MCH Immunization Program is within the Division of Primary Care and Health Access and works closely with the Massachusetts Immunization Program in the Bureau of Infectious Disease Prevention, Response & Services. The Division contracts with 32 comprehensive primary care provider agencies serving women and their families (typically community health centers). During FY08, immunization assessments were conducted at a total of eighteen (18) contracted sites; seven (7) of which failed their immunization assessment in FY07. Five of these sites that had failed for the last two to five years passed their assessments. Improved documentation and reminder/recall was evident. Of the two sites that failed, one site had failed for the last five years and 5 charts were late up to date, which were counted as not up to date according to CDC requirements. The other site primarily sees immigrant families that are catching up on their immunizations and therefore would also not be up to date according to CDC requirements. The population that these health centers serve is difficult to comply with follow-up therefore resulting in late immunizations.

The Immunization In-Services for outreach workers, community health center staff, and BCHAP contracted community program staff were offered in September 2007 and October 2007 in four regions. The locations were at the State Lab Institute in Jamaica Plain for the Boston-Metro region on 9/13/07, Fall River Heritage State Park for the southeast region on 10/18/07, Providence Hospital in Holyoke for the central/western region on 10/12/07 and Tewksbury Hospital for the northeast region on 9/18/07. There were 119 Nurses who attended and received CEU's. Providing CME/CEU's has a direct impact on attendance. In total, 300 packets were distributed to attendees and mailed out to sites that were unable to attend.

MCH IP continues to collaborate with the immunization staff of the Boston Immunization Program to better coordinate assessments and follow-up activities for contracted sites located in Boston.

The MIP in collaboration with Wellness at DPH conducted an Employee Flu Clinic on Monday December 10, 2007. A total of 188 people were screened and 179 received Flu Vaccine.

The MCH Immunization Program collaborates closely with Essential School Health Services (ESHS) and School Based Health Centers (SBHC) to ensure dissemination of the most current immunization information. ESHS supports public school districts and nonpublic schools in

providing all school age children with access to a school health service program that is comprehensive. Immunization information is forwarded to ESHS on a regular basis as well as answering questions by school nurses and providing them with resources. SBHC provide access to comprehensive services in a health center located in a school. This facilitates patients being served who would otherwise not seek health care.

The MCH IPC attended quarterly Immunization Initiative Meetings at MCAAP in Waltham MA.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. All BFHN and BCHAP programs that serve families of infants and young children assess for health care access and the child's immunization status. Referrals and assistance are offered to families of children who are not fully immunized.		X		X
2. All WIC children receive an immunization assessment at each WIC appointment until the primary series of shots has been completed.		X		
3. The MCH Immunization Program (MCH IP) promotes regular immunization assessments in all programs and compliance with immunization schedules.				X
4. BCHAP MCH IP staff work closely with the Massachusetts Immunization Program (MIP) in DPH's Bureau of Communicable Disease to ensure contracted providers have regularly updated information.				X
5. EIPP, A Helping Hand: Mother to Mother (AHH) and FOR Families, serving high-risk families, promote well-child care, including immunizations, coordinate and facilitate immunization knowledge and tracking.		X		X
6. EI programs provide information on immunization to all families and refer when indicated.		X		X
7. Child care providers provide information on immunization to all families and refer when indicated.				X
8. MCH IP staff meets routinely with Community Health Services Program managers to coordinate a plan to address failed immunization assessments during the previous year.				X
9. Immunization-related information is forwarded to the BFHN and BCHAP staff working with family-serving programs and/or children in the community and to contracted health centers and program sites, including services for CSHCN.				X
10. Most CHCs have bilingual staff and all have access to interpreters as part of practicing cultural competence when providing outreach and health education. Immunization Vaccine Information Statements (VIS) are available in many different languages.		X		X

b. Current Activities
See Summary Sheet for NPM 7.

MCH IP has collaborated with the Massachusetts Chapter of the American Academy of Pediatrics (MCAAP) in planning a program for staff and providers at one site that failed their immunization assessment for the past 2 years. This collaboration has worked well in the past.

- The MCH Immunization Specialist continues to include the Bureau's contracted health centers and program sites on her immunization information mailing list.
- All immunization-related information is forwarded to the Bureau program staff working with programs serving families and/or children in the community.
- The Bureau contracts with Family Home Visiting (FHV) programs to provide intensive home visiting services to high-risk families and young parents. Coordination between the Bureau and these programs is important and facilitates immunization knowledge and tracking.

Multiple BFHN and BCHAP programs address immunization issues. MCH IP regularly sends their program directors and staff at the service delivery sites information. Programs include community health centers, WIC, EI, EIPP, FOR Families, School-Based Health Centers, and Essential School Health Services, Children with Special Health Care Needs and health education programs.

ESHS is working with the Division of Immunization Preventable Diseases to revise the school entry regulations to include (a) second varicella, (b) inclusion of the Tdap, and to begin school-located flu clinics.

c. Plan for the Coming Year

Continue ongoing and current activities including:

- Improve Massachusetts's immunization rates to a level greater than 84.1% for the 4:3:1:3:3 series by continuing annual in-services and material distribution.
- Assist sites that fail with training on how to improve immunization rates.
- Implement a program for sites to share information and systems.
- Participation in a state immunization registry when implemented (currently on hold due to financial constraints).
- Continue with four regional in-services for the Bureau programs to facilitate immunization education at the community level.
- The new WIC computer system is near completion. Immunizations will be processed through collaboration with the EHS Virtual Gateway and their forecast module. It will interface with the state's "Immunization Wizard" to provide immunization recommendations as part of WIC immunization assessments. WIC plans on rolling out in late July 2009.
- Develop plan to monitor possible changes in immunization rates based on parental refusal.
- Expand school-located flu clinics.

One goal for the future will be to ensure that all contracted sites have an immunization tracking system that has the capacity to identify those clients who are overdue for immunizations. The future implementation of the Massachusetts Immunization registry will make the process of tracking immunizations easier and more cost effective for the sites. Pediatric practitioners at Community Health Centers must also implement quality improvement recommendations from MIP, collaborate with the local WIC program in planning mechanisms for same day immunizations, and implement the most up-to-date "Recommended Childhood Immunization Schedule".

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	14	12	11.5	11	10.5
Annual Indicator	11.8	11.5	10.4	11.5	11.5
Numerator	1454	1440	1379	1543	
Denominator	122847	125294	132803	134644	
Data Source					Mass. Vital Records
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	11	11	11	11	11

Notes - 2008
2008 birth data are not available. We have estimated the same rate to that for 2007. See 2007 for the most recent actual data and see the Note for 2007 for data sources and other comments.

Outyear Performance Objectives have been adjusted to reflect a leveling off of the rate, particularly in light of the effect of state FY09 budget cuts to teen pregnancy prevention and family planning services that are not expected to rebound quickly.

Notes - 2007
Birth data are from MDPH, Vital Records for calendar year 2007. This is the most recent year of data available.

The 2007 denominator is from the most recent population estimates for Massachusetts, as provided by the MDPH Bureau of Health Information, Statistics, Research and Evaluation. The number of female teens ages 15-17 is roughly estimated at 60% of the standard 5-year age group 15-19.

Notes - 2006
Birth data are from MDPH, Vital Records for calendar year 2006. The 2006 denominator is from population estimates for Massachusetts, as provided by the MDPH Bureau of Health Information, Statistics, Research and Evaluation. The number of female teens ages 15-17 is roughly estimated at 60% of the standard 5-year age group 15-19.

a. Last Year's Accomplishments
Eighteen evidence-based teen pregnancy prevention programs continued to be funded in high teen birth rate communities. All programs are implementing curriculum and providing referrals and additional services to youth, their families and their communities. Services continue to be evaluated through the cross-site evaluation managed by John Snow Inc.

In FY08 state legislation mandated that teen pregnancy prevention services be provided to youth in foster and out-of-home care. All 18 evidence-based funded programs received an increase in funding to provide services to this population. Since Nov. 2008, 1,550 youth in foster care and/or involved with the Department of Children and Families have been served by a teen pregnancy prevention program. Teen pregnancy prevention providers have also served 247 foster parents and/or DCF program staff.

Two rural community coalitions were funded to provide teen pregnancy prevention services and bring community awareness to the issue of teen pregnancy.

Family Planning (FP) funding increased significantly in FY08, from $4.4 million to $5.5 million.

To increase accessibility, one page downloadable birth control fact sheets were developed in English and translated into Chinese and Haitian Creole. The English, Chinese and Haitian Creole factsheets were reviewed by family planning providers and focus grouped by women in the target audience to ensure cultural competency and accuracy of translation. The "Choosing a Birth Control Method" brochure continues to be available in English, Spanish and Portuguese and over 7,500 were distributed in FY08 The brochures and fact sheets were are available online at www.maclearinghouse.com.

In FY08, the AIDS Action Committee and MDPH continued development of the statewide sexual health hotline and website program. The initial focus of the hotline and website was Emergency Contraception but as a result of the environmental scan and focus groups with teens, the focus was expanded to Sexual Health. The site concept -- MariaTalks.com-- was unveiled to MDPH in early 2008. The target population will be adolescents with the goal of providing accurate health information and referrals to family planning and related services.

In FY08, 38.13% of female clients aged 15 through17 years who had at least one visit to the SBHC were identified to be at risk for STD/pregnancy. Of those clients, 99.87% had a follow up plan (i.e., received risk reduction counseling), as appropriate.

With funding from AMCHP, DPH trained community partners in Massachusetts re focus groups, trend analysis and risk statistics related to disparities in teen pregnancy and adolescent health.

Of clients aged 15-17 years who had at least one visit to the SBHC, 19.37% had a pregnancy test at least once during FY08.

SBHCs in high schools provided extensive health education in class sessions on topics including contraception, STIs, healthy sexual relationships, reality-based implications of teen parenting. In 2 communities, a teen pregnancy task force was developed to address the issue of increasing rates of teen pregnancy. In several SBHCs where reproductive health service provision is restricted by the school, students received counseling and obtained referrals to see the SBHC nurse practitioner offsite (at sponsoring agency clinics) for contraceptive services. C.Q.I. activities demonstrate that students keep their ‘follow-up' appointments at a rate of 90%. In several sites, SBHC Nurse Practitioners participated in the activities of the Massachusetts Alliance on Teen Pregnancy Prevention.

In conjunction with the annual release of Massachusetts birth data, the MCH Epidemiologist completed and DPH regional managers distributed through their local contacts, fact sheets about teen pregnancy in the Massachusetts communities with the highest teen pregnancy rates and in communities with science-based programs. Communities use the fact sheets to generate media attention and inform local response.

The SHU distributed updated information on the new EC law to school nurses across the state.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Evidence-based teen pregnancy programs are funded in 18		X		X

communities with high teen birth rates (components include individualized case management, sex education, HIV/AIDS prevention, and service learning). Independent evaluation and TA are funded.				
2. Teen Pregnancy Prevention coalitions continue in 2 rural communities, and 1 coalition partners with 2 local school districts, all delivering evidence-based curricula.		X		
3. Family Planning (FP) agencies provide clinical and other services to adolescents statewide. An access coordinator and semi-annual statewide Abortion Advisory Committee meetings ensure all teens have access to services.	X			
4. The FP program works with Keep Teens Healthy, a Medicaid program providing family planning outreach to high-risk teens, and with the HIV/AIDS Bureau on integration of HIV Counseling and Testing into family planning clinics.	X	X		X
5. FP collaborates with the EC Network to implement EC legislation, provide resources to adolescents, and educate adolescent service providers; and with DVIP, BHCQ, and the pharmacy access program to monitor hospital compliance.				X
6. Implementation of and dissemination of knowledge about Emergency Contraception (EC) legislation and FDA ruling on over-the-counter status of Plan B continue including development of a statewide Sexual Health hotline and website.				X
7. Youth Risk Behavior Survey (YRBS) and Massachusetts Youth Health Survey (YHS) surveillance data help monitor pregnancy risk behaviors and inform work of the Adolescent Health Council (AHC) and Youth and Young Adult Working Group (YYAWG).				X
8. Community Based Services for Women of Reproductive Age and Adolescents program serves male and female adolescents and pre-adolescents between the ages of 9 and 18 in selected CHCs, including to reduce teen pregnancy.	X			
9. The Office of Adolescent Health and Youth Development (OAHYD) provides leadership for youth development within DPH and coordination for the Governor's Council on Adolescent Health.			X	X
10. SBHCs provide comprehensive primary care including reproductive health care. Most ESHS health education programs include reproductive health and the School Health Manual has a chapter on reproductive health.	X	X	X	

b. Current Activities
See also SPM 1.

OAHYD trained the 18 evidence-based programs in the Power Through Choices curriculum, the only promising practice curriculum to prevent teen pregnancy among youth in foster and out-of-home care.

OAHYD participated on a state team roundtable sponsored by the Annie E. Casey Foundation and The National Campaign to Prevent Teen and Unplanned Pregnancy to share MA success with 7 states re developing a statewide approach to reduce births among youth in foster care.

Rural community coalition budgets were cut by 50%.

The DPH Medical Director and staff provided information to investigate a publicized increase in

teen pregnancies in Gloucester.

MariaTalks.com, (see past accomplishments) launched in January 2009 hosted by AIDS Action Committee (AAC) and developed with the DPH Family Planning Program, OAYD, STD Bureau, DVIP and other related MDPH programs. It offers comprehensive, medically accurate information on 'sex, birth control and things that matter,' STI and STD, sexual violence, substance use, and GLBTQ information and programs. The website is linked to social networking sites such as MySpace and a Statewide Sexual Health Hotline (877) MA-SEX-ED or (877) 627-3933 which uses a multi-language service line to meet the needs of callers. In the first 3 months of operation, there were over 3,100 visits to the website.

The 2008 AMCHP project continued and DPH created a tool-kit for community partners on using data to inform program and policy development.

c. Plan for the Coming Year
See also SPM #1

The OAHYD will continue to work with the Department of Children and Families to offer statewide trainings in the Not Me Not Now curriculum to foster parents and Peacemaking Circles to DCF staff to increase their capacity to have discussions with young people on healthy relationships and adolescent sexual health topics.

Continue provision of evidence-based teen pregnancy prevention programming and programs with youth in foster and out-of-home care in high teen birth rate communities; Continuation of technical assistance by OAHYD, and cross-site evaluation provided by John Snow Inc. of statewide programming.

Continue implementation of MariaTalks.com, the Statewide Sexual Health Hotline and Website. The site will increase access to information and referrals for EC, STD, family planning and related services. The substance abuse and HIV components of the site will be developed and implemented. Increased collaboration/links with other MDPH websites will occur and monitoring and evaluation of services will continue.

Obtain family planning provider review and focus-group testing necessary before developing at least two additional language versions (Khmer and Vietnamese) of the birth control fact sheets.

Family Planning program will continue with implementation of EC legislation, including development of materials specific for consumers including adolescents, the monitoring of hospital compliance with services to sexual assault survivors and the pharmacy access program. Pharmacist and interns will continue to be on staff in FY10. EC educational materials and information will continue to be distributed to adolescent service providers.

The SBHC program will collaborate with the Family Planning program to conduct a needs assessment in response to provider concerns regarding barriers to contraceptives in the school setting. A subsequent meeting will be held for clinicians to systematically address the findings of the assessment. During this clinical training, the SBHC program will host AIDS Action Committee to promote the launch of www.mariatalks.com.

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	60	62.2	61	63	66.5
Annual Indicator	62.2	59.4	64.6	66.2	67.4
Numerator					
Denominator					
Data Source					Mass. BRFSS
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	68	69.5	71	71	72

Notes - 2008
The data for 2008 are taken from the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS). A children's dental health module, containing this and other questions, is carried out every year. The data are not specific for the narrow age range specified in the measure, but capture data for children ages 6 - 18.

Outyear Performance Objectives have been raised slightly, to reflect continued improvement in these results.

Notes - 2007
The data for 2007 are taken from the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS). A children's dental health module, containing this and other questions, was introduced in the 2001 Survey and is now being carried out every year. The data are not specific for the narrow age range specified in the measure, but capture data for children ages 6 - 18. The survey rates within various socioeconomic categories (preliminary data) continue to show consistently higher rates of sealants as family income rises: 49.8 % (C.I. 36.2% – 63.3%) at under $25,000 compared with 75.1 % (C.I. 69.0% – 81.2%) at over $75,000).

Notes - 2006
The data for 2006 are taken from the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS). A children's dental health module, containing this and other questions, was introduced in the 2001 Survey and is now being carried out every year. The data are not specific for the narrow age range specified in the measure, but capture data for children ages 6 - 18.

Other surveys, on large samples of schools, are being developed and may provide additional data in future years. Information from the field suggests that the use of sealants in the targeted age range is higher than what is being reported in BRFSS, where the data can be considered as showing an essentially flat rate.

a. Last Year's Accomplishments
See also SPM #4 and Priority Need #8.

In 2007, a statewide oral health assessment found that 48% of 3rd graders had at least one dental sealant, noting that children on MassHealth (Medicaid) had limited access to these preventive oral health procedures in comparison to those children with private dental insurance.

The results of the assessment revealed an 8% decrease in the number of 3rd graders with at least one dental sealant compared to a 2003 assessment. The assessment also noted that disparities exist among ethnicities, income levels and a child's access to regular dental care.

The state also measures the number of 6-17 year olds with at least one dental sealant using the annual BRFSS. According to 2008 data, 67.4% of children reported on had at least one dental sealant. This rate, while not for the exact age group specified in the measure, continues to show steady modest improvement since 2005. Survey rates within various socioeconomic categories show consistently higher rates of sealants as parent education levels rise.

The data is limiting in that it does not single out 3rd graders (8-9 year old children) from other age groups and at this time, the Office of Oral Health (OOH) has no way of tracking all 3rd grade students in the state, but did develop a monitoring form working with Essential School Health Services relying on the school nurses to report on the numbers of children served by the programs that enter their schools.

Due to fee increases in the MassHealth dental program, the latest in 2008, the reimbursement rate for dental sealants was increased and thus the number of programs providing this service in school-based and school-linked preventive dental programs has increased.

Historically, school-based and school-linked dental programs have served children who would not otherwise receive these services in a private practice. Third grade children covered by MassHealth and CMSP, as well as others with no insurance are increasingly able to access preventive dental procedures such as sealants through these mobile and portable programs. The percentage of MassHealth eligible children receiving dental sealants in the two most age appropriate groups, 6-9 and 10-14, range from 32-37% with a slight decrease in the 10-14 year old group in FY08.

The OOH received a HRSA Workforce Grant in the fall of 2006. This grant allows the OOH to expand school-based sealant programs, targeting not only 2nd and 3rd graders, but 7th graders (HP 2010 21-8(b). The OOH collaborates with the Mount Wachusett Community College dental hygiene program and the Fitchburg Community Health Center (as the referral source for restorative needs) to implement an oral health prevention program (Fitchburg SEAL) beginning at one Fitchburg Middle School. In the last two school years, the Program provided more than 200 fluoride treatments and 800 dental sealants with a sealant retention rate of 91.7%.

First conceived by the OOH, draft regulations are being developed for mobile and portable oral health programs by the Board of Registration in Dentistry and released in FY09.

The ESHS data tracks the percentage and numbers of children provided oral health screenings, whether screenings were performed by nurses, dentists or hygienists, third grade screenings, dental sealants, fluoride rinses, referrals to the dental provider. School nurses provide about one-third of screenings in these districts.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MassHealth, CMSP and most other 3rd party payor dental benefits include protective sealants for children.	X			
2. Outreach and improved reimbursement rates for the MassHealth/CMSP dental provider network using the state's Third Party Administrator, Doral Dental.				X
3. The Office of Oral Health (OOH) provides leadership to improve oral health status with a focus on children and				X

preventive services.				
4. OOH conducts surveillance of 3rd grade children's oral health status, including sealants and provides technical assistance to schools, community programs and community health centers interested in developing sealant programs.			X	X
5. School-based preventive (sealant) programs are statewide, including all public elementary schools in Boston. OOH also provides direct service delivery of dental sealants in state-funded SBHCs.	X			X
6. The OOH collaborates with ESHS and school nurses re programs and services and provides oral health training to school nurses in ESHS-funded districts; the revised school health manual includes an oral health chapter.				X
7. Dental services provided in community health centers and other contracted primary care sites. The OOH collaborates with many CHC dental programs to develop sustainability within programs and access to restorative treatment.	X			
8. Specialist oral health consultant promotes preventive dentistry services for CSHCN.	X		X	X
9. Expansion of school-based programs to 7th graders to measure against Healthy People 2010 Objective 21-8(b).	X			
10. Weekly school fluoride mouthrinse program serves approximately 50,000 children annually.	X			

b. Current Activities
See also ongoing activities Summary Sheet above and SPM #4 and Priority Need #8.

Fitchburg SEAL continued in school year 2008-2009 with a slight increase in participation among the students. The Program was funded through sustained funding from Year 2. The OOH implemented the CDC's SEAL data collection tool and determines the effectiveness of the Fitchburg SEAL program, as well as retention rates of sealants. Since its inception the program has placed 800 sealants.

OOH continued collaboration with the Chicopee Board of Health and Caring Health Center to implement a preventive (sealant) program in Chicopee for 7th graders. The program expanded to 2 middle schools. The CHC is providing the follow-up/restorative care and serving as the program's fiscal agent for sustainability. In fall 2008, the program placed more than 300 dental sealants.

In school year 08-09, the OOH expanded it school-based prevention program to 3 high-need communities, serving grades K-12 in 25 schools. Over 75% of the children with consent are MassHealth eligible. A 4-year MCHB grant supports the program; plans are to expand to at least 20 more schools in 2009-2010. Data from the program is managed and analyzed using the CDC's SEALs program.

The SHU distributes the School Health Manual chapter on oral health and in collaboration with the OOH continues to provide guidance to schools regarding mobile dental clinics.

c. Plan for the Coming Year
See also SPM #4 and Priority Need #8. Current activities continue.

The Chicopee program will increase to 3 middle schools in fall 2009.

In FY 2010 (September 2009) the OOH will be expanding its school-based sealant programs serving elementary, middle school and high school students. In the fall of 2007, the OOH received an MCHB grant to implement programs in the 47 state-funded school-based health center schools and has expanded its service to include other high-need schools. In the fall of 2008, the OOH received HRSA BHPr funding to develop a statewide plan for expanding school sealant program. This plan will be implemented in school year 2009-2010 in schools with high-need.

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	1.2	1.2	1.2	1.2	1.2
Annual Indicator	1.2	1.3	1.2	0.8	
Numerator	15	16	14	9	
Denominator	1222774	1214584	1202482	1188128	
Data Source					Mass. Vital Records
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	1.2	1.2	1.2	1.2	1.2

Notes - 2008
2008 death data are not available. We have estimated a rate in line with historical trend data, accounting for the possibility that the 2007 3-year average is overly affected by a single year's unusually low numerator. See 2007 for the most recent actual data and see the Note for 2007 for data sources and other comments.

Notes - 2007
Data on deaths are taken from MDPH Vital Records for calendar years 2005 - 2007. This is the most recent year of data available. Rates are calculated as rolling 3-year averages. (I.e. the 2007 numerator is the sum of the 2005, 2006 and 2007 numbers of deaths (10, 12, and 5) respectively and the denominator is the sum of the most recent Massachusetts population estimates for the age group for the same years. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere.
The denominator is from the most recent population estimates for Massachusetts, as provided by the MDPH Bureau of Health Information, Statistics, Research and Evaluation.

Notes - 2006
Data on deaths are taken from MDPH Vital Records for calendar years 2004 - 2006. Rates are calculated as rolling 3-year averages. (I.e. the 2006 numerator is the sum of the 2004, 2005, and 2006 numbers of deaths (19, 10, and 12) respectively and the denominator is the sum of the

Massachusetts population estimates for the age group for the same years. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere.

a. Last Year's Accomplishments

The Injury Prevention and Control Program (IPCP) accomplishments included:
- One certified child passenger safety (CPS) Technician was on staff.
- Coordinated with the Injury Community Planning Group (now called MassPINN, Prevent Injuries Now Network), and Partnership for Passenger Safety for Massachusetts successful adoption of a Booster Seat Bill for CPS.
-Created new educational materials for revised CPS law, per addition of booster seat law. Materials available on web.
- Partnered with MassPINN and the MA Coalition for Adolescent Road Safety to create educational and marketing campaign on risky teen occupant behaviors and received approval for funding from EOPSS Highway Safety Division to implement Teen Driver Safety Program. IPCP conducted focus groups with teens to begin developing messages. The program will strengthen compliance with the Junior Operator and Safety Belt Laws.
- Staff provided technical support and educational materials for numerous safety seat checkpoints.
- IPCP staff answered hundreds of calls on the Car-Safe Line, averaging 30 callers per month. The information line provides general passenger safety information to Massachusetts residents. Staff sends out materials as requested by the caller and refers to relevant partnering programs (WIC, School Health).
- Facilitated quarterly meetings of the Partnership for Passenger Safety; after 1/08, Partnership was restructured to include 3 subgroups: Child Passenger Safety; Teen Driver Safety; Older Adult Driver Safety
- Coordinated activities and educational outreach during Child Passenger Safety Week, including displays and mailings
- Coordinated with School Health staff to send out CPS materials regarding the new booster seat law to school nurses and administrators. Literature on safety issues is routinely disseminated through the weekly email to more than 1800 school nurses.
- Attended meetings and provided technical support to coalitions, such as the Greater Boston Safe Kids Coalition, Western Mass. Safe Kids Coalition, Injury Free Coalition for Kids of Boston, Injury Free Coalition for Kids of Worcester, and MassPINN.
- Planned 1 workshop for the Annual Moving Together Conference (FY 09), the statewide bike/pedestrian conference.
- Participated in meetings of the Executive Office of Transportation's Massachusetts Strategic Highway Safety Plan.

EIPP and AHH Home Visitors provided information to parents on infant passenger safety and resources to obtain child safety seats with instructions for their proper use.

SBHC standards recommend that all SBHC-enrolled enrolled students receive an annual risk and resiliency assessment that includes screening for seatbelt use. In FY08, SBHC clinicians screened students, including those 14 years and younger, who had at least one visit to the SBHC for "seatbelt non-use". Those students identified as "at-risk" were required to have a follow up plan that included risk reduction counseling and/or anticipatory guidance.

SBHC clinicians are also using the CRAFFT tool for substance use assessment; the first item on the screening tool asks "Have you ever ridden in a CAR driven by someone including yourself who was "high" or had been using alcohol or drugs?" This is a validated question intended to assess for risk of vehicular homicide.

During the school year 2007-08, school nurses were able to assess and/or treat 91.1% of the on-campus injuries and illnesses brought to their attention and return students to class. Of students who had to be dismissed, 90% were due to illness and 10% to injuries. For more serious injuries

nurses filed injury state and local reports, including reports of 17.594 unintentional injuries, 2,498 intentional injuries and 3,161 injuries of unknown intent. In 2,340 of these events, 911 or ambulance services were called and in 9,098 parents or others were called to transport the student to health services.

The updated School Health Manual was released with a chapter on safety and injury prevention.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Child Fatality Review Teams operate in every county; MDPH participates and IPCP responds to Child Fatality Review Annual Report recommendations re issues of child passenger safety and bike/pedestrian safety.				X
2. IPCP provides technical assistance to child safety seat checkpoints statewide.		X		
3. IPCP hosts the Car-Safe Line and distributes passenger safety information to Massachusetts residents. Disseminates educational materials on child passenger safety (CPS) to relevant MDPH programs, consumers, and providers.			X	X
4. IPCP coordinates with coalitions, such as the Greater Boston Safe Kids Coalition, Western Mass. Safe Kids Coalition, Injury Free Coalition for Kids of Boston, and Injury Free Coalition for Kids of Worcester, and work/advisory groups.				X
5. IPCP implements traffic safety objectives included in the 5-year injury prevention strategic plan and statewide highway safety plan.				X
6. IPCP continues to update and develop new passenger safety related materials and improve collaboration/integration of CPS information and materials with state and other agencies serving children.				X
7. EI, EIPP, AHH, FOR Families, ESHS, WIC, and SBHCs provide education to clients on passenger/ motor safety and on resources for obtaining child safety seats.		X		X
8. IPCP facilitates Partnership for Passenger Safety meetings and provides technical support to the MA Safe Routes to School Program.				X
9. IPCP maintains technical assistance capability by having at least one certified Child Passenger Safety Technician on staff.				X
10. IPCP works with Executive Office of Public Safety (EOPSS) to develop joint strategies and initiatives such as the Teen Driver Safety Program (new in 2008).			X	X

b. Current Activities

IPCP conducts or participates in many targeted activities related to motor vehicle safety, including those listed in Summary Sheet and the following:

- Help plan the Annual Moving Together Conference, with at least one presentation on the built environment and injury.
- Continue to organize the Partnership for Passenger Safety, with 3 subgroups including Child Passenger Safety, Teen Driver Safety and Older Adult Driver Safety.
- Implement ISA from HSD to conduct Teen Driver Safety Program.

SBHC clinicians attended a CRAFFT skill-building workshop that was sponsored by MDPH and presented by the Director of Research Operations for the Center for Adolescent Substance Abuse Research (CeASAR), Children's Hospital Boston.

c. Plan for the Coming Year
Continue ongoing activities.

The IPCP plans a number of targeted activities:

- Provide leadership to the MassPINN in planning a clinical symposium on passenger safety and emphasize high risk groups, including teen drivers.
- Work with Highway Safety Division and the MA State Police to expand the child passenger safety training program to recruit healthcare and childcare workers to become certified as CPS technicians. Encourage checkpoints at community health centers and hospitals.
- Participate in the development of action plans for each recommendation listed in the Massachusetts Highway Department's Strategic Highway Safety Plan.
- Continue implementation of the Teen Driver Safety Program (3 year project); add School Health Unit participation.

SBHCs will continue to promote the consistent use of CRAFFT screening across all SBHC's. The SBHC program will continue to analyze aggregate data to determine the prevalence of risk assessment in this category.

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			40	45	42
Annual Indicator		38.8	42.7	47	44.7
Numerator					
Denominator					
Data Source			CDC's 2006 National Immunization Survey		CDC, 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	45	45	46	47	48

Notes - 2008

Data Source: CDC National Immunization 2008 Survey Provisional data (for the 2006 birth cohort). (www.cdc.gov/breastfeeding/data/NIS_data/index.htm).
Because they are survey data, there are no numerator or denominator values. These data report breastfeeding rates for children born in 2006 (Hence the date on the reference source). They are provisional data, as CDC will continue to interview this cohort through November, 2009; final estimates for 2006 births will be available in August of 2010.
The data indicate a rate of breastfeeding at 6 months of 44.7% (plus or minus 7.5%) and a rate of ever breastfeeding of 78.2% (plus or minus 7.2%). These compare with provisional national average rates of 43.4% and 73.9%. The state rates for exclusive breastfeeding at 3 months and 6 months were 39.0% (+ or – 7.4) and 13.5% (+ or – 5.2) respectively; the comparable provisional national rates are 33.1% and 13.6%. This pattern indicates no statistically significant changes in Massachusetts from the 2005 birth cohort data (see 2007 Note), with all those rates still higher than national trends for all but exclusive breastfeeding at 6 months. However, differences between any of the Massachusetts rates and the national ones remain statistically insignificant, with overlapping confidence intervals.
The provisional NIS survey data for initiating breastfeeding compare closely with data from our 2006 birth certificate data on breastfeeding (or intent to breastfeed) at hospital discharge of 79.9%.

2008 Massachusetts PedNSS data about breastfeeding among WIC participants are now available. The breastfeeding rate at 6 months was 27.3% in 2008, up from 26.2% in 2006.

We remain uncertain as to which year's CDC/NIS survey data to report in which annual NPM boxes.

Notes - 2007
Data Source: CDC National Immunization 2007 Survey data (for the 2005 birth cohort).
Because they are survey data, there are no numerator or denominator values. These data report breastfeeding rates for children born in 2005 (Hence the date on the reference source). They are final data.

The data indicate a rate of breastfeeding at 6 months of 47.0% (plus or minus 6.7%) and a rate of ever breastfeeding of 78.9% (plus or minus 5.8%). These compare with national average rates of 42.9% and 74.1%. The state rates for exclusive breastfeeding at 3 months and 6 months were 37.6% (+ or – 6.5) and 14.0% (+ or – 4.8) respectively; the comparable national rates were 32.1% and 12.3%. This pattern indicates improvements from the previous survey in Massachusetts for ever breastfeeding, breastfeeding at 6 months, and exclusive breastfeeding at both 3 and 6 mos., and with all those rates slightly higher than national trends. However, differences between any of the Massachusetts rates and the national ones remain statistically insignificant, with overlapping confidence intervals.

The NIS survey data for initiating breastfeeding compare closely with data from our 2005 birth certificate data on breastfeeding (or intent to breastfeed) at hospital discharge of 79.3%.

The newly initiated Massachusetts PRAMS survey finalized data for 2007 indicate that 81.5% of women initiated breastfeeding, and 62.4% were still breastfeeding at 8 weeks.

Notes - 2006
These data are now final and the form and note have been updated accordingly. Because they are survey data, there are no numerator or denominator values. These data report breastfeeding rates for children born in 2004 (Hence the date on the reference source). The data indicate a rate of breastfeeding at 6 months of 42.7% (plus or minus 5.9%) and a rate of ever breastfeeding of 69.5% (plus or minus 6.2%). These can be compared with national average rates of 42.1% and 73.1%. The state rates for exclusive breastfeeding at 3 months and 6 months were 31.8% (plus or minus 5.5) and 12.4% (plus or minus 3.9) respectively; the comparable national rates were 31.5% and 12.1%. This pattern suggests that while Massachusetts had a slightly lower rate

of ever breastfeeding, those that did breastfeed continued breastfeeding, including exclusive breastfeeding, at rates comparable to the national trends. However, differences between any of the Massachusetts rates and the national ones are statistically insignificant, with overlapping confidence intervals.

The NIS survey data suggest a lower rate of initiating breastfeeding than the data from our 2004 birth certificate data on breastfeeding (or intent to breastfeed) at hospital discharge of 77.3%.

With this most recent survey, CDC has changed both the survey questions and the way it presents the data (by birth cohort). The result of the new questions (as discussed at length on the CDC website) is an overall drop in the estimated rates. Therefore, no trend analysis should be drawn between these rates and those cited for previous years. 2006 Massachusetts PedNSS data about breastfeeding among WIC participants is available. The breastfeeding rate at 6 months was 26.2% in 2006, slightly up from 26.1% in 2005.

a. Last Year's Accomplishments

According to the 2008 CDC PedNSS Report, 72% of WIC infants were breastfed in 2008, compared to 60% nationally in the previous year (2007). The breastfeeding rate at 6 months was 27.3% in 2008, up from 25.8% in 2007. Massachusetts performed higher than the national average in 2007 of 25.4%. PedNSS data largely consists of data from WIC participants.

Data released in 2008 from the 2005 CDC National Immunization Survey birth cohort, which includes participants from a more diverse socioeconomic background, shows an increased percentage of infants breastfeeding at 6 months in Massachusetts (43.3%) and nationally (43.1%) than in the previous year.

See notes above for 2005 - 2007 for additional information about the available survey data and changes to the survey questions that have affected trend analysis. Also note that surveys released in a particular year present data on cohorts of children born several years earlier (e.g. the "2007" Survey reports on children born in 2005).

32 WIC Programs with nearly 100 peer counselors (many having multiple years of service) were funded for the 'Mother to Mother' Breastfeeding Peer Counselor Program, including the addition of one new program. The peer counseling program continued to be significantly strengthened and enhanced with the addition of federal "Loving Support" funds.

WIC offered biannual "Breastfeeding Basics" training and annual "Beyond Breastfeeding Basics" training to WIC nutrition staff and other interested staff of related programs.

The Nutrition Division, in partnership with perinatal programs within the Bureau, updated and distributed Guidelines for Breastfeeding Initiation and Support to all birth hospitals in Massachusetts. The Guidelines were endorsed by the Massachusetts Chapters of the AAP and ACOG as well as the Massachusetts Breastfeeding Coalition. DPH Breastfeeding Achievement Awards were given to hospitals that instituted policies and procedures to promote early breastfeeding success as well as to those with outstanding breastfeeding initiation rates.

The Nutrition Division continued to distribute the breastfeeding brochure "You've Got What It Takes…Give Your Baby the Best" in multiple languages to birth hospitals.

"Breastfeeding Works: Breastfed Babies in Childcare" was available to local child care providers, as was training by local WIC Program staff.

DPH was an active member of the Massachusetts Breastfeeding Coalition (MBC). In collaboration with MBC, DPH revised and distributed the Massachusetts Breastfeeding Resource Guide to more than 1,000 health professionals statewide.

In FY08, MDPH staff used linked birth certificate and hospital discharge data in the PELL dataset to evaluate perinatal outcomes for women enrolled in EIPP and compared them to population matched by community, age, and race. Data were analyzed for births occurring from 2003 -- 2005. Despite the high prevalence among EIPP participants of risk factors that could not be adjusted for in these analyses (e.g. depression, substance use and family violence) data indicated that 1) EIPP participants were more likely than non-participants to breastfeed; and 2) there were no differences in length of stays in birth hospitals or charges between EIPP participants and non-participants.

Also in FY08, 61% of all EIPP Participants were breastfeeding at birth and 47.39% were still breastfeeding at 2 weeks. Only 10.43% continued to breastfeed at six months post partum. Barriers for mothers continuing to breastfeed include domestic violence, depression, easy access to infant formula, lack of support at place of employment or school, mothers being prescribed psychotropic medications, and breast-related problems.

In FY08, MDPH staff from both the BFHN and Health Care Quality continued to survey hospitals to designate appropriate level based on the 2006 revised perinatal regulations. To date, 24 of the 50 Massachusetts birth hospitals have been surveyed and designated. As part of the survey process, MDPH staff review compliance with regulations that support initiating breast feeding; provide the updated Massachusetts Breastfeeding Resource Guide; and offer information about training hospital staff on how to best support breastfeeding mothers.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Breastfeeding Coordinator provides active leadership to promote breastfeeding statewide, and multifaceted approaches reach health care professionals, parents/extended family, and general public.				X
2. The Nutrition Division produces and disseminates educational materials and provides basic and advanced training to professional and paraprofessional staff in WIC and other DPH programs to promote breastfeeding.				X
3. Guidelines for Promoting and Supporting Breastfeeding are updated and promoted through all hospital maternity units; BFHN and HCQ joint hospital perinatal licensure visits review hospitals' compliance with breastfeeding regulations.				X
4. Local WIC programs encourage and counsel all women on breastfeeding benefits, provide manual pumps, refer, offer classes and support groups in multiple languages, and establish goals re breastfeeding initiation rates for women enrolled prenatally.		X		
5. Virtually all local WIC programs provide breastfeeding peer counseling services, and local offices offer community-wide celebrations of World Breastfeeding Week to increase awareness and support.		X		X
6. WIC and community health center nutritionists actively cross-refer, including health centers referring to peer counselors, based standing agreements between local organizations required of all local WIC offices.		X		X
7. The Nutrition Division is active in the Massachusetts Breastfeeding Coalition and annually distributes the MA Breastfeeding Resource Guide and other educational materials				X

to birth hospitals, physicians and other health professionals.				
8. EIPP provides intensive breastfeeding support and coordinates with WIC to improve initiation and duration rates through its services and referrals to advanced lactation support, and EIPP collects and manages related data to inform program development		X		X
9. Annually, the Partners in Perinatal Health Conference updates MA perinatal providers about breastfeeding topics.				X
10. Through PNSS, PedNSS, other WIC resources, PRAMS, and EIPP, Massachusetts collects, evaluates and disseminates data related to breastfeeding initiation, duration and exclusivity.				X

b. Current Activities
See Table 4A above.

DPH recognized hospitals that have comprehensive breastfeeding programs and an increased percent of mothers breastfeeding and that eliminated formula logo bags at the annual Breastfeeding Coalition Council.

The Nutrition Division and WIC continue to distribute materials in multiple languages to birth hospitals and OB/GYN community providers to improve early breastfeeding success and enhance hospital collaboration with community-based programs such as WIC's Peer Counselor Program. Local WIC programs are increasing face-to-face contact with health professionals.

WIC is implementing a statewide Breastfeeding Performance Improvement Project to improve breastfeeding initiation and duration rates as well as prepare staff, providers and participants to transition successfully to breastfeeding components of the new WIC food package. WIC is training all clerical and clinical staff and working with community physicians to ease the transition and support breastfeeding.

WIC added 2 peer counseling programs in January 2009; now 34 of 35 MA WIC programs have these services.

Employer-based breastfeeding guidelines are included in DPH Wellness efforts.

The Nutrition Division and Breastfeeding Coalition are working to promote public awareness of recent legislation to protect women breastfeeding in public and, with the DPH Wellness program CDC obesity grant, to provide breastfeeding workshops to nursing students and medical residents.

c. Plan for the Coming Year
Continue ongoing activities.

In October 2009, WIC will implement of the new food package. The new package emphasizes early and exclusive breastfeeding and contains many policies and incentives designed to improve breastfeeding support.

Massachusetts WIC will continue the statewide Breastfeeding Performance Improvement Project. WIC will be attending a federal training program in August 2009 to learn and implement a competency-based breastfeeding curriculum for all WIC staff.

MDPH will continue to survey hospitals. In addition to reviewing protocols and offering training for breastfeeding, MDPH will encourage active participation in the CDC mPINC survey (maternity Practices in Infant Nutrition and Care). The mPINC is a biannual national census of facilities that

is designed to allow data to be used for advocacy and policy development to influence practice at facility and state levels.

In FY10, BFHN staff will continue to collaborate with Vital Statistics to propose adding a question on exclusive breastfeeding at discharge to the electronic birth certificate. This would provide the capacity to infer the degree to which women who indicate their intent to breastfeed on the birth certificate will be successful.

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	99	99.9	99	99.8	98.8
Annual Indicator	100.0	98.9	98.9	98.8	98.3
Numerator	79399	76991	77656	77762	77413
Denominator	79438	77841	78511	78724	78791
Data Source					Mass. Child Hearing Data 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?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	98.8	99	99.2	99.4	99.6

Notes - 2008
Pre-discharge screening rates as tracked by the Childhood Hearing Data System (CHDS). Using birth data before their final de-duplication, cleaning and release ("closed" 2008 birth data will not be available until winter 2010) makes the reported data preliminary or provisional. The UNHSP preliminary numerator and estimated denominator are reported here and will be updated at a later date.

Screening rates are slightly less than 100% and will remain so due to a small number of parents who refuse the screening, infants who die prior to discharge, and unknown/missed screens. See notes for 2007 for examples of these numbers. The majority of those not screened are unknown or missed screens, including those missed due to transfers. Our goal – which is reflected in our performance objectives through 2013 is to reduce the unknown/missed number to close to zero, leaving only refusals and deaths prior to discharge as unscreened.

Notes - 2007
Pre-discharge screening rates are reported initially by the Childhood Hearing Data System (CHDS). The 2007 data have been updated based on final, "clean" screening data and the closed 2007 birth file.
Screening rates are slightly less than 100% and will remain so due to a small number of parents

who refuse the screening (e.g. 30 in 2007), infants who died prior to discharge (284 in 2007) and unknown/missed screens (648 in 2007).

Notes - 2006
The 2006 screening rates shown are final, as 2006 birth data have been released.

Screening rates are slightly less than 100% and will remain so due to a small number of parents who refuse the screening (e.g. 31 in 2006), infants who died prior to discharge (258 in 2006) and unknown/missed screens (587 in 2006).

a. Last Year's Accomplishments
The UNHSP tracked the approximately 78,800 infants born in MA to ensure that 98.3% were screened for hearing loss. Of the infants that did not pass the screening in one or both ears, 230 were diagnosed with hearing loss. A Parent Outreach Specialist, who has two children with hearing loss, provided parents experiencing this loss with support and technical assistance. Outreach staff actively followed up with phone calls and letters to other families. The Childhood Hearing Data System facilitated tracking, outreach, follow-up and documentation of the results.

Electronic Birth Certificate numerator data about screening were determined to be reliable and valid for updating this measure.

Assisted by the data agreement established in FY06 with the EI program, UNHSP continued develop systems to track newborns to ensure services.

Provided the 52 MA birth facilities with data quality reports every two months.

Held bi-annual UNHSP Advisory Committee Meetings.

Provided 3 statewide trainings to 29 DPH Approved Audiological Centers (Cochlear Implant Candidacy and Outcomes for Infants with Hearing Loss, Laterality of Hearing Loss by Screening Result, Pediatric Ophthalmology and Preschool Vision Screening)

Used the Spanish translation of the Parent Information and the Telephone Translation Language Line to enable outreach to families in numerous languages.

Analyzed data about families who did not receive follow-up appointments, presented analysis to stakeholders and amended outreach protocols to target families at higher risk of lost to follow-up.

Collaborated with EPSDT Program to update Massachusetts policy guidelines.

Published "Evaluating Loss to Follow-up in Newborn Hearing Screening in Massachusetts" in Pediatrics (Volume 121, Number 2, February, 2008.

Disseminated educational materials including over 70,000 UNHSP brochures and newly-developed family resources (mild, unilateral hearing loss)

Provided DPH lobby display for Deaf Awareness Week.

Participated in several workgroups to identify hearing loss early.

Disseminated recent JCIH Position Statement to stakeholders and, with Advisory Committee, update guidelines and protocols to JCIH recommendations.

Completed interstate data sharing agreement and plans for collecting results and demographic information across states.

Disseminated RTI findings to stakeholders and TA re family satisfaction survey to other states.

Participated in congenital CMV study group, Children's Hospital Boston

Began work on National Initiative for Children's Healthcare Quality (NICHQ) project, with focus on home births and discharges of reverse transfer infants home from community hospitals.

Dialogued with WIC and MassHealth re reaching families lost to follow-up they serve.

Participated in Directors of Speech and Hearing Programs for State Health and Welfare Agencies and National Early Hearing Detection and Intervention Conferences.

Developed a Memorandum of Agreement with the MCDHH to ensure families with children with hearing loss are referred early.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Universal Newborn Hearing Screening Program (UNHSP) conducts activities related to HP 2010 Goal # 28-11: all newborns are screened by age 1 month, diagnosed by 3 months if they do not pass screening, and enrolled in EI by 6 months.			X	
2. The UNHSP reviews and approves all hospital newborn hearing screening protocols and disseminates new guidance, amended policies, and other information to birth facilities and diagnostic centers.				X
3. UNHSP staff conducts site visits to all hospitals, mails monthly data quality reports, and provides technical assistance as needed.				X
4. UNHSP maintains an Advisory Committee and, with members, updates guidelines and protocols as needed per Joint Committee on Infant Hearing (JCIH) and other expert input, and provides training to 29 approved audiological centers 3 times a year.				X
5. Outreach staff assures that all children receive appropriate follow-up diagnosis and care and refers infants diagnosed with hearing loss to EI, primary care, and CSHCN programs.		X		
6. UNHSP participates in local, regional and national workgroups and activities to develop information, resources and collaborations that continuously improve policies, services, and data.				X
7. UNHSP disseminates parent and provider information materials, including UNHSP brochures, parent information kits, provider information through the American Academy of Pediatricians Champion, meetings with graduate students, LEND Fellows and others.			X	X
8. UNHSP offers parent-to-parent support to all families of children identified with hearing loss.		X		
9. The UNHSP partners with the EI Partnering for the Success of Children with Hearing Loss initiative to ensure appropriate services are available for infants and young children with hearing loss.		X		
10. UNHSP evaluates its program, including surveying families				X

and primary care providers, analyzing data re screening and loss to follow-up and publishing findings.				

b. Current Activities
See also Summary Sheet and NPM #1, #2, and #3.

Oversaw hearing screening for all infants born in MA

Provided technical assistance and data reports to facilities, reviewed and approved hospital screening and audiological diagnostic center protocols

Collected hearing screening results, medical and demographic information through the Elec. Birth Cert. and contacted by telephone the approximately 1,400 families whose infants did not pass the screen to ensure they received a diagnostic appointment and logged approx. 2,640 calls into the Early Childhood Data System

Hired a 1 FTE Parent Outreach Specialist to support >200 families annually with infants with hearing loss

Participated in the NICHQ Learning Collaborative, addressed issues related to lost to follow-up for infants that are transferred at birth to a NICU, drafted "best practices" algorithm and related documents

Developed a data sharing agreement with the MA Comm. for the Deaf and Hard of Hearing to connect families to services

Published "Developing a Strong Early Hearing Detection and Intervention Program" in the American Speech-Language and Hearing Association ASHA Leader (March 2009).

Participated in national workgroup that published the ASHA, (2008) Loss to Follow-up in Early Hearing Detection and Intervention Technical Report

Presented on MA NICHQ project and two posters at the national EHDI conference

Evaluated program performance according to EHDI goals and worked on QI goals and objectives detailed in MCHB grant.

c. Plan for the Coming Year
See also NPM #1. Continue ongoing activities.

Oversee hearing screening for all infants born in MA annually and provide technical assistance/site visits and data reports to facilities.

Review and approve hospital screening and audiological diagnostic center protocols.

Collect hearing screening results, medical and demographic information through the electronic birth certificate and contact by telephone the approximately 1,400 families whose infants do not pass the screen to ensure they receive a diagnostic appointment.

Convene Universal Newborn Hearing Screening Program Advisory Committee and Audiological Diagnostic Center Meetings and provide presentations on emerging medical topics and program data to stakeholders.

Title V Director will continue to actively participate in EHDI conferences and an EHDI/Part C

workgroup to enhance practice between newborn hearing screening and Early Intervention programs nationally.

Distribute hearing screening information in multiple languages to the approximately 79,000 families with infants born in MA annually.

Develop brochures in two additional languages.

Work with the DPH Office of Health Equity and adopt Culturally and Linguistically Appropriate Standards (CLAS) into all program activities.

Provide parent to parent support at diagnosis of hearing loss, including a written Parent Information Kit available in English and Spanish

Enhance statewide support for parent to parent activities

Minimize loss to follow-up by making additional calls to document infants with hearing loss are enrolled in Early Intervention

Participate in statewide efforts focused on ensuring every child with special health needs has a medical home

Analyze program data to understand disparities in receiving care and tailor outreach efforts accordingly

Support providers interested in expanding services in areas with identified geographic disparities, including providing supporting data

Disseminate "NICHQ best practices" documents related to infants in the NICU

Work with Children's Hospital Boston on quality improvement project regarding hearing screening for infants transferred to that facility

Use small tests of change theory (plan, do, study, act) to carryout Quality Improvement projects detailed in MCHB grant

Work on roadmap started in NICHQ Project and disseminate widely

Work with nurse mid-wives to improve hearing screening rates for infants born at home, including developing additional outreach materials

Continue to work with other New England states to sign "Border Babies" data sharing agreement

Submit abstracts and attend the national EHDI Conference sponsored by MCHB and CDC

Continue working with the American Academy of Pediatrics EHDI Champion on educating providers about newborn hearing screening and hearing loss in the early childhood population

Continue working the DPH Legal Office, BU, and DPH partners responsible for PELL access

Continue to educate providers, including medical homes, and others about newborn hearing screening

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	3.5	3	2.5	2	2
Annual Indicator	3.2	3.2	2.5	2.3	1.2
Numerator					
Denominator					
Data Source					MA Div. of Hlth Care Finance & Policy survey
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	1.2	1.2	1	1	1

Notes - 2008
Data source: Massachusetts Division of Health Care Finance and Policy (HCFP). “Health Insurance Coverage in Massachusetts: Estimates from the 2008 Massachusetts Health Insurance Survey;” Updated Powerpoint summary presentation, March 2009. (www.mass.gov/dhcfp)

The impact of the Massachusetts Health Care Reform Law is clearly demonstrated in the continued reduction in the % of uninsured children. Our outyear Performance Objectives have been adjusted again accordingly.

Notes - 2007
Data source: 2007 household survey of Massachusetts residents conducted by the Massachusetts Division of Health Care Finance and Policy (HCFP). “Massachusetts Household Suvey on Health Insurance Status, 2007;” Powerpoint summary presentation released, July, 2008. (www.mass.gov/dhcfp)

Another comparative data source is the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS), which includes questions on insurance coverage for household members under the age of 18. These questions are also asked every year. The 2007 BRFSS survey reported a rate of 1.1% (confidence interval of .4% - 1.9%), unchanged from the previous year. The BRFSS rates have historically been consistently lower than those found in the HCFP surveys, but both surveys have demonstrated similar trends.

As a result of the major health care reform currently getting underway in the Commonwealth – which is designed to achieve universal health care coverage - we have set Performance Objectives reflecting a further drop in the rate, although with a higher residual uninsured percentage than previously projected. We will continue to monitor and adjust these projections as needed, as the economic downturn affects more families and federal decisions on Medicaid policy (e.g. the maximum FPL that can be covered) and the Massachusetts Medicaid waiver may affect the insurance situation for children.

Notes - 2006

The primary data source for this indicator is a 2006 household survey of Massachusetts residents conducted by the Massachusetts Division of Health Care Finance and Policy (HCFP). ("Health Insurance Status of Massachusetts Residents: Fifth Edition"; issued in December, in 2006. (www.mass.gove/dhcfp)

As part of the recent Health Care Reform legislation, the HCFP survey is now done annually and should provide even more information about who is uninsured and how various aspects of health care reform affect children in particular.

Another comparative data source is the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS), which includes questions on insurance coverage for household members under the age of 18. These questions are asked every year. The 2006 BRFSS survey reported a rate of 1.01% (confidence interval of .39% - 1.62%), down dramatically from 2.4% the previous year. The BRFSS rates have historically been consistently lower than those found in the HCFP surveys, but both surveys have demonstrated similar trends.

As a result of the major health care reform currently getting underway in the Commonwealth – which is designed to achieve universal health care coverage - we are setting Performance Objectives reflecting a sharp and steady drop in the rate to essentially no children without insurance by 2009. The impact of the initial expansion of SCHIP to 300% of the FPL for children can already be seen in the 2006 data.

a. Last Year's Accomplishments

Massachusetts Health Care Reform legislation passed in the Spring of 2006 and Title V programs continued to monitor implementation and participate in activities to encourage full coverage. The coverage rate had remained at just over 93% for some years but rose in FY06 to over 96%, and to 98.8% by 2007, with the expansions under health care reform of Medicaid eligibility for children up to 300% of the FPL. The survey findings that only 1.2% of children in Massachusetts are uninsured makes the state's rate the best in the country. Public outreach and information were increased to inform families both to the benefits they are now eligible for and to their responsibilities under the new law (e.g. purchasing insurance under various subsidies).

With the expansions in coverage, the majority of children have moved from the PCC plan to a MCO plan. As the majority of pediatric providers are members of the 3 major MassHealth MCOs, there was no disruption in care. CMSP (Children's Medical Security Plan) remains in place for children not eligible for MassHealth. Coverage has remained high.

As of April 2008 premium payments for children in the State Children's Health Insurance Program (SCHIP) were waived when they have parents with Commonwealth Care coverage who are paying individual premiums. This saves families with children receiving coverage through the MassHealth program monthly premiums of $12-$28 per child.

Of children in EI, 97% have private or public insurance. The remaining 3% receive state-funded EI services, and assistance is provided by EI staff to assess, as appropriate, public health insurance benefits.

EIPP negotiated with 2 of 4 Massachusetts Managed Care Organizations (MCOs) to provide reimbursement for home visits and groups, expanding insured benefits for EIPP participants and thus stretching our program funds for un-covered services further. MCOs have identified CPT codes and reimbursement rates for home visiting services to improve the health and well-being of pregnant and post partum women and their infants.

DPH Care Coordinators assisted 322 families through the Flexible Family Support Fund to reimburse costs of goods and services related to raising a child with special health care needs. These expenses tend not to be medical in nature and therefore not covered by health insurance.

The ESHS programs referred a total of 8,062 students for health insurance.

In October '08, MassHealth began reimbursing pediatric health providers to apply fluoride varnish during well-child visits. OOH developed a tool kit and is conducting trainings of medical providers focusing on community health centers. New legislation has created a public health dental hygienist category to work without the supervision of a dentist. Dental hygienists can now bill MassHealth directly, increasing the number of low income children receiving sealants and fluoride.

MDPH SBHC Quality Standards require SBHCs to assist uninsured students in determining eligibility for and enrollment into a state health insurance plan. Some electronically enroll students in MassHealth on-site using the Virtual Gateway at the SBHC (all are offered training) and others refer patients to another community location where they can be enrolled. All see patients regardless of insurance status and assume the costs.

All MassHealth recipients who are required to pay premiums and are in arrears began to be notified (beginning in June 2008) of payment plans that have been developed for each of them to facilitate continued enrollment. To prevent current eligible clients from losing coverage, DPH programs began reminding them to read all MassHealth communications promptly and carefully.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. All BFHN and other DPH programs (e.g., ESHS, SBHCs) with direct family contact screen for health care access and insurance coverage, make referrals, and provide assistance to access coverage and care appropriate to the program and family.		X		
2. Training and technical assistance is given to community health workers on addressing barriers to health care access.				X
3. DPH works with Medicaid/SCHIP and the new Health Connector on joint efforts to promote and sustain enrollment. DPH staff will continue to participate in EOHHS Health Reform development and implementation and monitor access for MCH populations.		X		X
4. DPH works with provider, professional, and community groups to maintain awareness of Health Care Reform and the multiple options and programs available, and to facilitate enrollment.				X
5. DPH works with community and advocacy groups to maintain awareness of programs and to facilitate enrollment.		X		X
6. Training and technical assistance is offered to providers and parents on SSI and public benefits that provide health insurance for CSHCN.		X		X
7. FOR Families and EIPP home visitors provide information to families on public benefits and assist with enrollment in health insurance.		X		
8. The SHU updates information on insurance through its weekly email to school nurses and presents programs on the topic through the School Health Institute at Northeastern University.				X
9. See also activities for NPM #4, re adequate insurance for CSHCN.		X		X
10.				

b. Current Activities
See also Summary Chart and NPMs #2 and 4.

DPH assures that all existing and new programs continue to focus on enrolling all uninsured children and families in appropriate insurance plans and address incremental changes and developments as the plan continues to be implemented.

EIPP negotiated with an additional 1 of 4 Massachusetts Managed Care Organizations (MCOs) to provide reimbursement for home visits and groups, bringing the total participating to 3 out of 4. The fourth MCO declined to participate since they cover <2% of clients served by EIPP. MDPH covers the cost of providing services to this group of families.

BFHN continued to work with MassHealth and the Health Connector to assure children and families are enrolled in appropriate health coverage plans, to monitor effects of recertification and possible disenrollment due to premium nonpayment. Effects on the current programs, such as family planning and EI continued to be reviewed and programs modified as indicated. DPH participated in quality and cost control council and activities.

c. Plan for the Coming Year
See also NPM #4. Continue ongoing activities.

BFHN will continue to work with MassHealth, the Health Connector, and others to assure children and families are enrolled in appropriate health coverage plans and to monitor effects of any changes in health care reform policies, procedures, or options under the current severe budgetary strains and various proposals to control costs. Effects on the current programs, such as EI will continue to be reviewed and programs modified as indicated.

In March, 2009, the Robert Wood Johnson Foundation awarded $1 million to Massachusetts' Office of Medicaid, in partnership with the University of Massachusetts (UMass) Medical School, to help support enrollment of eligible children in the Children's Health Insurance Program (CHIP) over the next four years. One of only eight states to receive funding from a field of 28 applicants, Massachusetts was selected based on its proven success in and ongoing commitment to increasing children's health insurance enrollment. With support from the Foundation, Massachusetts hopes to become the first state to achieve full participation for eligible children. The initiative is under the direction of the National Academy for State Health Policy (NASHP), which serves as the national program office for Maximizing Enrollment for Kids. As part of the grant, the Office of Medicaid will receive an assessment of the strengths and weaknesses of the state's enrollment and renewal systems, policies, and procedures; tailored technical assistance to help develop and implement plans to increase enrollment and renewal of eligible children; peer-to-peer learning opportunities; and assistance with data collection and analysis to help the state measure its progress. BFHN looks forward to participating in this new initiative and assisting in its success.

Early Intervention benefits under Medicaid have been expanded effective July 1, 2009 with the addition of Medicaid coverage for developmental specialists. All professional disciplines are now covered by MassHealth. This will help assure equitable EI services for all participants.

EIPP and FOR Families, when working with their clients, and homeless families, will continue to assess health insurance status and work with families to enroll them and their children as needed.

Efforts will be made to enhance capacity for electronic, on-site SBHC access to MassHealth and Connector programs enrollment and to provide or assure training in how to utilize this

computerized system.

With virtually all children in the Commonwealth having either public or private insurance, our focus is on assuring timely and appropriate use of health care services and on promoting high quality care for all.

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			34	34	34
Annual Indicator		34.1	34	33.8	33.5
Numerator					
Denominator					
Data Source					Mass. WIC Program data
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	33.5	33	33	32	32

Notes - 2008
Data Source: Final calendar year 2008 Massachusetts WIC Program PedNSS data, from the CDC report. The rate has again dropped slightly from the previous year.

Notes - 2007
Data Source: Final calendar year 2007 Massachusetts WIC Program PedNSS data, from the CDC report. The rate has dropped slightly from the previous year.

Notes - 2006
The 34% recorded for 2006 represents final calendar year 2005 Massachusetts PedNSS data from the CDC report; the rate has dropped .1% from the previous year.

These data indicate that Massachusetts rates for overweight in children are no longer increasing but have remained stable. We project only modest improvements for the years through 2012.

a. Last Year's Accomplishments
WIC is a unique health and nutrition program serving women and children with--or at risk of developing--nutrition-related health problems. Designed to influence lifetime nutrition and health behaviors, WIC provides nutrition education and counseling, free nutritious food and access to health care to low- to moderate-income pregnant women, infants and kids under five. WIC plays an important role in assisting families in achieving positive nutritional habits and healthy weights.

Program participation reflects emphasis on services to high-risk and minority populations: 31% of participants are Hispanic, 19% Black, 6% Asian/ Pacific, <1% Native American, and 44% White. A total of 204,874 individuals and their families received WIC benefits at least once during FY07.

Thirty percent of participants were pregnant, breastfeeding or non breastfeeding postpartum women, 29% were infants and 41% were children under five.
According to calendar year 2007 Massachusetts PedNSS data from the CDC report, 16.8% of 2-5 year olds had a BMI >95% for their age and 17.0% were between 85th and 95th percentile of BMI for age. For comparison, in 2006 the rates were 16.4% and 17.3% and the national 2007 PedNSS findings were 14.8 % and 16.4% respectively. This data indicates that Massachusetts rates for overweight in children have remained stable.

In 2008, the Massachusetts WIC Nutrition Program continued activities related to the "Weigh of Life…Taking Action Together Initiative." This initiative promotes collaborations with medical providers to promote healthy eating behaviors and healthy weights in children. Materials distributed through this initiative included: a toolkit for providers to establish successful partnerships and promote consistent nutrition messages which utilized an innovative advertising style to effectively interact with WIC families. Medical providers received individual visits from local WIC nutritionists. There was overwhelmingly positive support from the providers, acknowledging appreciation for knowing the messages provided by WIC. They valued efforts of shared messages. In follow-up with providers, over 70% believed that it was important to share the same messages with WIC and 50% are utilizing the 'Steps to a Healthy Weight for Children'.

The Massachusetts WIC Nutrition Program provided community nutrition partners with training on WIC nutrition education and counseling methodology: "Touching Hearts and Minds: Using Emotion-Based Messages to Promote Healthy Behaviors". WIC staff are using this style in both individual appointments and in facilitated group discussions with WIC parents. New educational materials developed for WIC participants are designed using this model.

The statewide Nutrition Education Task Force (NETF) and Targeting Obesity Through Education (TOTE) Workgroup -- representing more than half of all local WIC programs - provided activities to promote healthy weights through good dietary and physical activity practices throughout the year. The TOTE physical activity challenge was adopted by agencies beyond WIC to promote fitness and wellness among public health staff.

The WIC Program implemented year one of a three-year USDA Special Projects Grant, "Getting to the Heart of the Matter: Using Emotion-Based Techniques to Implement the Value Enhanced Nutrition Assessment" (GHM) to expand on the success of the Touching Hearts, Touching Minds project. This initiative explores the use of emotion-based techniques in WIC eligibility determination process to use as a springboard to meaningful and productive nutrition education sessions. This process builds on staff's current skills in rapport building, establishing counselor-participant trust, creating an environment for open discussion and effective identification and prioritization of the participant's personal goals and needs regarding nutrition behaviors. Year One of the grant focused on formative research and subsequent tool and technique development that will be used for pilot testing in six local WIC programs during Year Two.

In anticipation of the new WIC food package, WIC families were surveyed to assess preferences and shopping habits that would affect their acceptance of coupons for low-fat milk, whole grains and fruit and vegetables from the WIC program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. WIC local programs screen and assess BMI and provide caregivers with information regarding child's weight.	X			X
2. Provide caregiver messages included in "Steps to Healthy Weight in Children" which promote good nutrition and feeding patterns and encourage physical activity.		X		X

3. Partner with medical providers to coordinate nutritional care and provide consistent nutrition and physical activity messages to promote healthy weights, utilizing both the Weigh of Life and Touching Hearts messages and materials.	X	X		X
4. Provide training to nutrition staff on approaches to talking effectively with parents about their child's weight and ways to ensure a healthy weight for their child, highlighting emotion-based, participant-centered model.				X
5. WIC staff utilizes emotion-based service methodology to provide WIC families with messages about healthy eating, increased physical activity, and healthy weights, utilizing Touching Hearts, Touching Minds materials.		X		X
6. Annually communicate trends in state and local WIC program rates for children with BMI's at or above 85th percentile, review current efforts and strategize individual program activities and initiatives to improve rates.				X
7. Implement USDA's Value Enhanced Nutrition Assessment initiative to ensure the completion of a participant-centered nutrition assessment process.				X
8. Through the Getting to the Heart of the Matter grant activities achieve a nutrition assessment interaction that is emotion-based and participant-centered.				X
9. Develop weekly messages for Mix 98.5FM Nutrition Buzz promoting healthy eating and physical activity.			X	X
10.				

b. Current Activities
Initiate the pilot phase of the "Getting to the Heart of the Matter" in 6 local WIC programs, using client-centered, emotion-based based tools and techniques to perform more meaningful, productive nutrition assessment and set the stage for behavior change.

The NETF and TOTE provided activities to promote healthy weights, reviewed education materials, provided healthy recipes and focused on staff wellness for the WIC Program and other public health staff across the state.

The NETF and TOTE reviewed and proposed educational activities to promote healthy weights in children.

Expand the use of facilitated group discussions for follow-up nutrition education for WIC families.

Develop 52 healthy weight messages for young children for Mix 98.5FM Nutrition Buzz.

Implement the WIC "Mooove to Lowfat Milk" campaign, prompting discussion and progress towards issuance of low-fat milk for all children over the age of two in advance of the new WIC food package.

Complete preparations to implement the new WIC food package.

c. Plan for the Coming Year
Continue ongoing activities.

Finalize hiring of new Nutrition Division/WIC Director.

Implement the new WIC food package, which supports healthy weight in children by providing fruits, vegetables, whole grains and lowfat milk.

Continue partnering with medical providers and focusing on the shared messages to encourage healthy weights and to facilitate the implementation of the new WIC food package.

Based on completion of the pilot phase of the GHM grant, assess the impact of the emotion-based tools and techniques on the nutrition assessment process.

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			6	6	9
Annual Indicator		6	6	9.2	9
Numerator					
Denominator					
Data Source					MA PRAMS
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	9	8.9	8.8	8.7	8.6

Notes - 2008
Data Source: Massachusetts PRAMS. 2008 PRAMS data are not yet available. We have estimated a slight improvement based on the 2007 data.

Notes - 2007
Data Source: Massachusetts PRAMS. This is the first PRAMS data available in the state. MA PRAMS sampled women who were Massachusetts residents and delivered a live-born infant within the state, including infants who died after delivery and multiples up to triplets. In 2007, 9.2% of women smoked cigarettes during the last 3 months of pregnancy (95% CI: 6.8 – 11.5) according to PRAMS. Among the same population of women, 6.6% reported on the birth certificate that they had smoked cigarettes at any time during pregnancy (95% CI: 4.5 – 8.7). Among all PRAMS states, MA has the third lowest prevalence of cigarette smoking during the last 3 months of pregnancy (most recent national PRAMS data available is 2003).

Differences between these initial PRAMS survey data and the smoking during pregnancy data from the birth certificate (see State Performance Measure #02) are being analyzed. The PRAMS data suggested higher rates of smoking during pregnancy than reported from the birth files (although the wide confidence intervals for both overlap). This external validation source (PRAMS) may result in further efforts to improve the quality and reliability of the birth certificate data in future years.

In the interim, we have adjusted our future performance objectives to be more in line with PRAMS data and realistic expectations of rates of reducing smoking, particularly in the face of major state budget cuts to a number of smoking cessation efforts. The result is that there are some discrepancies between the future performance objectives shown here for NPM #15 and for SPM #02. One result of the analyses mentioned above and described in our FY09 Planned Activities for these measures, will be a more formally coordinated set of projections.

Notes - 2006
We have no new data to report for 2006, so are reporting the same rate as 2005 (which was estimated from data from the PRAMS pilot test. Based on our progress in increasing the % of women who report not smoking during their pregnancy (see SPM # 2), we are projecting a further slight decrease in this rate through FY11. More solid statewide estimates will be available from PRAMS beginning in 2008.

a. Last Year's Accomplishments
See State Performance Measure # 2, which monitors the percentage of women who report not smoking at any time during their pregnancy. Most of the Commonwealth's extensive efforts to reduce smoking during pregnancy are reported under that measure. In addition, given that teen mothers are more likely to smoke than older women, see state priority #2, improve adolescent health through youth development and risk reduction, which highlights adolescent-related smoking prevention and cessation. This report for NPM #15, smoking in the third trimester, highlights activities that are focused on smoking cessation after a pregnancy begins.

Data about smoking during the third trimester are not available on the Massachusetts birth certificate. PRAMS, which asks a representative sample of Massachusetts women who gave birth about smoking in the third trimester, reported preliminary findings in 2008 (for calendar 2007) about smoking in the third trimester.

2007 PNSS data indicated that 11.9% of low income women participating in the Massachusetts WIC program smoked during their last 3 months of pregnancy, a decrease from 12.4 in 2006.

The Massachusetts Tobacco Control Program (MTCP) Smoker's Helpline continued to promote services and materials tailored for pregnant women who smoke.

MTCP added a third hospital to funded programs at rural birth hospitals in Western Massachusetts to train hospital and community-based healthcare providers to conduct and track brief interventions with pregnant smokers. The programs also collected baseline data from hospitals and community practices and provided supportive counseling to women who accepted referrals. North Adams Regional Hospital showed a particularly strong improvement. In FY08, documented brief interventions nearly doubled from 45% to 75% for women of childbearing age, and women who reported being smokers were offered services and support to help them quit in much higher numbers than in 2007.

In FY 08, pregnant women and women with young children accessed smoking cessation benefits through the new MassHealth smoking cessation benefit. In FY 07, MTCP had provided extensive technical assistance to help MassHealth design a smoking cessation benefit that provided counseling and pharmacotherapy for pregnant women and women with young children. This benefit has been widely used.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. The Community Based Services for Women of Reproductive Age and Adolescents program provides screening and health education for smoking and referrals to community services for smoking cessation.		X		
2. FOR Families and EIPP home visitors screen and assess for tobacco use at regular intervals during pregnancy and postpartum, and make referrals as needed. Formal collaboration with MTCP and QuitWorks provides smoking cessation services.		X		X
3. WIC services assess for smoking during pregnancy and provide information and counseling on smoking cessation, offering enrollment into QuitWorks, a smoking cessation program and assisting interested women enroll.		X		X
4. PRAMS collects information from women postpartum, specifically assessing the proportion of women giving birth in Massachusetts who smoke in the last three months of pregnancy.				X
5. The MCH program works closely with the Massachusetts Tobacco Control Program (MTCP) on program development, new initiatives, training and technical assistance.				X
6. EIPP home visitors collect this data element for all EIPP enrolled pregnant and postpartum women.				X
7. See also State Performance Measure #2, which reports additional Massachusetts activities to prevent smoking at any time during pregnancy.				X
8. See also State Priority #2, improve adolescent health through coordinated youth development and risk reduction, for adolescent-focused activities.				X
9.				
10.				

b. Current Activities
See State Performance Measure # 2 and state priority # 2, where most of the Commonwealth's extensive efforts to reduce smoking during pregnancy are reported.

PRAMS analyses for 2007 were finalized in collaboration with the Centers for Disease Control and Prevention PRAMS team.

We plan to report the prevalence of cigarette smoking in the last 3 months of pregnancy over 3 years when available (2 years for FY09), to improve the precision of our estimates and continue the validation study which is underway comparing smoking reported on birth certificate and PRAMS.

In FY 09, the Massachusetts Tobacco Control Program (MTCP) continued funding three rural birth hospitals to pilot systems change strategies to refer pregnant women to services and supports.

MTCP conducted analysis in FY 09 to assess the amount of underestimate of smoking on the birth certificate. The analysis is complete and will be further developed into a publication in FY10.

c. Plan for the Coming Year

See additional plans under State Performance Measure # 2 and State Priority #2. Continue ongoing activities.

Due to anticipated budget cuts in FY10, the Massachusetts Tobacco Control Program will be unable to fund rural birth hospital contracts.

Reporting the prevalence of cigarette smoking in the last 3 months of pregnancy over time from the PRAMS database will continue as additional years of data become available. This will improve the precision of our estimates and enhance our understanding of related maternal characteristics, risk factors, and sub-populations to target for interventions when funds permit.

We will also continue the validation study which is underway comparing smoking reported on birth certificate and PRAMS.

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	5	5	4.3	4.3	4.3
Annual Indicator	4.3	4.5	3.7	3.6	4.2
Numerator	18	19	16	16	
Denominator	414020	420641	431669	442849	
Data Source					Mass. Vital Records
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	4.2	4.2	4.1	4.1	4

Notes - 2008
2008 death data are not available. We have estimated a 2008 rate higher than for 2007 that is more in line with the secular trend. See 2007 for the most recent data and see the Note for 2007 for data sources and other comments.

Notes - 2007
Data on deaths are taken from MDPH Vital Records for calendar years 2005 - 2007. Rates are now calculated as rolling 3-year averages. (I.e. the 2007 numerator is the sum of the 2005, 2006, and 2007 numbers of deaths (18, 11, and 19 respectively) and the denominator is the sum of the most recent Massachusetts population estimates for the age group for the same years, as provided by the MDPH Bureau of Health Information, Statistics, Research and Evaluation. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere.

Notes - 2006

Data on deaths are taken from MDPH Vital Records for calendar years 2004 - 2006. Rates are now calculated as rolling 3-year averages. (I.e. the 2006 numerator is the sum of the 2004, 2005, and 2006 numbers of deaths (19, 18, and 11 respectively) and the denominator is the sum of the Massachusetts population estimates for the age group for the same years, as provided by the MDPH Bureau of Health Information, Statistics, Research and Evaluation. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere.

a. Last Year's Accomplishments
See also Priority Need # 9.

MDPH received its 6th year of state funding for a Suicide Prevention Program. With leadership and funding from the Program, activities for adolescents, their parents, teachers and caregivers included:

The Sixth Annual Suicide Prevention Conference was held with participation by 750 providers and advocates.

SOS (Signs of Suicide) kits were received by150 Massachusetts middle schools and 125 staff trained to implement the program.

A Depression Wellness Guide was developed and distributed to high school students and parents.

The Massachusetts Strategic Plan for Suicide Prevention was revised by Program staff and the MA Coalition for Suicide Prevention.

DMH and the Program are collaborating to offer suicide prevention training to staff of the 500 residential programs who serve children and youth.

Nine AMSR trainings were held for 450 mental health clinicians.

The SAMHSA grant trained 1200 foster parents and Department of Social Service social workers in suicide prevention. The Department of Youth Services served 55 families and trained 255 DYS staff.

QPR (Question Persuade Refer, national recognized) certified gatekeeper instructors conducted 36 trainings for 3045 participants. More than 80% of attendees reported an increase in knowledge of signs of suicide and confidence in intervening with a person at risk.

American Foundation for Suicide Prevention training was given to 60 facilitators on how to lead survivor support groups.

The Program continues to disseminate suicide prevention materials.

The Program was awarded a second grant of SAMHSA funding for youth suicide prevention. The ESHS school districts reported 833,158 student encounters in which mental health counseling was the primary reason for the visit; 40% of the ESHS districts had emotional support groups for students, with an average of 124 meetings and 204 student participants monthly. In addition, 23% of the ESHS districts provided anger/conflict/violence management support groups with an average of 25 group meetings and 69 student participants monthly. Nurses reported diagnoses of depression at a rate of 8.9 per 1,000 students in the ESHS districts.

The Northeastern University School Health Institute provided the following mental health programs: (a) 5 programs on depression prevention curriculum training with multidisciplinary attendees, (b) mental health updates for school nurses with 77 school nurse participants, (c) a

summer institute which included programs on cyber-bullying, concussions, etc.: 310 nurses attended. The School Health Institute also offered a program, in collaboration with the Department of Elementary and Secondary Education, on health risks for GLBQ youth: 70 individuals fro a variety of professionals attended.

In FY08, 14.09% of students aged 15 through 19 years who had at least one visit to the SBHC were identified to be at risk for depression. Of these students, 99.82% were assigned a follow up plan by the SBHC clinician. 29.08% of students at risk for depression were referred to a mental health clinician for follow up care and 6.51% were referred to student support services. 1.50% of students ages 15 through 19 who had at least one visit to the SBHC were identified to be at risk for suicide attempt. Per the SBHC standards, clinicians are required to develop extensive referral networks in their communities and to identify the level of acuity/response needed.

Questions were included on the 2008 BRFSS survey specific to suicide and survivors in order to gather additional data on suicidal behavior in the Commonwealth.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Suicide Prevention Program carries out a comprehensive array of suicide surveillance, intervention and prevention activities, seeks to identify adolescents at risk for suicidal behavior and intervene with an appropriate preventive strategy.	X	X		
2. Safe Spaces for Gay, Lesbian, Bisexual and Transgender Youth Program addresses suicide risk amongst GLBT youth; working with community based providers to create safe spaces within schools and communities that promote healthy youth development.			X	X
3. Extensive training and technical assistance is provided to SBHC clinicians and school nurses (ESHS) in mental health and suicide screening and prevention, and they screen and refer for treatment.				X
4. Collect input from adolescent residential facility program managers about their suicide prevention needs, develop curriculum and provide ongoing training.			X	X
5. Provide postvention services with suicide survivors and affected schools through a statewide contract.	X			
6. Sponsor trainings, an annual conference, and seminars on suicide prevention; promote and use curricula for various providers. Distribute Signs of Suicide® (SOS) program kits and train schools to implement. Update data and prevention resources.				X
7. School nurses do assessment and referral for depression and other mental health issues for children in grades K-12. This is a requirement of the ESHS grants and the School Health Manual provides information on this subject.		X		X
8. SBHC standards require annual risk and resiliency assessments with validated screening instruments. All clinicians are trained in the child symptom checklist. Several use SOS and others use additional validated instruments.		X		X
9. . Implement a federal SAMHSA grant focused on at-risk youth in the DSS and DYS population. Train DSS foster parents and case managers in suicide sign recognition and intervention skills				X

and strategies.				
10. Through the SAMHSA grant, guide families of DYS youth in how to help their suicidal sons and daughters and train DYS staff in suicide sign recognition and intervention skills and strategies.		X		X

b. Current Activities
See also Summary Chart and Priority # 9
- The 2-day Suicide Prevention Conference was attended by 750 providers and advocates

- A half-day conference for school personnel guided 50 professionals to develop school policies to manage sudden traumatic loss

- The SAMHSA-funded youth suicide prevention program trained 1200 foster parents and DSS social workers

- 2 QPR Instructor Certification Trainings were held at no cost to 80 community coalition members and EMT's. The certified QPR trainers conducted 45 trainings in which 765 individuals participated

- DPH staff participated in all Massachusetts Coalition for Suicide Prevention activities and provided technical assistance and funding for a Regional Coalition Development Coordinator.

- 8 full-day AMSR trainings by a nationally certified instructor were held for 450 clinicians at locations in various parts of the state

-4 graduate schools of social work were awarded grants to include suicide prevention training in their curricula

- 150 high school and middle schools received Signs of Suicide program kits and 125 school personnel participated in implementation training

- 35 facilitators were trained to lead survivor support groups through a partnership with the American Foundation for Suicide Prevention

-A statewide postvention contract was awarded to provide assistance to communities and school districts after a suicide event

- 300 school personnel and child caregivers attended a conference on "Asphyxial Games"

c. Plan for the Coming Year
See also Priority Need # 9.

Continue ongoing activities to build sustainability of substantial new activities implemented in this area during FY08 and FY09.

Continue ongoing training of adolescent residential facility program managers based on the curriculum developed from a 2008 survey of their suicide prevention needs.

The SBHC program will continue to support enhanced mental health/substance abuse services in the funded SBHCs with the goal of disseminating identified best practices throughout the state network of SBHCs.

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	86	88	86	86
Annual Indicator	88.2	85.6	85.5	88.5	88.5
Numerator	946	887	826	886	
Denominator	1072	1036	966	1001	
Data Source					Mass. Vital Records
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	88.5	88.7	88.7	88.9	88.9

Notes - 2008
2008 birth data are not available. We have estimated the same rate as that for 2007. See 2007 for the most recent actual data and see the Note for 2007 for data sources and other comments.

Notes - 2007
Data on VLBW, birth hospitals, and resident births are from MDPH Vital Records for calendar year 2007. The nine Level III units are at Baystate Medical Center, Beth Israel Deaconess, Boston Medical Center, Brigham and Women's, Massachusetts General Hospital, Medical Center of Central Massachusetts, New England Medical Center, South Shore Hospital, and St. Elizabeth's Medical Center. Data include only those resident births that occurred in-state at Massachusetts hospitals, as the birth file used for analysis does not contain the necessary information (specific hospital of birth) for births to residents at out-of-state facilities to be categorized by Level III facility. In one region of the state enough births occur out-of-state (in Rhode Island) to distort the statistic otherwise.

Revised Hospital Licensure Regulations for Maternal-Newborn Services did not change the hospitals that we consider to have Level III units. Therefore the data reported are from the same nine hospitals as in previous years. The percentage of VLBW infants delivered in these 9 sites continues to fluctuate slightly and may be improving slightly, perhaps reflecting the impact of new regulations on the perinatal regional system and the facilities considered to be appropriate for high-risk deliveries and neonates. We are therefore treating the 2007 birth data as a new baseline. The impact of the regulatory changes on the system and on the resulting data is described in the narrative and will continue to be monitored in future years.

Notes - 2006
Data on VLBW, birth hospitals, and resident births are from MDPH Vital Records for calendar year 2006. The nine Level III units are at Baystate Medical Center, Beth Israel Deaconess, Boston Medical Center, Brigham and Women's, Massachusetts General Hospital, Medical Center of Central Massachusetts, New England Medical Center, South Shore Hospital, and St. Elizabeth's Medical Center. Data include only those resident births that occurred in-state at Massachusetts hospitals, as the birth file used for analysis does not contain the necessary information (specific hospital of birth) for births to residents at out-of-state facilities to be

categorized by Level III facility. In one region of the state enough births occur out-of-state (in Rhode Island) to distort the statistic otherwise.

Revised Hospital Licensure Regulations for Maternal-Newborn Services did not change the hospitals that we consider to have Level III units. Therefore the data reported are from the same nine hospitals as in previous years. The percentage of VLBW infants delivered in these 9 sites continues to fluctuate slightly but remain essentially unchanged. The impact of the new regulations on the perinatal regional system and the facilities considered to be appropriate for high-risk deliveries and neonates is still to be seen. It is likely that new baselines will be established for 2007 births. The impact of the regulatory changes on the system and on the resulting data is described in the narrative and will be monitored in future years.

a. Last Year's Accomplishments
See also NPM 15 and SPM 9.

After concerns about the smaller percentage of VLBW infants born at Level III facilities in Massachusetts, revised state Hospital Licensure Regulations (105 CMR 130.000) governing maternal and newborn services were promulgated by DPH and put into effect in March 2006. In FY08, the BFHN and the Bureau for Health Care Safety and Quality (BHCSQ) collaborated on a system of reviewing services in each birth hospital to determine an appropriate level designation. To date, 24 of the 50 Massachusetts Birth Hospitals have been surveyed and re-designated.

DPH has convened the Perinatal Advisory Committee (PAC) whose members represent all hospital levels of care, all regions in Massachusetts, and each professional organization identified as a key stakeholder (e.g. MA ACOG, MCAAP, MNA, Mass. Medical Society). The PAC advises DPH on maternal and newborn policy and regulations, advises on regulation waiver requests and monitors the impact of the regulatory changes on care.

In addition, DPH submitted a request to the Department's Human Research Review Committee for a perinatal data review project to establish a process to review preterm births at all hospital levels to determine factors that may enhance perinatal outcomes. The perinatal data group will report back to the PAC using aggregated and de-identified data so that the PAC can make clinical and systems recommendations to increase the percentage of VLBW infants born at appropriate facilities for their medical needs.

A cost study of EI services using PELL demonstrated that EI costs must be included when considering the long-term costs of prematurity and low birth weight. Data informed a comprehensive review of EI and its costs.

DPH staff and the PAC data subcommittee developed a 24AB application to use PELL for a more indepth look at morbidity and mortality at each hospital level to monitor the impact of the regulations.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Perinatal regulations promulgated to ensure women and infants receive the most appropriate care for their medical needs and to reflect current state of practice at Level II and Level III hospitals.				X
2. Perinatal primary care providers screen for risk conditions and refer to appropriate level of care.	X	X		
3. The Perinatal Advisory Committee (PAC) brings multiple hospital level and professional discipline perspectives to bear on				X

ongoing implementation of the regulations.				
4. Per the regulations, hospitals collect infant and maternal indicators. Level IIIs must participate in the Vermont Oxford Network, providing NICUs reliable, confidential data for quality management, improvement, internal audit and peer review.				X
5. The PAC data subcommittee functions as a research body that operates under the guidance of a 24AB and reports relevant (aggregated – de-identified) results to the PAC to inform their decision-making/policy development process.				X
6. In collaboration with DPH Bureau of Health Care Safety and Quality (BHCSQ), a special project status has been established through the hospital regulatory process that allows a Level II B hospital to provide Short Term Mechanical Ventilation (STMV).				X
7. BFHN and MDPH BHCSQ survey/conduct site visits participate of hospitals and review compliance with new regulations.				X
8. Home visiting programs screen for risk conditions and refer to appropriate level of care.		X		
9. Through the Perinatal Disparities project, MDPH works with communities to use local data on VLBW infants to identify program priorities and policies to address VLBW and preterm birth (see SPM #9).				X
10.				

b. Current Activities
Level III hospitals and those with an identified concern for the standard of care being provided were prioritized for on-site surveys by BFHN/BHCSQ staff of hospitals requesting a change in level of care. Since the regulations were promulgated in 2006, 24 of the 50 operational facilities subject to the regulations were surveyed. Of these, 21 were complete and 3 are pending. Of the 21 completed surveys, 18 received new level designations (all but one were differentiated into either level A or B within their original designation level), and three received additional waivers. Two facilities (one NICU only, and one level III) surveyed retained their original designation.

The Betsy Lehman Center for Patient Safety and Medical Error Reduction convened an expert panel on obstetrics, with a focus on labor and delivery. Title V has been participating in the planning and implementation. A full report will be released in 2009.

The NeoQIC chairman joined the Perinatal Advisory Committee and will join the Perinatal Data Review Workgroup, whose 24AB was approved, which met again in June.

c. Plan for the Coming Year
Continue ongoing activities.

Building on the report on Patient Safety and Medical Error Reduction, Title V will work with the Betsy Lehman Center to disseminate the results and recommendations from the committee with a focus on developing standardized protocol to reduce medical error. Recommendations are grouped into several topic areas: Electronic Fetal Monitoring; Cesarean Births (including Trial of Labor after Cesarean (TOLAC)); Disparities in Perinatal Outcomes; Inductions; and Staffing and Communications. In addition, several members of the expert panel agreed to collaborate with members of the Maternal Mortality and Morbidity Committee to develop protocols for addressing hemorrhage in the obstetric setting.

The Perinatal Data Workgroup will work closely with the DPH Privacy and Data Access Office (PDAO) to implement the Perinatal Data Review Project. The goal of the project is to 1) monitor outcomes of mothers and infants over time to measure the success of the revised maternal and newborn hospital licensure regulations in assuring all mothers and infants receive care at a hospital licensed at the appropriate level for their needs and 2) to measure whether the regulations help reduce maternal, fetal and infant morbidity and mortality.

MDPH will continue to conduct hospital surveys in all Massachusetts birth hospitals with the hope of completing this process in the coming year. The MDPH will work closely with each hospital to implement an improvement plan based on the outcome of their survey. MDPH staff will provide technical assistance as needed in implementing hospital based improvement plans and will assess the ratio of VLBW infants in each Massachusetts region to determine whether an adequate number of NICU beds exist in each region, or that a well functioning system of transfer of VLBW requiring level III services is in place to ensure that high-risk deliveries are managed in these hospitals.

MDPH will continue to convene a workgroup composed of internal staff, providers, and academics to review birth statistics and identify two to three areas for greater focus In the past year, the focus was on cesarean births and gestational diabetes.

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	85	85	83	83	82
Annual Indicator	82.8	82.5	81.5	81.4	81.5
Numerator	64958	63410	63326	63408	
Denominator	78460	76824	77670	77934	
Data Source					Mass. Vital Records
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	81.5	81.5	81.5	81.5	81.5

Notes - 2008
2008 birth data are not available. We have estimated a similar rate to that for 2006. See 2007 for the most recent actual data and see the Note for 2007 for data sources and other comments.

We do not expect improvement in this rate for the foreseeable future, due to health care systems limitations in scheduling routine prenatal care within the first trimester of pregnancy.

Notes - 2007
Data are from MDPH Vital Records for calendar year 2007. This is the most recent year of data available.

The percentages shown differ from those published elsewhere, due to how missing data are handled. The MCHB definition of the denominator is specified as all resident births during the referenced year. In MassCHIP and most Massachusetts publications (such as Massachusetts Births), percentages are reported only for cases where information is known (i.e. the denominator excludes births for which data on the variable are missing). Using the MCHB definition reduces the calculated percentage slightly.

The percentage of women receiving prenatal care in the first trimester in Massachusetts continues to decline, from 84.3% in 2001 to 81.4% in 2007.

Notes - 2006
Data are from MDPH Vital Records for calendar year 2006.

The percentages shown differ from those published elsewhere, due to how missing data are handled. The MCHB definition of the denominator is specified as all resident births during the referenced year. In MassCHIP and most Massachusetts publications (such as Massachusetts Births), percentages are reported only for cases where information is known (i.e. the denominator excludes births for which data on the variable are missing). Using the MCHB definition reduces the calculated percentage slightly.

The percentage of women receiving prenatal care in the first trimester in Massachusetts continues to decline, from 84.3% in 2001 to 82.5% in 2006.

The continued lack of significant improvement in this measure continues to be of concern and is part of the perinatal disparities work that is reflected in our SPM #9. However, another major factor is that women are increasingly receiving appointments for their first prenatal visit after twelve weeks of pregnancy, often because they no longer need a health care visit to confirm a pregnancy due to the availability of accurate over-the-counter tests. This factor is not readily susceptible to change and we have adjusted our future performance objective goals to reflect a lower baseline of first trimester visits even among healthy and well-insured women.

a. Last Year's Accomplishments
See also SPM #9 and State Priority Need #10.

Massachusetts Pregnancy Nutrition Surveillance (PNSS) 2007 Statewide Summary Data Report indicated that 72.4% of women on WIC entered prenatal care in the 1st trimester. Prenatal care initiation during the first trimester improved since 1992 when the figure was 63.8%; this trend has leveled off or declined in recent years from over 75% in 2003. PNSS also indicated that 34.1% of pregnant women enrolled in WIC by the first trimester.

At local WIC program request, a poster emphasizing the benefits of early WIC enrollment was made available to all WIC outreach staff in September (and continues to be made available).

All WIC clinics tracked (and continue to track), through quarterly reports, their progress for enrolling prenatal women in WIC in the 1st trimester. WIC outreach coordinators sought appropriate settings and strategies to outreach to women in early pregnancy. The state office worked with community coordinators to identify and implement innovative local outreach strategies. Specific strategies to reach the prenatal population early were incorporated into each local programs annual outreach plan.

To better understand the nature of disparities in care and outcomes, BFHN ODT staff conducted a comprehensive evaluation of EIPP, (a program serving very high risk women). EIPP data were linked with PELL data to conduct a population-based analysis comparing perinatal outcomes for EIPP participants with outcomes for a socio-demographically and geographically similar comparison group.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC and EIPP reach out in communities to pregnant women to encourage early enrollment into their programs, helping to reach women at risk of late entry to prenatal care.		X		
2. WIC services statewide refer for prenatal care at first contact with pregnant women.		X		
3. EIPP and FOR families programs provide assistance with accessing prenatal care and optimizing health benefits.		X		
4. BFHN continues to strengthen collaborations with state and community partners to identify and address barriers to getting early prenatal care, for example, local federally-funded Healthy Start programs.				X
5. The state Healthy Start Program administered by MassHealth insures pregnant women not eligible for MassHealth at or below 200% FPL, in order to improve access to early, comprehensive, and continuous prenatal care.	X			
6. MassCARE provides prenatal care to HIV infected pregnant women through 3 regional perinatal centers. The regional coordinators, all high-risk obstetric nurses, engage in case finding and educate community providers in treatment guidelines.	X			
7. Family Planning and other DPH-programs that include among their clients pregnant teens, as well as others at risk of late entry to care, encourage and help clients access prenatal care as early as possible.		X		
8. ODT performs statistical analyses with state birth data to monitor trends and assess populations at higher risk for late entry into prenatal care and related factors.				X
9. WIC disseminates quarterly reports to assist programs in tracking progress for enrolling women in the first trimester of pregnancy. Outreach strategies that have proven successful are shared and discussed among program outreach staff.				X
10. MDPH encourages all programs to take a life-course perspective on health care and programming leading to broad based consideration of preconception for all childbearing aged women.				X

b. Current Activities

See also Summary Chart above and State Priority Need #10.

EIPP continues its relationships with Managed Care Organizations (MCO's) to reimburse for home-visits to pregnant women to ensure that low-income women, and women living in communities with poorer birth outcomes are connected with healthcare providers early in pregnancy.

PRAMS data about prenatal care timing and related factors are now being used for ongoing assessment. Preliminary counts and percentages for 2007 first trimester care have been obtained. The 2007 MA PRAMS surveillance report was presented to the PRAMS Advisory meeting in June 2009 and suggestions for the state analytical plan were solicited. Among the

topic-specific fact sheets based on PRAMS data is one on prenatal care entry by the first trimester.

WIC developed launched a new performance management system including a measure related to early enrollment. Thus far, regular monitoring indicates that 40% of WIC participants entered the program in the 1st trimester in FY09.

MDPH encourages all programs and community partners to apply a life-course perspective on their programs and the populations they serve. This translates into promoting preconception and interconception healthcare messages that encourage all women of childbearing age to plan their pregnancies, and seek early prenatal care.

c. Plan for the Coming Year
See also SPM #9 and Priority #10.

Continue ongoing activities.

We plan to expand analysis of data related to delay in prenatal care and develop processes to better understand the current environment, including barriers, in order to develop a plan to assure women obtain prenatal care as early as possible. Current information suggests that some providers are not booking first appointments until the beginning of the second trimester. Additional information to inform work in this area, for example, about OB/GYN availability, effects of insurance changes, availability of home pregnancy testing, and cultural beliefs affecting women's choices, will be sought as part of Title V needs assessment.

For example, PRAMS data indicate that 86% of women entered prenatal care during the first trimester. Women who were white, non-Hispanic, married, had private insurance, or more than 12 years education were the only groups to reach the HP2010 target (of 90%) for early initiation of prenatal care. The most common barriers reported by mothers were: having no transportation, not being able to get a doctor's appointment, and having a doctor or health plan that would not start care as early as the mother wanted. Overall, one out of five women reported experiencing at least one barrier to receiving PNC during pregnancy. Women experiencing at least one barrier to receiving PNC were almost 3 times as likely to receive late or no PNC compared to those experiencing no barriers.

The argument has been made that women are not getting early into care because they may not know that they are pregnant until after the first trimester. However, PRAMS data show that only 5% of women were unaware of the pregnancy until after the first trimester. Women who said that they had not been trying to become pregnant were more likely to report starting prenatal care after the first trimester than women who said they had been trying to become pregnant (22% vs. 8 %). Women who said that they had wanted to become pregnant later or never were more likely to report starting prenatal care after the first trimester than women who said they had wanted to become pregnant then or sooner (24% vs. 9%).

Determine feasibility in FY10 of expanding EIPP to additional high risk communities based on available state and federal funds.

MDPH will continue to seek opportunities to encourage preconception and interconception care as part of taking a life-course perspective on women's health and maternal and child health. In this context, discussing both the need to plan pregnancies, and receive early prenatal care becomes part of any health care discussion with women at each health care visit.

D. State Performance Measures

State Performance Measure 1: *The percentage of pregnancies among women age 18 and over that are intended.*

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	75	76	76	76	79
Annual Indicator	75.6	75.6	78.4	78.4	80.3
Numerator					
Denominator					
Data Source					Mass. BRFSS bi-annual survey
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	80.3	81	81	82	82

Notes - 2008
The data for the measure are available every other year from the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS); the current survey data are for 2008. See the Detail Sheet (in Form 16) for this measure for definitions, data source and issues, and a discussion of its significance.

Our projected target rates have been raised again slightly, based on the continued improvement shown in the 2008 survey.

Notes - 2007
There were no updated data for 2007. The data for this measure are available every other year from the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS). The 2007 estimate is from the 2006 survey data. See the Detail Sheet (in Form 16) for this measure for definitions, data source and issues, and a discussion of its significance.

Our projected target rates have been raised, based on the 2006 improvements.

Notes - 2006
The data for the measure are available every other year from the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS); the reported survey data are for 2006. See the Detail Sheet (in Form 16) for this measure for definitions, data source and issues, and a discussion of its significance.

The weighted percentage has been revised - to 78.35% of pregnancies being intended -- to correct a typographical error in last year's application.

a. Last Year's Accomplishments
See also NPM #8 and SPM #3.

Family planning services funding was increased by 14% in FY08. With the implementation of health care reform, fewer women are uninsured and family planning agencies will use more of their funding for community education and outreach efforts. By late FY08, funding for these efforts had increased from 5% to 21% of total funding, while funding for clinical services decreased from 95% to 79%.

The Sharing Arrangement was implemented in 2003 to improve statewide access to hospital based termination services for low-income and uninsured pregnant women. In FY08 the FP Access Coordinator received 466 total contacts/referrals, a 13% decrease from FY07. However, there was a 6% increase in the number of contacts by program-eligible women, totaling 234 contacts in the fiscal year. Of those women who were eligible for the program, 180 had at least one abortion appointment scheduled with a participating provider, representing a 54% increase over FY07, during which 117 eligible women had appointments scheduled.

In FY08, the AIDS Action Committee and MDPH continued development of the statewide sexual health hotline and website program. The initial focus of the hotline and website was Emergency Contraception but as a result of the environmental scan and focus groups with teens, the focus was expanded to Sexual Health. The site concept - MariaTalks.com and the Statewide Sexual Health Hotline (877) MA-SEX-ED or (877) 627-3933 - was unveiled to MDPH in early 2008. The target population will be adolescents with the goal of providing accurate health information and referrals to family planning and related services.

To increase accessibility, one page downloadable "Choosing a Birth Control Method "fact sheets were developed in English and translated into Chinese and Haitian Creole, with new content on additional FP methods (e.g., Implanon and Cycle beads). The English, Chinese and Haitian Creole fact sheets were reviewed by family planning providers and focus grouped by women in the target audience to ensure cultural competency and accuracy of translation. The "Choosing a Birth Control Method" brochure continues to be available in English, Spanish and Portuguese. Over 7,500 were distributed in FY08. The brochures and fact sheets were are available online at www.maclearinghouse.com.

Because of the increased risk of unintended pregnancy among women experiencing domestic violence, an initiative was started in FY07 and continued in FY08 to train all of the state funded family planning programs. This work was an enhancement of DVSCRIP activities that became possible due to the Safe Families initiative and collaboration with the Family Violence Prevention Fund. Staff in most programs received the four-hour training or a follow-up training on intimate partner violence, connections to reproductive health issues and how to assess and care for family planning clients regarding domestic and sexual violence.

The Family Planning Program began collaboration with Ibis Reproductive Health on a research grant to do a preliminary analysis of the impact of health care reform on low-income women's access to contraception.

The 2006 BRFSS report was released. The Family Planning module was analyzed, including questions on pregnancy intentions and new questions on Emergency Contraception. In 2006:
--22% of Massachusetts women ages 18-44 reported having had an unplanned pregnancy. This is a decrease since 1998 when 30.9 % of MA women ages 18-44 reported having had an unplanned pregnancy
--80% of Massachusetts women ages 18-44 reported that they or their partner use some form of birth control.
Planning occurred for the FP sections of future BRFSS surveys and report and PRAMS.

DPECHSN perinatal programs focused education on reproductive life plan for all women of childbearing age, with emphasis on preconception and interconceptual care within home-based and center-based programs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Comprehensive clinical reproductive health care, community education and outreach are provided through a statewide family planning provider system.	X			
2. Reproductive health services are provided through Community Based Services for Women of Reproductive Age and Adolescents program sites, School Based Health Centers, and most ESHS programs.	X			
3. Family Planning and perinatal programs participate in planning and national, state and local collaborations to assure continued availability of basic reproductive health care.				X
4. Family Planning standards are set by MDPH; programs are monitored for adherence, including vendor site assessments and technical assistance.				X
5. FOR Families and EIPP home visitors assess women to determine family planning information and referral needs and follow-up referrals to family planning or primary care providers.		X		
6. Increase access to emergency contraception and sexual health services through the development of a statewide website and hotline, and inclusion of EC information and protocols in all sexual assault evidence collection kits.	X	X		
7. Collaborate with BSAS in substance abuse prevention and services (including those for youth).			X	X
8. Improve surveillance of women of reproductive age through implementation of PRAMS, as well as questions already included in the BRFSS.				X
9. Implement statewide sexual health hotline and website.		X		X
10. Train and support Family Planning providers to screen for and respond to intimate partner violence and sexual assault.				X

b. Current Activities
See also NPM #8, SPM #1 and #3, PN#9 and "Summary Sheet"

Family planning services funding was decreased by 11% in FY09 due to budget reductions.

Khmer, Russian, Vietnamese and Arabic translations of the downloadable "Choosing a Birth Control Method" fact sheets are underway or planned.

FP staff coordinates the Abortion Access Committee, a forum for clinicians, health care organizations, public health advocates and government agencies to advise the DPH on the implementation of legislative mandates and on strategies that support reproductive healthcare and reduction of unintended pregnancy.

The FP Program continued to collaborate with Ibis Reproductive Health on a 3-year grant from the National Campaign to Prevent Teen and Unplanned Pregnancy. REaDY (Reproductive Empowerment and Decision Making for Young Adults), is a coalition of Massachusetts health service providers, advocates, and researchers collaborating statewide to reduce unplanned pregnancy among young adults given health care reform in the Commonwealth. Preliminary analysis of the impact of health care reform on low-income women's access to contraception has been done. Results of the research were disseminated to FP providers in May 2009.

MariaTalks.com was launched and had over 3,100 website visits in the first 3 months of operation.

FP conducted 3 vendor site assessments.

c. Plan for the Coming Year
See also NPM #8, SPM #1 and #3, and continue ongoing activities.

Continue implementation of MariaTalks.com, the Statewide Sexual Health Hotline and Website. The site will increase access to information and referrals for EC, STD, family planning and related services. The substance abuse and HIV components of the site will be developed and implemented. Increased collaboration/links with other MDPH websites will occur and monitoring and evaluation of services will continue.

Continue the REaDY initiative. The initiative is to better understand individual, community, provider, and structural factors that influence the contraceptive behaviors of young adults aged 18-26 and develop strategies to ensure that this age group has the resources they need to lead healthy sexual and reproductive lives, including making decisions about whether/when to become parents. Ibis is leading formative research to inform actions led by a statewide, multi-agency taskforce chaired by the FP Program and coordinated by the Pro-Choice Massachusetts Foundation. These actions are to improve the health care system and better prepare health service providers to care for young adults. Supported by the National Campaign to Prevent Teen and Unplanned Pregnancy, this project promises to offer a model for addressing pregnancy prevention and planning for young adults at the state level. Research findings and lessons learned will also inform national health care reform efforts.

Obtain family planning provider review and focus-group testing necessary before developing at least two additional language versions (Khmer and Vietnamese) of the birth control fact sheets.

Family Planning program will conduct 3-4 vendor site assessments in FY10.

Family Planning program will continue with implementation of EC legislation, including development of materials specific for consumers including adolescents, the monitoring of hospital compliance with services to sexual assault survivors and the pharmacy access program. Pharmacist and interns will continue to be on staff in FY10. EC educational materials and information will continue to be distributed to adolescent service providers.

Materials and follow-up training on violence screening in family planning clinics will occur in 2010.

The Massachusetts New Parents Initiative (MNPI), a HRSA/MCHB funded innovative social marketing project (begun in FY09), will continue to develop emotion-based messages and digital stories on new parents' experience receiving family planning messages from their providers. MNPI will also develop a training manual and resources, and train providers in effectively communicating with their clients. The goal of this social marketing campaign is to improve communication between providers and new parents to encourage effective family planning.

State Performance Measure 2: *The percent of births to women who report not smoking during their current 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	91	91	92.5	92.5	93
Annual Indicator	92.4	92.5	92.5	92.3	93

Numerator	72518	71098	71813	71949	
Denominator	78460	76824	77670	77934	
Data Source					Mass. Vital Records
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	93	93	93	93	93

Notes - 2008
2008 birth data are not available. We have estimated the same rate as that for 2007. See 2007 for the most recent actual data and see the Note for 2007 for data sources and other comments.

We are not projecting any improvement in this rate from 2008 onward, primarily in light of some budget cuts in FY09 and larger additional cuts in FY10 due to the state budget crisis. These rates have previously been very sensitive to the level of state prevention and awareness programming.

See also NPM # 15 and its 2008 note for other data issues that are being reviewed. Due to differences between reported smoking rates from the birth certificate and PRAMS (which do not contain data items for precise comparison), there are some discrepancies between the future performance objectives shown for SPM #02 and NPM #15 at this time. One result of the analyses mentioned above will be a more formally coordinated set of projections.

Notes - 2007
Maternal smoking during pregnancy and resident birth data are from MDPH, Vital Records for calendar year 2007. This is the most recent year of data available.
See the Detail Sheet for this measure for definitions of the numerator and denominator and a discussion of the limitations of the data. Early success slowed or reversed in 2002 and 2003, as funding for tobacco control activities was significantly reduced. Funding has become stabilized again and was growing, but at a lower level (although it is being reduced again in FY10), and we believe that our target levels are achievable.
The rates on Form 11 may differ from those published elsewhere, due to how missing data are handled. For comparability with other MCH Core Performance Measures related to pregnancy outcomes and birth statistics, we have defined the denominator for this Negotiated Measure as all resident births during the referenced year. In other Massachusetts publications (such as Massachusetts Births), percentages are usually reported based on denominators from which birth records with information missing about the variable have been removed. The result is a lower apparent rate.
See also NPM # 15 and its 2007 note for other data issues that are being reviewed. Due to differences between reported smoking rates from the birth certificate and PRAMS (which do not contain data items for precise comparison), there are some discrepancies between the future performance objectives shown for SPM #02 and NPM #15 at this time. One result of the analyses mentioned above and described in our FY09 Planned Activities for these measures, will be a more formally coordinated set of projections.

Notes - 2006
Maternal smoking during pregnancy and resident birth data are from MDPH, Vital Records for calendar year 2006.
See the Detail Sheet for this measure for definitions of the numerator and denominator and a discussion of the limitations of the data. Early success slowed or reversed in 2002 and 2003, as funding for tobacco control activities was significantly reduced. Funding has become stabilized again and is growing, but at a lower level, and we believe that our target levels are achievable.
The rates on Form 11 may differ from those published elsewhere, due to how missing data are handled. For comparability with other MCH Core Performance Measures related to pregnancy outcomes and birth statistics, we have defined the denominator for this Negotiated Measure as all resident births during the referenced year. In other Massachusetts publications (such as

Massachusetts Births), percentages are usually reported based on denominators from which birth records with information missing about the variable have been removed. The result is a lower apparent rate.

a. Last Year's Accomplishments
See also NPM #15 for smoking cessation accomplishments targeting women after they become pregnant and Priority #2 for additional adolescent-focused accomplishments.

The Department's Massachusetts Tobacco Control Program (MTCP) funding continued to increase from $4.3M (FY06) to $8.3M (07) and $12.75M (08).

The Massachusetts Smoker's Helpline and its Quitworks fax service developed a web-based system to expand capacity during high call times. The website was integrated into MTCP's overall communications campaign website. It includes an interactive quitting tool, articles from experts, follow-ups on real people who have quit, access to other resources, and e-postcards to encourage smokers who are trying to quit.

The Helpline had 5,650 callers and Quitworks received 3,000 faxed referrals from professionals. Quitworks is a collaboration of MTCP with all major health plans linking providers and their patients who smoke to the state's cessation services.

In FY07, 8 community health centers received grants to improve their clinical protocols and medical record systems to implement systems-level, evidence-based interventions to address tobacco use. The initiative was expanded to include 19 community health centers in FY08. In FY08, 3 rural birth hospitals received grants to pilot systems change strategies to refer pregnant women to services and supports.

Community Smoking Interventions (CSIs), which address disparities in high need communities, continued in five geographic areas and two planning-phase CSIs were initiated. CSIs build on community connections, such as religious institutions, local advocacy groups and cultural organizations, to increase awareness and quitting, including among women of childbearing age.

MTCP research indicated that support was an important part of women's decisions to quit. A Fight 4 Your Life ad campaign was designed to reach people in low socioeconomic groups with higher smoking levels. The ads targeting women appealed to their health concerns and also offered support and encouragement from other women who spoke from the heart about what it meant to them to successfully quit. Telephone surveys showed a 9.4% increase in quit attempts during the campaign among the target audience (including men, for whom ads targeting their concerns were also designed). Smokers who recalled seeing the ads were 78% more likely to have made a quit attempt than those who did not.

In the Berkshire County, where the smoking rate is about 25% higher than the state average, this campaign was linked with a nicotine patch giveaway (2-week free supply) for callers to the Helpline, to which 403 smokers responded. Promotions of the giveaway by local community outreach and earned media in Lowell and Worcester, which paid special attention to linguistic minorities with higher smoking rates (Hispanic, Cambodian, Brazilian, and Portuguese), generated 1450 Helpline calls.

A 2-year MassHealth pilot of a smoking cessation benefit to Medicaid subscribers, whose smoking rate is 33% higher than the general population, was made a general benefit in FY08, after it was shown to increase the number of MassHealth smokers who quit.

Analyze and continue to collect PRAMS data to improve capacity to survey reproductive aged women throughout the Commonwealth, including the capacity to assess smoking within the last 3 months of pregnancy among Massachusetts women.

EI began collaboration with the Institute for Health and Recovery on the Massachusetts Smoke -- Free Families Initiative to promote services to at-risk families in order to integrate secondhand smoke awareness and cessation messages.

Based on FY07 training, in FY08, providers from EIPP, CHCs, and rural hospitals used the 5A counseling approach to assess interest to quit smoking and referred women to help with their smoking cessation goals.

School nurses in ESHS districts provided the following tobacco prevention/cessation services:
-- 143 tobacco group prevention meetings were held in 17 districts, in which attendance summed to 12,377 students and 149 adults.
-- 242 tobacco group cessation meetings were held in 19 districts, in which attendance summed to 548 students and 11 adults.
-- individual tobacco cessation counseling sessions were delivered to 2,035 students and 325 adults in 71 districts.
-- In 39 of the districts, students were referred to other tobacco prevention/cessation services 685 times, and adults were referred to outside sources 93 times.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue Massachusetts Tobacco Control Program (MTCP) birth hospital-based: Systems-Based Interventions to Decrease Smoking Across the Childbirth Continuum.		X		X
2. Training and technical assistance are provided to prenatal care providers on screening and brief intervention for substance use.				X
3. WIC, EIPP, and FOR Families assess pregnant women for smoking, and counsel and refer to smoking cessation services (Quitworks), in collaboration with MTCP.		X		
4. Continue surveillance of smoking among women of childbearing age, including adolescents and pregnant women, through PRAMS, the BRFSS, YRBS, and YHS.				X
5. MTCP directs multifaceted tobacco control program including Smokers Helpline, media campaigns, community programs, evaluation and surveillance, compliance checks, smoke-free workplace, second-hand smoke campaign.		X	X	X
6. Implement other MTCP interventions to assure that all health care providers who serve pregnant and postpartum women and their children are trained or retrained in the implementation of the 5A's tobacco counseling method.		X		X
7. Initiate system-wide changes to incorporate the 5 A's counseling method into the care of all women along the childbearing continuum, including documentation, coding, and tracking.				X
8. Through MTCP projects, pregnancy-specific support interventions are provided to address the woman's life circumstances.		X		
9. The QuitWorks program, a collaboration of MTCP with all major health plans, links providers & their patients who smoke to the state's cessation services, promoting services & materials tailored for pregnant women who smoke (e.g. "Ready Set Quit").		X		
10. Community Based Services for Women of Reproductive Age	X	X		

and Adolescents contracted sites provide screening and health education for smoking and referrals to community services for smoking cessation.				

b. Current Activities
Continue most FY08 activities. See also NPM #15 for smoking cessation activities targeting women after they become pregnant and Priority #2 for additional adolescent-focused activities.

An increase in the cigarette tax of $1.00, which became law and went into effect July 1, 2008, created an increased demand for cessation services for smokers. MTCP implemented a set of targeted initiatives to provide free nicotine patches to special populations of smokers whom the increased tax might motivate to quit -- veterans, people in recovery from substance abuse, and those living in certain communities.

The EI Smoke-Free Families Initiative continued, with education and materials dissemination in daycares and other community-based centers focusing on young children. The focus continues to be secondhand smoke awareness, with the offer of cessation.

c. Plan for the Coming Year
Ongoing activities continue. See also NPM #15 for smoking cessation activities targeting women after they become pregnant and Priority #2 for additional adolescent-focused activities.

Due to budget constraints, the EI Smoke-Free Families initiative will not be funded in FY 10 by the MTCP. The free nicotine patch promotions will also not be funded in FY 10, nor will the rural birth hospital programs.

As funding permits, EI, EIPP and FOR Families will continue an on-going collaboration with the Institute for Health and Recovery on the Massachusetts Smoke -- Free Families Initiative model of services to promote home visits and other services to at-risk families in order to integrate secondhand smoke awareness and cessation messages. The project is currently targeting a few communities such as Springfield and Boston that are willing to pilot the initiative. If possible, training will be offered to all home-visitors in EIPP and FOR Families.

State Performance Measure 3: *The percentage of women with an interpregnancy interval (IPI) less than 12 months.*

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			17	13.5	13.5
Annual Indicator	13.8	13.8	13.8	13.8	13.8
Numerator					
Denominator					
Data Source					PELL (linked births, hosp. dischs, & fetal deaths)
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance	13.8	13.7	13.6	13.6	13.6

Objective					

Notes - 2008
2008 birth data are not yet available for linkage. Therefore, no analysis can be done to calculate I.P.I. for 2008 using the Pregnancy to Early Life Longitudinal (PELL) data. We have estimated a similar rate to that projected for 2007, and only a gradual improvement through 2013.

Notes - 2007
2007 birth data are not yet available for linkage. Therefore, no PELL analysis can be done to calculate IPI for 2007. We have estimated a similar rate to that projected for 2006.

See 2006 Note for information on methodology and PELL data linkage details.

Notes - 2006
Data Source: PELL linked data from birth certificates and fetal death reports with hospital discharge records for mothers with deliveries. 2006 data have now been updated with final PELL data.

IPI is calculated using PELL as follows. Starting with all deliveries from 2006, women were linked to previous deliveries between 2006 and 2000. For those who had delivered twice in 2006, the latest delivery was included. Then for all women with deliveries in 2006, we linked back to the most recent delivery if available or to the last reported live birth if we were unable to link to any earlier pregnancies. IPI is calculated as the time passed between the delivery date of the first pregnancy and the start of the second pregnancy, as defined by the delivery date minus gestational age.

We calculated IPI two different ways. First we calculated it based on the delivery date of the most recent pregnancy linked. We also calculated it based on the reported date of last live birth. When we were able to calculate IPI using the most recent linked pregnancy, we used that as the final IPI. When we were unable to link any earlier pregnancies, we used the IPI as calculated based on reported date of last live birth, if available, as the final IPI. For those women for whom we could not identify an earlier delivery and who did not report an earlier live birth, IPI was not calculated.

Of the 78,382 women with deliveries in 2006, we identified 32,727 earlier deliveries. Of the 78,382 women, 76,206 were MA residents, for whom we identified 31,671 earlier deliveries. Although we were able to link back to only 31,671 earlier deliveries for MA residents, we were still able to calculate IPI for many of the women for whom we could not find deliveries because we were able to use their reported date of last live birth. Consequently, the total number of MA residents for whom IPI was calculated was 41,974 out of the 76,206.

Of the 41,974 MA residents for whom IPI was calculated, 13.8% had a short IPI defined an IPI less than twelve months. This is the final estimate for 2006.

a. Last Year's Accomplishments
Also see NPM#8 and SPM#1 for programmatic accomplishments related to this measure.

See the extensive Data Note above for 2006 for an explanation of how we calculate IPI and the data for the most current year, 2006. These final 2006 calculations were completed during FY08 and FY09.

Interpregnancy interval data was included in the 2006 annual birth report released in 2008. This report uses data from the Birth records alone, which includes the hospital's report of the date of last live birth. Inclusion of IPI as a measure in the Birth Report (using birth certificate data only) is now ongoing, which highlights the issue for a larger public.

IPI less than 6 months was also calculated. In the analysis, 5.4% of Hispanic women were

identified as pregnant again within 6 months postpartum and this finding noted for further study.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. FOR Families and EIPP provide assistance to pregnant women with accessing prenatal health care and optimizing health benefits.		X		
2. FOR Families and EIPP offer family planning counseling and referrals to all enrolled women of childbearing age.		X		
3. Improve surveillance of IPI and identification of high-risk groups and geographic areas through use of PELL data, PRAMS data, and Massachusetts Birth Data.				X
4. Encourage integration of IPI into needs assessments and program RFRs.				X
5. Integrate IPI measures into annual birth report and other MDPH publications and presentations to provide forums to discuss this issue.				X
6. Family planning and Community Based Services for Women of Reproductive Age and Adolescents providers counsel individual women pre- and inter-pregnancy about spacing pregnancies to achieve best outcomes.	X	X		
7. Report IPI related to birth outcomes in the annual release of birth certificate data.				X
8. The Massachusetts New Parents Initiative has chosen family planning as one of its social marketing focus areas	X	X		
9.				
10.				

b. Current Activities
Also see NPM#8 and SPM#1 for programmatic activities related to improving pregnancy spacing.

IPI data was included in the 2007 annual birth report released in 2009.

DPH continues to analyze the finding about Hispanic women with IPI less than 6 months in depth, as new data become available, and encourages the use of IPI for quality improvement.

WIC and EIPP providers seek to assure that women return for their 6 week postpartum visit, including discussion on family planning.
WIC staff encourage women to receive post partum visits and provide referral to family planning services as needed. An IPI of less than 16 months is one of the numerous risk factors that WIC staff determine and report for clients. In mid 2009, 14.5% of pregnant women and 7.6% of breastfeeding women in WIC had IPIs of less than 16 months.

EIPP has begun collecting data on post partum visits and identifying barriers to having participants seen by their health care provider during the 4 60 6 weeks post-partum time period. See below for issues to be addressed.

The Family Planning program monitors changes in data by community and informs providers.

In FY09, we wrote a grant, and received funding to develop an emotion-based social marketing campaign to enhance how providers engage and provide family planning services to new

mothers. Materials developed will include both digital stories and innovative emotion-based techniques to provide more effective family planning counseling to postpartum women.

c. Plan for the Coming Year
See NPM#8 and SPM#1 for most activities related to improving pregnancy spacing.

Continue ongoing activities.

The Title V agency had been interested in calculating IPI and monitoring this indicator in order to get a Medicaid waiver to pay for postpartum family planning services. In the meantime sweeping health reform legislation was passed in MA; all women should be covered now. We will continue to monitor this indicator to make sure the goal of universal coverage is realized in Massachusetts for services that promote planned and appropriately spaced pregnancies for all women.

The newly federally funded Massachusetts New Parents Initiative (MNPI) has hired a social marketing vendor who will be producing a training curriculum targeting providers of new parents on the use of developed emotion based messages. All EIPP providers will be trained in the Fall 2009 and this will include messages developed with a focus on increasing the use of family planning. In addition, the MNPI has hired a consultant who has developed and implemented a comprehensive training curriculum on the use and production of digital stories with EIPP staff who are currently working on developing digital stories with one focus including increased family planning services. Data collection and analyses activities will continue among EIPP participants.

Through the Massachusetts New Parents Initiative, results from focus groups of new parents will inform strategies that providers in multiple settings (clinics, home-visiting services, birth hospitals) can use to engage and effectively counsel new mothers in implementing a family planning method that will work to increase their interpregnancy interval.

A new PELL epidemiologist will be hired and IPI analyses will be expanded to include factors that contribute to short IPI including maternal age, race, and education. PRAMS data on pregnancy intention will be used better understanding women behaviors.

Continue to collect data in EIPP programs on post partum visits and identifying barriers to having participants seen by their health care provider during the 4 to 6 weeks post-partum time period. The most recent data found that among the EIPP participants who attended a post partum visit with a health care provider, 36% were seen between 28-47 days post partum and 61% were seen by 90 days post partum. For those who did not meet their health care providers between 4 and 6 weeks, the following barriers were reported;
• appointment not available between 4-6 weeks post partum (34%)
• client declined visit (6%)
• seen before 4 weeks and informed that an appointment between 4-6 weeks was not necessary (4%)
• transportation barriers; child care barriers; and mother unable to negotiate time off from work(3% each)

The Women of Reproductive Age and Adolescents Program will be terminated due to lack of funding.

State Performance Measure 4: *Percent of children and youth (ages 3 - 18) enrolled in Medicaid who receive preventive dental services annually.*

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			41	45	50
Annual Indicator	39.6	40.8	42.5	45.9	50.6
Numerator	143959	151089	165682	180416	201655
Denominator	363162	369993	389674	392765	398531
Data Source					Mass. Medicaid agency, HCFA Form 416
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	55	60	60	65	65

Notes - 2008
See the Detail Sheet for this measure for definitions of the numerator and denominator and a discussion of data limitations. The data correspond to those reported by DMA to HCFA on Form HCFA 416, Annual EPSDT Participation Report; the most recent data are from the period October 1, 2007 - September 30, 2008.

The rate continues to improve each year and we have adjusted some outyear Performance Objectives accordingly.

Notes - 2007
See the Detail Sheet for this measure for definitions of the numerator and denominator and a discussion of data limitations. The data correspond to those reported by DMA to HCFA on Form HCFA 416, Annual EPSDT Participation Report; the most recent data are from the period October 1, 2006 - September 30, 2007.

Notes - 2006
See the Detail Sheet for this measure for definitions of the numerator and denominator and a discussion of data limitations. The data correspond to those reported by DMA to HCFA on Form HCFA 416, Annual EPSDT Participation Report; the most recent data are from the period October 1, 2005 - September 30, 2006.

a. Last Year's Accomplishments
See also NPM # 9 and Priority Need #8

EPSDT rates increased from FY07, following a judgment in Health Care For All, Inc. et al v. Governor Mitt Romney, et al and rate increase. The dental services utilization rates among the 509.905 MassHealth eligible children are low, although children receiving dental examinations and preventive services increased to the following FY08 percentages:
• Dental Examination: 49.4%
• Prophylaxis: 44.8%
• Topical fluoride: 42.5%
• Dental Sealant: 14.1%

In addition to increasing rates, MA contracted with a third-party administrator (TPA) to coordinate Medicaid dental services and payments to providers. A cap of one patient was placed on the number of dental patients that a dentist has to accept to become a MassHealth provider. FY07providers totaled 939; FY08, 1,360. Only 12.5% (815) filed claims totaling more than $10,000 for the year.

ESHS 2007-2008 data indicate that the typical district participating in oral health screening activities screened students at an annual (median) rate of 58.5 per 1000 students for those districts with any screening, with a third of the screenings performed by school nurses. Of the ESHS districts conducting oral health activities, 38% had dental sealant services (reaching 7,285 students); 55% had fluoride rinse programs (reaching 23,715 students); and 60% made referrals to dental providers for 7,842 students.

The OOH supports the delivery of comprehensive oral health services to teens in DYS custody. Through OOH coordination of service delivery, more than 2,652 patient visits occurred in FY08, with more than 9,447 dental sealants being placed.

OOH began the direct delivery of dental screenings, sealants and topical fluoride using portable dental equipment in 6 schools with SBHCs in western MA though a pilot, named MDPH-SEAL. The OOH continues to implement Neighborhood Smiles, a dental screening and referral program for children 0-3 years of age enrolled in Early Intervention. In FY08, the program was offered to 400 children and their families.

In addition to participation in MDPH-SEAL, SBHC sites performed a number of oral health activities. Many offered dental screenings. Patients identified with dental problems, such as cavities, were referred to a SBHC sponsoring agency, a community agency or university that offered low-cost dental care to SBHC students. Some SBHCs offered dental services through collaboration with mobile dental programs; others had on-site dental clinics that included cleanings, exams and sealants. Some sites conducted classroom-based education on oral health. One site conducted a quality assurance review of their dental program, which resulted in the development of comprehensive safety training with per diem staff, interns and residents.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Office of Oral Health coordinates and provides leadership for oral health planning and activities.	X		X	X
2. Training and technical assistance are provided to school nurses and school-based health center (SBHC) clinicians re: screening for oral health needs.				X
3. WIC distributes dental health education materials as well as child and adult toothbrushes.				X
4. SBHCs, Essential School Health Services sites (ESHS), and other pediatric primary care sites screen for oral health needs, and refer for care. Some SBHCs and ESHS sites offer preventive oral health care on site.	X	X		
5. CHCs screen and refer for care and many provide on site care. Women of Reproductive Age and Adolescents contracts require CHCs to provide dental services on site or through contracted dental providers. DPH annual site visits review compliance.	X	X		
6. EIPP, FOR Families and Care Coordination for CSHCN assess and refer children for oral health needs.		X		
7. Work closely with Medicaid, providers, and other interest groups on issues of facilitating access, oral health services options, rates, and promoting preventive care.	X		X	X
8. Some Early Intervention sites offer oral screening, anticipatory guidance and referrals for needed dental care.	X	X		

9. See also activities for NPM #9 and Priority Need #8.	X		X	X
10.				

b. Current Activities
See also ongoing activities Summary Sheet above.

The Office of Oral Health (OOH) collaborates with dental and health professionals interested in developing school-based oral health programs and increasing the number of MassHealth children served in this venue. In January 2009, the Massachusetts legislature passed a bill creating a public health dental hygienist category to work without the supervision of dentist. This should assist in increasing the number of children provided preventive dental services in public health settings, such as schools. This bill will allow dental hygienists to bill MassHealth for their services directly, increasing the number of low income children receiving sealants and fluoride.
The Department continues to implement and expand MDPH-SEAL, a school-based sealant and fluoride program, in more than 25 schools in 5 different communities.

The Massachusetts Oral Health Action Plan for CSHCN has been revised and with a 4-year MCHB grant the activities are being implemented beginning with the development of a toolkit to educate child health providers on the integration of oral health into the medical home. In person trainings are being implemented statewide focused on community health centers.

The state's weekly fluoride mouthrinse program is serving about 52,000 children in living in non-fluoridated communities.

c. Plan for the Coming Year
See also NPM #9 and Priority Need #8. Current activities will continue.

The OOH will begin implementing its statewide plan for the expansion of school-based oral health prevention (sealant) programs statewide focusing on schools with greater than 50% free and reduced school lunch participation and in communities with greater than 5,000 MassHealth children.

The OOH will continue to provide fluoride mouthrinse to elementary school students in non-fluoridating communities. In FY 2010, charter public schools will be offered participation in school year 2009-2010.

Oral health trainings of medical providers including the application of fluoride varnish will continue in FY10.

State Performance Measure 6: *The extent to which the Commonwealth is making progress in developing a system to promote healthy weight, including nutrition and physical activity, as measured on a unique scale from 0 - 87.*

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			24	1	64
Annual Indicator			24	56	64
Numerator			24	56	64
Denominator	87	87	87	87	87
Data Source					Program data

Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	73	80	84	85	85

Notes - 2008
This measure is scored from a Checklist that includes five components (some with several subcomponents), each scored on a separate scale; the maximum total score is 87. See previous year's note and Notes to Form 16 (Detail Sheet) for details on components and scoring. See the Detail Sheet (in Form 16) for this measure for definitions and discussions of its significance and development.
The Checklist itself, with the FY08 scoring by component shown, is provided as an Attachment to the "Last Year's Accomplishments" sub-section of the narrative for this Measure.

Notes - 2007
This measure is scored from a Checklist that includes five components (some with several subcomponents), each scored on a separate scale; the maximum total score is 87. The components are: 1) establishment of active internal task force to assure implementation of healthy weight systems as developed; 2) establishment of consistent nutrition and physical activity messages across core DPH programs and others as appropriate; 3) promotion of these consistent messages across all core DPH programs and others, including active engagement with external partners; 4) improved policies and systems for nutrition and healthy weight in schools; and 5) capacity to measure weight status and change in key programs: Essential School Health schools, school-based health centers, and WIC programs (through PNSS). See Notes to Form 16 (Detail Sheet) for details on components and scoring. See the Detail Sheet (in Form 16) for this measure for definitions and discussions of its significance and development.

How checklist is scored: A lead person with knowledge of the topic being measured works with a team to score the checklist and to propose target scores for future years. Team members may be responsible for different elements on the checklist, depending on the nature of the element and their expertise; some elements may be jointly scored. Checklists include multiple types of elements. Some come from survey results or other instruments, which directly translate into rating scheme on the checklist. Checklist elements have been designed to be as objective as possible, e.g., specifying a number of sites in which a program should be implemented to attain a given score. For example, the person with knowledge of the number of sites implementing the program scores that element and communicates the score to the lead person. When an element has some degree of subjectivity to it (e.g. if a question is raised about what constitutes program implementation), the team members negotiate a joint score. The proposed current and projected scores are reviewed and approved by the Title V director before being finalized.

The details on the specifications and scoring system for this measure were modified after it was proposed in our FY06 Application; it has not been modified this year.

Due to a glitch in the previous version of the EHB/TVIS software, we were not able to directly enter our Annual Performance Objectives for future years. This bug has been corrected and Annual Performance Measures are now shown for Years 2008 forward. However, we could not correct the FY07 Objective – which was 53. Our actual FY07 annual score was 56, above this target.

Notes - 2006
This measure is scored from a Checklist that includes five components (some with several subcomponents), each scored on a separate scale; the maximum total score is 87. See Notes to Form 16 (Detail Sheet) for details on components and scoring. See the Detail Sheet (in Form 16) for this measure for definitions and discussions of its significance and development.

The details on the specifications and scoring system for this measure were modified after it was proposed in our FY06 Application. Further modifications – both in its content and scoring – are

possible for future years. If it is modified, any objectives and previous scoring will be adjusted if possible for accurate trend analysis.

a. Last Year's Accomplishments

High level attention to obesity was given with announcement of the HealthyMass Compact by Governor Deval Patrick and HHS Secretary JudyAnn Bigby. The DPH Commissioner convened an obesity task force with public and private organizations represented to identify and prioritize key strategies for coordinated action. A Wellness Division was established in spring 2008 within BCHAP, encompassing NPAU, Obesity Prevention and Control, and a new Worksite Wellness program.

The Nutrition Division ensured consistent message for young children and pregnant women; the NPAU for youth and across chronic disease programs. CHSP organized the School Health Collaborative convening MDPH youth-centered programs and the MA ESE.

WIC implemented in all local programs new advertising style messages connecting with parents' emotional "pulse points" for behavior change and Touching Hearts Project materials across all local programs and among community nutrition providers statewide.

In FY08. DPH completed work with the AMCHP/CityMatch Healthy Weight Action Learning Collaborative (HWALC) with Boston Public Health Commission. The HWALC completed a report that included provider interviews and focus groups with black and Latina women, ages 18-45, designed to inform provider practices and other HWALC teams across the country on healthy weight interventions, and to help frame perinatal healthy weight recommendations from a life course perspective. The report was submitted to BPHC for approval and is being widely disseminated through the city -- with a particular focus on providers who counsel women on attaining and maintaining a healthy weight through nutrition and physical activity.

With $150,000 of state funding, 2 school food vendors made changes to increase access to and promote selecting healthy foods during lunch, reaching over 15,000 students in elementary and middle schools. Schools indicated that new food had wide appeal and increased awareness of healthier food.

DPH funded 26 organizations to implement wellness activities in community, school and workplace.

WIC and Title V participated in a Children's Museum effort to revamp museum messages and programs to encourage physical activity and healthy eating, especially for children ages 1-5.

ESHS surveyed its 102 programs on their nutritional environment: 45% had nutrition/physical activity support groups with 61 meetings attended by 481 students in an average month; school nurses averaged 288 presentations with 7,133 students attending per month; 89 districts reported 91,687 BMI screenings for at least 1 of 4 grades and 51 reported for all 4 grades. Overweight/obesity ranged from a low of 28% for 10th grade females to a high of 37.8% for 4th grade males.

2008 Pregnancy Nutrition Surveillance data (released in 2009) indicated that the % of women overweight pre-pregnancy rose to 41.2% from 39.9% in 2007, continuing the secular of a gradual increase since 1990 when it was 25%. The % of WIC enrollees with greater than ideal weight gain during pregnancy remained essentially unchanged at 45.9% from the 2007 rate of 45.6%; this overall trend has also been gradually increasing since 1990 when it was 35.7%.

SBHCs were involved in a number of activities to promote healthy weight, including nutrition and physical activity, and 96% reported BMI to DPH through the ESM data system. SBHCs provided nutrition assessment and risk reduction counseling; nutrition education via health education classes and health fair displays; and assessment of physical activity, specifically sports

involvement and TV/internet time. Several SBHCs had a licensed nutritionist on site, and others provided sports physicals to students. Several conducted CQI activities for healthy weight.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Through work groups for pregnant women, young children, school age/youth, and adults, establish consistent nutrition and physical activity messages across programs and monitor their use and effectiveness.				X
2. Assure that all relevant BFHN and BCHAP programs document, monitor and evaluate the use of standard nutrition and physical activity messages.				X
3. Focusing on each population group, develop and update guidelines and standards for BFHN and BCHAP direct service programs regarding nutrition screening, education and referral.		X		X
4. Improve systems in schools with multiple initiatives through Mini-grants, Healthy Choices (HC), School Based Health Centers (SBHC), Essential School Health Services (ESHS), School Health Unit (SHU), and Coordinated School Health Program (CSHP).				X
5. Systematically engage with school personnel and affiliated groups in improving school policies and systems for nutrition and healthy weight, provide training and guidelines, and annually survey the schools to document ongoing improvement.				X
6. . Implement and continuously improve systematic collection and reporting of BMI in school age children, with a BMI workgroup including the CSHP, SHU, ESHS, and the Nutrition and Physical Activity Unit (including its program, HC).				X
7. Local WIC programs identify and implement strategies to promote healthy weight gains for pregnant women, including to improve local program baselines set in FY08 for monitoring weight gain among pregnant women.		X		X
8. WIC and EIPP assess participating pregnant and postpartum women for nutrition, BMI, and physical activity and provide appropriate counseling and referrals.		X		X
9. Implement consistent messages on healthy eating, physical activity and healthy weights in BFHN and BCAHP program services, targeting children birth to five, and evaluate the implementation and utilization of messages in program service delivery.				X
10. Continue the Massachusetts Partnership for Healthy Weight network to promote healthy nutrition and increased physical activity by fostering policy, systems, and environmental changes using evidence-based strategies and surveillance.				X

b. Current Activities

See summary chart and NPM #14. A change is that the new Wellness Division began to provide leadership to promote, develop and implement evidenced-based policies, practices and programs that support healthy lifestyles.

DPH launched Mass In Motion in January 2009 as a priority area of the HealthyMass Compact.

Mass In Motion promotes wellness to prevent overweight and obesity in Massachusetts -- with a particular focus on the importance of healthy eating and physical activity. See details of initiative in "Plan for the Coming Year".

ESHS programs did BMIs on about 91,000 students as the program already required before the MA regulations were amended.

NPAU piloted HC in Brockton elementary schools to determine affects of younger age and district level coordination on program implementation and student knowledge and behavior.

The Nutrition Division will continue to ensure the use of consistent messages for women and young children.

WIC continued to facilitate the use of emotion-based nutrition education materials in all local programs and with community nutrition partners statewide.

c. Plan for the Coming Year

Mass In Motion will expand its efforts initiated in FY09 including:

- Report on extent of the obesity epidemic in MA, its consequences and efforts to fight back.
- Support regulatory changes for healthy diet and exercise, including Body Mass Index (BMI) testing (below) and menu labeling for large chain restaurants.
- Provide wellness initiative grants to localities funded by five major health-funding foundations and other leading health organizations in the Commonwealth
- Expand a state-sponsored Workplace Wellness program to help employers create work environments that encourage healthy behaviors and reduce absenteeism and health insurance costs;
- Launch Mass in Motion website providing simple, cost-effective ways for Massachusetts' residents to improve eating habits, increase physical activity and ask experts questions about improving their diet and physical exercise routine.

Work will continue to implement the new Physical Examination Regulations in FY11. School districts receiving ESHS funds must screen BMIs in grades 1, 4, 7, and 10, send their child's results with supportive information to parents and report aggregate data to DPH per the regulations. SBHC clinicians measure BMI for all sports physicals and well-child exams, and standards require clinicians refer for elevated BMIs to a hospital or community nutritionist.

NPAU in collaboration with CSHP (Coordinated School Health Program) will release the Schools Wellness Policy Awards to recognize schools' work around nutrition, physical activity and tobacco policy implementation and enforcement in schools.

Continue Brockton Healthy Choices in 12 schools.

The Nutrition Division will continue to ensure the use of consistent messages for women and young children through Touching Hearts, Touching Minds and "Weigh of Life…Taking Action Together" Initiative materials focusing on partnering with medical providers and the messages in "Steps to Healthy Weights in Children".

WIC will provide staff follow-up training and TA to staff using its emotion-based, participant-led service delivery model to assure effectiveness. Staff will expand the use of facilitated group discussions for follow-up nutrition education for WIC families.

The "Getting to the Heart of the Matter" grant pilot phase will continue to test new emotion-based

assessment techniques to enhance WIC service delivery and opportunities for behavior change.

Funding was not appropriated for mini-grants to two food service vendors selected through competitive RFR in FY09 to promote healthy foods in schools, so this program will end.

WIC will continue messages for women for Mix 98.5FM Nutrition Buzz promotions to maintain good health and adopt habits that will contribute to healthy weight gains during pregnancy and returning to normal BMI's postpartum.

WIC will provide anticipatory guidance to families and providers regarding the implementation of the new food package, which includes key components of a diet that promotes a healthy weight.

State Performance Measure 8: *The percent of licensed child care centers serving children age birth to five who have on-site health consultation*

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	22.5	25
Annual Indicator		20	20	22.5	25
Numerator					
Denominator					
Data Source					State agency survey estimates
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	30	40	50	50	50

Notes - 2008
The annual indicator percent is an estimate based on the previous years' numbers. Much of our work in capturing this data has been put on hold as EEC is still in the process of developing an electronic record system for all licensing information, which should yield a clearer picture of ECE program CCHC utilization. Based on program staff experience and anecdotal information, we believe the actual % continues to improve slightly.

Notes - 2007
The annual indicator percent is an estimate based on the previous year’s numbers. Much of our work in capturing this data has been put on hold as EEC is currently in the process of developing an electronic record system for all licensing information, which should yield a clearer picture of ECE program CCHC utilization.

Notes - 2006
The annual indicator percent is an estimate by program staff based on information about past and current utilization of child care health consultants and surveys of child care consultants being initiated by MDPH. For 2006, responses to a preliminary survey were obtained from consultants serving approximately 50% of all child care sites.

a. Last Year's Accomplishments
Massachusetts Early Childhood Comprehensive Systems (MECCS) continues to contact centers to update the existing CCHC database. EEC is still moving forward on its electronic database, though progress has been slow due to state budget cuts and difficulty in finding an appropriate IT consulting group. The final report on consultant utilization has been completed and is currently being reviewed internally. Discussions are currently being held as to how to disseminate the

report, possible audiences and how best to utilize the information contained in the report.

MECCS provided TA on the roles of CCHCs to EEC, which has updated its child care licensing regulations and will promulgate them soon. New proposed regulations include an Individualized Health Care Plan requirement and enhanced medication administration training.

MECCS completed a text-only version of a health and safety website for child care consultants and providers. MECCS director is currently discussing next steps with IT department.

In collaboration with the BU Department of Pediatric Ophthalmology, the Massachusetts Medical Society sent a CD on the new preschool vision screening protocols to all primary care providers. The SHU gave copies to the Early Childhood Division for the health consultants.

A telephone survey to a sample of PCPs was completed regarding their use of the preschool vision protocols and an electronic survey of school nurses regarding status of implementation was sent; results of both are currently being analyzed.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Staff and complete the HRSA-funded Massachusetts Early Childhood Comprehensive Systems (MECCS) projects, including the following:				X
2. With the Head Start (HS) Quality Initiative & regional Healthy Child Care New England collaborative, provide annual, comprehensive training of Child Care Health Consultants (CCHCs), HS Health Managers and related consultants, reaching 40 per year.				X
3. Provide technical assistance to the Department of Early Care and Education (EEC) as it undertakes reform of the child care licensing regulations and begins to plan a tiered Quality Rating Scale.				X
4. Contact child care centers and CCHCs to update the MECCS database, originally created from a 2007 survey, of CCHCs' activities and barriers and supports to their work, and clean and maintain the CCHC database.				X
5. Complete the final report from the survey and build awareness of CCHCs by disseminating it.				X
6. Further build awareness by developing a brochure on How to Choose a Child Care Health Consultant, adapted from a National Training Institute for Child Care Health Consultants (UNC, Chapel Hill) brochure.				X
7. Develop a web page to share key resources for health and safety in child care with CCHCs and other Early Care and Education staff.				X
8. Convene leaders in various disciplines working with young children and their families, build on existing collaborations, develop system-wide goals and outcomes, and implement effective strategies utilizing these strong partnerships.				X
9. In collaboration with Boston University and the Massachusetts Society of Eye Physicians and Surgeons, promote preschool vision screening protocols, provide training on them, and monitor				X

their implementation at kindergarten entry.				
10.				

b. Current Activities
MECCS will support EEC in developing the infrastructure and training to support any final regulatory changes, as well as any criteria about CCHCs adopted in EEC's planned Quality Rating System. MECCS will utilize current and future CCHC data and databases to help determine any needed changes to policy or regulations regarding CCHCs and their roles.

MECCS has hired a consultant to rework the CCHC report to make it more engaging to the general public and the field, while also expanding on a brief history of health and safety in child care in the state, particularly the role of MDPH. The completion of this report will hopefully coincide with other events, such as the general promulgation of EEC's new regulations and an update of MDPH's Growing Up Healthy guide, in an effort to highlight the role of the health consultant and to promote the overall health and well-being of young children.

Due to state budget cuts across multiple agencies, MECCS' plan to develop a brochure or online resource on How to Choose a Child Care Health Consultant, adapted from a brochure developed by the National Training Institute for Child Care Health Consultants, at the UNC - Chapel Hill has been put on hold.

MECCS has "gone online" with the health and safety in child care website, which includes a link to a TA paper on NAEYC's Health requirement that MECCS completed, and is exploring the development of an interactive process for gathering users' opinions and assessing areas for improvement.

c. Plan for the Coming Year
Continue ongoing activities.

MECCS plans to further develop, clean, and maintain a database of CCHCs, which will be used to disseminate health and safety information, as well as an urgent health alerts and updates.

MECCS will support EEC in developing the infrastructure and training to support any final regulatory changes, as well as any criteria about CCHCs that might be adopted in EEC's planned Quality Rating System. MECCS will utilize current and future CCHC data and databases to help determine any needed changes to policy or regulations regarding CCHCs and their roles.

MECCS plans a campaign to build awareness of CCHCs through the dissemination of the CCHC study report and the development of a brochure or online resource on How to Choose a Child Care Health Consultant, adapted from a brochure developed by the National Training Institute for Child Care Health Consultants, at the University of North Carolina at Chapel Hill.

Obtain EEC input and approval on draft policy development guidelines for HIV in School and ECE settings. Finalize and disseminate.

State Performance Measure 9: *The extent to which perinatal health disparities are addressed at the state and local levels, collaboratively with stakeholders and community partners, as measured by a unique scale from 0 - 33.*

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			8	1	14
Annual Indicator			8	11	14
Numerator			8	11	14
Denominator	33	33	33	33	33
Data Source					Program data
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	18	20	24	27	31

Notes - 2008
This measure is scored from a Checklist that includes a sequence of six components (some with subcomponents or steps), each scored on a separate scale; the maximum total score is 33. See Notes for 2007 and the notes to Form 16 (Detail Sheet) for details on components and scoring. See the Detail Sheet (in Form 16) for this measure for definitions and discussions of its significance and development.

The Checklist itself, with the FY08 scoring by component shown, is provided as an Attachment to the "Last Year's Accomplishments" sub-section of the narrative for this Measure.

Due to a glitch in the previous version of the EHB/TVIS software, we were not able to directly enter our Annual Performance Objectives for future years. This bug has been corrected and Annual Performance Measures are now shown for Years 2008 - 2013. However, we could not correct the FY07 Objective – which was 11 (not 1).

The Checklist and its scoring, along with outyear Performance Objectives have been modified, based on greater than expected progress in FY09. (See checklist attachment under Part IV. B. (State Priorities.)

Notes - 2007
This measure is scored from a Checklist that includes a sequence of six components (some with subcomponents or steps), each scored on a separate scale; the maximum total score is 33. The components are: 1) development & implementation of a state plan & other support for programs that address perinatal disparities [Sub-components include: 1a) establishment of statewide advisory group to develop a state plan; 1b) revision & promulgation of state perinatal regulations; 1c) development of protocols to address racism in all state-supported perinatal programs; & 1d) development of statewide strategic plan with community input;]; 2) establishment of functioning community-based advisory groups in at least 5 communities with high perinatal disparities; 3) increased use of state & local data to develop community-based strategic plans; 4) MDPH engagement with communities with high perinatal disparities in development of their strategic plans; 5) completion & approval of strategic plans to address perinatal disparities in high disparity communities; and 6) the implementation of these plans. See Notes to Form 16 (Detail Sheet) for details on components and scoring.

How checklist is scored: A lead person with knowledge of the topic being measured works with a team to score the checklist and to propose target scores for future years. Team members may be responsible for different elements on the checklist, depending on the nature of the element and their expertise; some elements may be jointly scored. Checklists include multiple types of elements. Some come from survey results or other instruments, which directly translate into rating scheme on the checklist. Checklist elements have been designed to be as objective as possible, e.g., specifying a number of sites in which a program should be implemented to attain a given score. For example, the person with knowledge of the number of sites implementing the program scores that element and communicates the score to the lead person. When an element has some degree of subjectivity to it (e.g. if a question is raised about what constitutes program implementation), the team members negotiate a joint score. The proposed current and projected scores are reviewed and approved by the Title V director before being finalized.

Details on the specifications and scoring system for this measure were modified after it was proposed in our FY06 Application. Further modifications will be made to this measure during FY09, based on our first several years experience.

Due to a glitch in the previous version of the EHB/TVIS software, we were not able to directly enter our Annual Performance Objectives for future years. This bug has been corrected and Annual Performance Measures are now shown except for the FY07 Objective – which was 11 (not 1).

Notes - 2006
This measure is scored from a Checklist that includes a sequence of six components (some with subcomponents or steps), each scored on a separate scale; the maximum total score is 33. See Notes for 2007 and the notes to Form 16 (Detail Sheet) for details on components and scoring. See the Detail Sheet (in Form 16) for this measure for definitions and discussions of its significance and development.

a. Last Year's Accomplishments
See also NPMs #17 and #18, as well as Priorities #1, #4 and #10 for information on additional activities.

See the Attachment to this section for a copy of the complete checklist being used and details on scoring of this measure for FY08 by component.

In collaboration with 19 statewide perinatal advocacy and support agencies, MDPH implemented the 19th annual "Partners in Perinatal Health Conference," which provided up-to-date training and multidisciplinary networking opportunities for over 500 perinatal care providers of all levels. Workshops focused on paradigms of healthcare, the history of birth, using data to inform community action, and a variety of other topics related to perinatal health.

The March of Dimes Massachusetts Chapter Annual Prematurity Summit, held in collaboration with the MDPH and other state partners, emphasized the impact of racial and ethnic disparities on birth outcomes, creating a forum for multidisciplinary discussions for addressing racial and ethnic barriers to access care.

The Massachusetts Community Health Worker (CHW) Network Project continued to use CHWs to reduce health disparities by seeking opportunities for promoting MCH services in underserved populations, through culturally and linguistically competent outreach and collaboration building with rural health care organizations. The Massachusetts Community Health Worker Network continued to hold trainings designed specifically to teach outreach educators strategies for increasing prenatal care utilization in culturally and geographically diverse target populations.

An expert group of clinicians continues to review all pregnancy associated and pregnancy related maternal deaths in Massachusetts to establish recommendations for improving health systems and clinical care for women giving birth.

In FY08 DPH continued the CDC-funded Safe Families Project to address the link between perinatal disparities and domestic violence.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. With DPH Health Care Quality (hospital licensing), survey and educate MA Birth Hospitals to determine level of care and compliance with recent perinatal hospital regulations, and provide health and regulatory information to hospitals.				X
2. Annually analyze birth data at both the state and community level--including Perinatal Periods of Risk (PPOR), Population Attributable Risk (PAR) and risk statistics--and share results with state and community partners.				X
3. Continue to work with stakeholders and community partners to assess strengths, skills and capacity to collect and analyze data pertinent to disparities.				X
4. In collaboration with 18 statewide perinatal advocacy and support agencies, support annual "Partners in Perinatal Health Conference," reaching audiences of over 500 providers and including workshops focused on perinatal racial disparities.				X
5. The Perinatal Disparities Project actively collaborates with Fetal-Infant Mortality Review (FIMR) initiatives in Boston, Worcester and Springfield.				X
6. The Maternal Mortality Review Committee, convened by the MDPH, reviews all maternal deaths in Massachusetts and develops recommendations for clinical and systems improvement to ensure safe motherhood.				X
7. The Perinatal Advisory Committee, convened by Health Care Quality and BFHN, meets at least twice annually to review and advise DPH on perinatal services in birth hospitals.				X
8. The Perinatal Disparities Project developed a tool kit to train communities in using state and local qualitative and quantitative data related to infant and maternal outcomes to identify priorities and inform policy and strategic planning. This kit i				X
9. Participate with Boston Public Health Commission and 7 other states in AMCHP/CityMatch Learning collaborative to promote healthy weight in women of reproductive age in Boston, with emphasis on African-American & Hispanic communities.		X		X
10. Community Services for Women of Reproductive Age and Adolescents aims to improve perinatal outcomes through reducing health disparities and improving health status for women and adolescents.		X		X

b. Current Activities
See Summary Sheet above, NPMs #17 and 18, as well as Priorities #1, #4 and #10.

Collaboration continued with Boston, Worcester and Springfield to implement community plans. In Springfield, presentation of population-attributable risk (PAR) analysis of LBW/VLBW highlighting the high risk attributable to Black race and Hispanic ethnicity helped move forward a DPH collaboration with local partners including the FIMR to conduct focus groups with black and Hispanic women on the perception of care they received while pregnant, giving birth or in the postpartum period, and impact of racism on it. DPH staff presented at a Grand Rounds at Baystate Medical Center in Springfield to review quantitative and qualitative Springfield data and discuss how providers can review their respective practices to address outcome disparities.

The Perinatal Disparities Project, with funding from AMCHP mini-grants, finished training of community partners in using data to evaluate programs and influence policy, and developed and disseminated a toolkit to community partners.

The Safe Families Project, a collaboration between AMCHP and the Family Violence Prevention

Fund, was completed. It built capacity of state-level MCH professionals and their community partners to integrate family violence prevention, assessment and intervention into community-based MCH programming.

The Massachusetts Community Health Worker Initiative is collaborating with relevant MDPH staff to plan a sustainable CHW program.

c. Plan for the Coming Year
See also NPMs #17 and #18, as well as Priorities #1, #4 and #10 for information on additional activities.

Continue ongoing activities.

The Perinatal Disparities Project completed its tool kit in the past year and will work with additional communities to provide training and technical assistance in developing plans to use state and local qualitative and quantitative data to inform policy and identify program priorities. The MDPH will continue providing technical assistance in evaluating disparities at the community level. In the coming year, the project will seek support for establishing a formal communication network between Massachusetts communities to encourage information sharing, raise public awareness, and advocate for resources to eliminate institutional racism, or the differential access to goods, services, and opportunities of society by race. The initial forum for this communication may be a summit or regional conferences/meeting. This project will continue to collaborate with NE regional efforts to train stakeholders in a lifecourse approach to women's health with an emphasis on preconception care.

The Perinatal Advisory Committee will continue to meet to review perinatal clinical care provided in Massachusetts Birth Hospitals, and establish or review QI in each institution. The Perinatal Data Committee, having just received IRB/24AB approval, will develop a plan for reviewing data to establish a baseline for assessing whether all infants are born at the appropriate level hospital for their medical needs.

In FY10, all EIPP's will be required to sign and implement the CLAS requirements as a condition of their contract. At the end of FY10 reviewing that they have done this will become a part of their annual performance review and a condition for on-going funding.

The scope of the Massachusetts Community Health Worker Initiative in FY10 will be affected by state budget cuts. It is meant to implement Section 110 of Massachusetts health care reform legislation (Chapter 58). Section 110 calls for the MDPH to: 1) Conduct an investigation to determine a) The current use and funding of community health workers (CHWs) in Massachusetts; b) The effectiveness and unique role of CHWs in increasing access to health care, particularly Medicaid-funded health and public health services; c) The effectiveness and unique role of CHWs in eliminating health disparities among vulnerable populations; 2) Convene a statewide advisory council to assist in developing recommendations for a sustainable community health worker program in Massachusetts.; and 3) Make a report, including the results of the investigation and recommendations for a sustainable CHW program, to the general court.

State Performance Measure 10: *The percentage of adolescents reporting no current use (in past 30 days) of either alcohol or illicit drugs.*

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			59	59	66
Annual Indicator		59	59	66	66
Numerator					
Denominator					
Data Source					MA bi-annual Youth Hlth Survey
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	67	67	68	68	69

Notes - 2008
This measure is based on information from the Massachusetts Youth Health Survey (MYHS). Because the MYHS results are reported as population-based estimates based on weighted survey data, only the percent will be reported, without numerators and denominators. Because the survey is conducted every other year, there are no new data for FY08 and the results of the 2007 survey are reported.

Notes - 2007
This measure is based on information from the Massachusetts Youth Health Survey (MYHS). Because the MYHS results are reported as population-based estimates based on weighted survey data, only the percent will be reported, without numerators and denominators. The survey is conducted every other year and the data have been refreshed from the FY07 survey.
Illicit drug use asked about includes those in the HP 2010 definition (with the exception that hashish is not asked), plus specific questions about "club drugs," over-the-counter drugs to get high; use without a prescription of steroids, Ritalin or Oxycontin; and drugs from prescriptions that weren't his/her own.
In 2004 on MYHS, over half (59%) of Massachusetts middle and high school students reported no alcohol or drug use. This became the baseline for this new state measure.

Notes - 2006
This measure is based on information from the Massachusetts Youth Health Survey (MYHS). Because the MYHS results are reported as population-based estimates based on weighted survey data, only the percent will be reported, without numerators and denominators. Because the survey is conducted every other year, there are no new data to report for FY06. However, the FY07 survey has just been completed and initial analyses made available. Based on that preliminary information, we have modified future year objectives upward.
Illicit drug use asked about includes those in the HP 2010 definition (with the exception that hashish is not asked), plus specific questions about "club drugs," over-the-counter drugs to get high; use without a prescription of steroids, Ritalin or Oxycontin; and drugs from prescriptions that weren't his/her own.
In 2004 on MYHS, over half (59%) of Massachusetts middle and high school students reported no alcohol or drug use. This is the baseline for this new state measure.

a. Last Year's Accomplishments
Implementation of the state's Substance Abuse Strategic Plan strengthened responses to substance abuse (SA) issues regarding adolescents:
--Implementation plans began to standardize alcohol and drug screening, assessment & referral services within DPH Bureau of Substance Abuse Services (BSAS), BFCH, other EHS agencies & juvenile courts.

--28 BSAS-funded community coalitions in MA provided science/evidence-based substance abuse Prevention Programs to prevent SA (especially underage drinking), marijuana, and other drug abuse among children, pre-K to youth up to 18 years of age. Of the 28 programs, 12 implemented environmental approaches seeking to change the overall context within which substance abuse occur, focusing on substance availability, norms and regulations. The other 16

programs implemented other program/strategies from the Center for Substance Abuse and Mental Health Services Administration Center for Substance Abuse Prevention's (CSAP) science/evidence-based models list. Programs served 126,345 individuals.

--BSAS offered Prevention Programs training ranging from individual on-site orientations to a broad public health primary prevention conference. BSAS Prevention Programs also received technical assistance on MIS and CSAP Core Measures. Free social marketing oriented materials and other resources were highlighted on the BSAS web page.

--BSAS supported 6 Regional Centers for Healthy Communities (RCHCs) to train community residents, organizations and coalitions to become leaders to prevent alcohol, tobacco, and other drug (ATOD) abuse. Special emphasis was placed on science/evidence-based principles, strategies, models and environmental strategies. The RCHCs provided training and technical assistance to groups within their local communities and served 16,232 individuals. Representatives from the RCHCs served on the Gay, Lesbian, Bisexual and Transgender Task Force, the Media Production Committee and the Massachusetts Epidemiological Workgroup.

--BSAS involved youth in all stages of planning as it continued to develop and implement youth-oriented activities in ATOD-free settings. After-school programs included creative writing contests, photography, theater productions, community service, adventure and team-building activities.

--BSAS facilitated 49 Underage Drinking Prevention Town Hall meetings, an underage drinking campaign on the various state transportation systems and continued an OxyContin prevention campaign including youth-oriented messages.

--Contracts awarded for intensive early intervention case management programs targeting at-risk youth and families.

--BSAS Office of Youth and Young Adult Services (OYYAS) began to collect information on youth entering the state treatment system via the Youth Outcome Monitoring survey. The survey tracks adolescents' risk and progress during and after residential SA treatment and is the first initiative in MA to collect longitudinal data on this population.

--OYYAS sponsored a 2-day training on trauma-informed SA treatment for adolescent girls, conducted by Dr. Stephanie Covington.

--BSAS hosted trainings for clinicians on evidence-based practices, such as the GAIN bio-psychosocial assessment tool, Motivational Interviewing, and CBT/MET.

--BSAS has continued to fund adolescent residential treatment programs that are gender-specific, trauma-informed, and able to address co-occurring mental health needs. The programs provide SA treatment as well as adolescents' other health needs, such as medical and dental visits.

--Three Recovery High Schools continue to operate with an average of 30 students enrolled per school and over 90% attendance.

--Grants continue with 7 school districts to implement an evidence-based early intervention program for elementary and middle school students (CASASTART). The program identifies youth exhibiting risk factors (individual risk, family risk, school-based risk) for substance use problems and provides intensive, family-centered case management for up to two years.

The School Health Institute offered a program on drugs and poisonings to 63 school nurses and, with DOE, on motivational interviewing for 114 school nurses.

The new School Health Manual was distributed including chapter on addictions and the CRAFFT

and other screening tools.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. BFHN and BCHAP collaborate on a variety of youth programs and initiatives conducted by BSAS to prevent alcohol and illicit drug use and support community-based programs that target known risk and protective factors.				X
2. Support implementation of the state's Substance Abuse Strategic Plan including multiple policy and programmatic initiatives and an epidemiological work group conducting state and local needs/resource assessment and gap analysis.				X
3. Provide screening, assessment and treatment services for male and female pre-adolescents and adolescents, and continue to increase access to services, including specialized services for high risk youth (e.g., out of school, special health needs).	X	X	X	
4. Increase systematic screening and intervention for substance use and other adolescent risk behaviors, through a DPH-wide Youth and Young Adult Work Group.			X	X
5. Through BSAS, train MCH vendor clinicians (including SBHC) and, through The School Health Institute, train school nurses and other school personnel re substance abuse including (as relevant) prevention, screening, assessment and treatment.				X
6. Enhance collaboration with the Office for Healthy Communities and Tobacco Control Program to develop, maintain, and support BSAS Prevention Programs and the Regional Centers for Healthy Communities (formerly the Prevention Centers).		X		X
7. Promote and support increased youth involvement in the planning and implementing of youth-focused health initiatives.				X
8. Support local community coalitions, including BSAS funding for science/evidence-based prevention programs to address environmental & other sources of risk and protective factors (community-specific or statewide).			X	X
9. Implement public information campaigns using paid media and social marketing techniques to promote culturally competent primary prevention among youth.				X
10. Conduct substance abuse surveillance through the combined Youth Health Survey and Youth Risk Behavior Survey and collect/analyze service and/or outcome data from BSAS, BFHN and BCHAP youth programs.				X

b. Current Activities

BSAS reprocured its Prevention System, funding 31 Prevention Programs with a particular focus on Underage Drinking and with a SAMHSA grant funded 15 communities to implement evidence-based strategies to prevent/reduce unintended fatal and non-fatal opioid overdoses.

BSAS continues to fund a pilot program, the School Community Partnership, in 6 communities. It is a media program that involves teachers, youth and media experts to design a media campaign for each school.

BSAS opened the first state-funded youth stabilization/detoxification unit in Worcester in October.

OYYAS hosted a 2-day training on SA treatment for adolescent girls and a 1-day training on adolescent males in SA treatment.

Residential programs, recovery high schools, a juvenile drug court, and the DYS CASASTART now all use the Youth Outcome Monitoring survey.

OYYAS sponsored 1st statewide meeting of providers & state agencies serving youth & young adults.

OYYAS hosted a job/internship fair for current students & recent graduates interested in working in the adolescent SA treatment field.

To open access to services, Central Intake and Care Coordination for residential treatment programs was established.

A workgroup (that includes DPH) of the Children's Mental Health Task Force focused on early ID of substance use, integration of ongoing screening and linkage of evidence-based treatment programs with primary care. It endorsed CRAFFT, trained trainers, and is developing a tool kit for pediatric primary care settings.

c. Plan for the Coming Year

BSAS will fully implement 31 Prevention Programs with a particular focus on Underage Drinking and, with a grant from the Substance Abuse Mental Health Services Administration, Center for Substance Abuse Prevention, 15 communities to implement evidence-based strategies focused on the prevention/reduction of unintended fatal and non-fatal opioid overdoses. The Regional Center for Healthy Community System, funded by BSAS will continue to provide training, technical assistance and support to all BSAS funded Prevention programs.

BSAS will continue to fund a pilot program, the School Community Partnership, in 6 communities across the Commonwealth. The pilot program is a media-based prevention program will continue to involve teachers, youth and media experts to design a media campaign for each school.

BSAS has procured and will fund a second youth stabilization and detoxification unit in Brockton. An expected start date for implementation is Fall, 2008.

OYYAS will sponsor the second annual statewide meeting of providers and state agencies serving MA youth and young adults.

BSAS will continue to sponsor trainings on evidence-based practices for providers working with adolescents in substance abuse treatment settings. One specific initiative is to hold a training and begin ongoing coaching with Dr. Dave Mee-Lee on the ASAM Adolescent Patient Placement Criteria in FY09.

State Performance Measure 11: *The percentage of Massachusetts births that occur in a hospital that has an active Shaken Baby Syndrome Prevention Program.*

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
Annual Indicator				0.0	76
Numerator				0	
Denominator				78000	
Data Source					Program data
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
This is a new State Performance Measure which was added in FY09. The percentage rate is estimated from preliminary baseline information from program staff. Based on the rate of adoption of the program model, we now expect all hospitals to have active programs by the end of FY09. As a result, the measure may be modified or dropped during our 5-Year needs assessment process.

Notes - 2007
Not Applicable. This is a new State Performance Measure which was added in FY09.

a. Last Year's Accomplishments
Not applicable. This is a new State Performance Measure for FY09.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Convene and support the Shaken Baby Syndrome Prevention Advisory Group with representatives from key state agencies, parent and advocacy groups, to guide DPH in implementing the SBSP Initiative.				X
2. Administer state budget funding and maintain staff.				X
3. DPH collaborates with Children's Trust Fund (CTF) and DCF hospital-based education of new parents and works closely with a Hospital Program Subcommittee of the Advisory Board.		X		X
4. Issue Guidelines and assist hospitals to comply with legislation and Advisory Group recommendations, including one-on-one education by nurse educators and written materials to all new parents.				X
5. Financially support Massachusetts parental support hotline.		X		X
6. Develop and provide hospitals with educational materials for parents in many languages, and with fact sheets for nurses on how to talk with parents about this topic.				X
7. Create fact sheets and a Talking Points brochure for DCF social workers to assist them in prevention education with their clients; DSS implement prevention education program.				X
8. Support CTF training for community-based providers who serve infants and children and their caregivers and for "trained-trainers," who make a commitment to train other professionals in their agencies and communities, including at DSS Area Offices.				X
9.				
10.				

b. Current Activities
Continue or began key activities listed in the "Summary Chart, including active Advisory Group."

A priority is the implementation of the statutory requirement that all maternity hospitals have a plan in place for training new parents/caregivers on Shaken Baby Syndrome Prevention. We have surpassed our performance objectives goals by training all maternity hospitals' staff by May 2009! (See Plans for the Coming Year section below for more information on how this was accomplished.)
Over 163,000 copies of parent education materials developed for maternity hospitals by DPH have been ordered, many by other organizations working with parents and families.

Established an Interagency Service Agreement with CTF to support community provider training. As of April 2008, CTF had directly trained more than 1800 people in multiple communities and 75 "trained-trainers" including in more than ¾ of DSS Area Offices and other sites.

Began work with WIC training their staff in infant soothing methods so they can educate their clients.

Began working with a subcommittee of the Advisory Group to develop a pilot surveillance strategy to clarify the number of cases of SBS identified annually in hospitals.

Collaborated with developing local effort in Middlesex County and tracked ongoing efforts in Worcester and Berkshire Counties.

c. Plan for the Coming Year

We expect to be able to meet the State Performance Measure 11 ahead of schedule (100% by the end of FY2009) primarily due to five important assets of the program:
1. The Initiative is a multidisciplinary collaboration among state agencies, nonprofits, and professionals. Participants include pediatricians, social workers, and managers of service agencies, including Early Intervention and The Parental Stress Line. DPH, the Children's Trust Fund, and the Dept of Children and Families are lead agencies. This statewide collaboration was able to create a Hospital Program Committee which worked extensively on the content and structure of the strength-based education program in the maternity hospitals.

2. DPH made the hospital education program top priority, and focused on providing all the maternity hospitals with everything they needed to begin educating parents of newborns.

3. DPH trained a team of 4 highly experienced Master's prepared nurse educators, and created a Power point presentation for their use. These nurse educators conducted trainings in the hospitals for their nursing staff on SBS and on talking to parents about prevention as required by the legislation.

4. DPH kept in close touch the hospitals and responded quickly to their needs. "All Babies Cry," the fact sheet which fulfills the requirement of printed information for parents, was made available free in 7 languages. For hospitals that wanted the option of computer based training (e.g. for new staff and reviews), DPH created such an option with a posttest and answers. A Train the Trainer curriculum allows hospitals to designate managers or clinical leaders to be trained as experts to educate their own staff. Anticipating that some nurses would find the topic difficult to discuss, DPH created a guide, "Tips on Talking with New Parents about Preventing Shaken Baby Syndrome," which has been widely used and appreciated.

5. Almost all the hospitals were extremely cooperative. Some had been doing SBS prevention education previously and most of those who had not were eager to begin doing so.

In FY10 the Department anticipates a significant reduction in the state funding that supports current activities. This will curtail the program's efforts, but they will include:

Continue to support the Children's Trust Fund to provide training of community-based providers on SBS prevention.

Work with VIDA Communications as they implement an NIH grant to develop an SBS Prevention education video for new parents/caregivers.

Develop a strategy to provide support to emergency departments. Because staff in these settings may not be available for training, this may take the form of accessing materials for parents with crying infants so that they make a role in prevention education.

Continue efforts to develop improved surveillance of abusive head injuries in infants.

Work with the Advisory Group to develop shared learning objectives and strategies for community-based trainings modeled on the hospital program.

E. Health Status Indicators

Introduction

/2010/ The Health Status Indicators are all actively used by Massachusetts to track the health of the Commonwealth and to inform public health policy and practice. These indicators are part of a much larger set of indicators that are routinely reviewed and that help shape efforts to reduce health disparities and target programs appropriately. Analyses by race, ethnicity, age, and other characteristics -- at both the state and local levels -- are key components of our approach. A particular emphasis is working with communities at greatest risk to develop their own capacity to use data to create, implement, and monitor strategic plans. These indicators are also among the risk indicators that we use for tracking and early identification and for needs assessments for procuring community-based services. Massachusetts has been a leader in the development of programs based on data analysis. We have dedicated epidemiology resources and provide leadership using surveillance data, expanding data utilization and applying data to public health policy.

These HSIs are closely related to a number of NPMs, SPMs, and Priority Needs. There is additional information in those sections of the narrative:
For HSIs 1A, 1B, 2A, 2B
NPMs # 8, 15, 17, and 18
SPM # 1, 2, 3, 9
Priority Need # 4
For HSIs 3A, 3B, 3C, 4A, 4B, 4C:
NPM # 10
SPM # 8, 10
Priority Needs #4 and 7
For HSIs 5A, 5B:
NPM # 8, 18
SPM # 1
Priority Need # 4
//2010//

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	7.8	7.9	7.9	7.9	7.9
Numerator	6125	6073	6150	6147	
Denominator	78460	76824	77670	77934	
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
2008 birth data are not available. We have estimated the same rate as that for 2007. See 2007 for the most recent actual data and see the Note for 2007 for data sources and other comments.

Notes - 2007
Data for both the numerator and denominator are taken from MDPH Vital Records for calendar year 2007. This is the most recent year of data available. The denominator is all resident births for the year.

Notes - 2006
Data for both the numerator and denominator are taken from MDPH Vital Records for calendar year 2006. The denominator is all resident births for the year.

Narrative:
/2010/ Low birthweight infants (LBW, weighing less than 2,500 grams) are at increased risk of morbidity and mortality compared with infants of normal weight and are at higher risk of delayed development and poor school achievement later in life. MDPH uses this HSI to monitor the prevalence of LBW infants and to track progress toward achieving the Healthy People 2010 goal of 5% LBW births. The percentage of LBW infants in MA in 2007 (7.9%) was 36% higher than it was in 1990 (5.8%). Since 2005, LBW births have remained stable. Data on the percentage of births that are LBW are published annually and widely disseminated in the Massachusetts Birth Book. The proportion of LBW in each community is compared with other communities and the overall state LBW percentage. Each year with the release of the Birth Book, MDPH creates Community Packets which provide city/town specific data on the proportion of LBW infants among infants born to teen mothers and among infants who died in the first year of life. Data on percent LBW and preterm infants born at each maternal and newborn care facility in MA are also used to monitor adherence to new perinatal regulations, implemented in March 2006, to ensure that infants are born at birth hospitals licensed at a level of care that is appropriate for their anticipated level of need. This HSI also enables MDPH to monitor disparities in low birthweight by race/ethnicity and other socio-demographic factors (e.g., Medicaid vs. non-Medicaid). With the full implementation of PRAMS (starting with 2007 births) and ongoing linkages in the population-based Pregnancy to Early Life Longitudinal Data System we have steady access to information on perinatal risk factors associated with adverse birth outcomes including low birthweight. Findings from such analyses can be used to inform efforts to develop effective, targeted interventions for the prevention of prematurity and low birthweight, both at the state level and in concert with local areas at particular risk. //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	5.4	5.6	5.8	5.7	5.7
Numerator	4015	4126	4264	4258	
Denominator	74677	73258	74146	74498	
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
2008 birth data are not available. We have estimated the same rate as that for 2007. See 2007 for the most recent actual data and see the Note for 2007 for data sources and other comments.

Notes - 2007
Data for both the numerator and denominator are taken from MDPH Vital Records for calendar year 2007. This is the most recent year of data available. The denominator is all resident singleton births for the year.

Notes - 2006
Data for both the numerator and denominator are taken from MDPH Vital Records for calendar year 2006. The denominator is all resident singleton births for the year.

Narrative:
/2010/ The percentage of LBW infants among multiple births is much larger than among singletons. In addition to monitoring the overall prevalence of low birthweight infants (as described under HSI#01A), MDPH stratifies LBW trends by plurality. This allows an estimation of what proportion of the increase in low birthweight births can be accounted for by the increase in multiple births. Data are analyzed by plurality and maternal age. In 2007, 5.7% of singleton births were LBW, whereas 53.6% of twins and 92.9% of higher order births were LBW. The percentage of births that were multiples has been stable over the last three years. The total percentage of multiple births (twins, triplets or more) was 4.4% in 2007, which has decreased 8% from 2004 (4.8%). White mothers continue to have the highest percentage of multiple births. These data are published annually and widely disseminated in the Massachusetts Birth Book. //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	1.5	1.4	1.3	1.4	1.4
Numerator	1148	1098	1041	1053	
Denominator	78460	76824	77670	77934	
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
2008 birth data are not available. We have estimated the same rate as that for 2007. See 2007 for the most recent actual data and see the Note for 2007 for data sources and other comments.

Notes - 2007
Data for both the numerator and denominator are taken from MDPH Vital Records for calendar year 2007. This is the most recent year of data available. The denominator is all resident births for the year.

Notes - 2006
Data for both the numerator and denominator are taken from MDPH Vital Records for calendar year 2006. The denominator is all resident births for the year.

Narrative:
/2010/ In addition to the reasons described under HSI#01A for monitoring LBW births in general, the percent of live births that are very low birth weight (VLBW, weighing less than 1,500 grams) is of primary importance since these infants are at highest risk of morbidity and mortality. MDPH uses this HSI to monitor the prevalence of VLBW infants and to track progress toward achieving the Healthy People 2010 goal of 0.9% LBW births. These data are published annually and widely disseminated in the Massachusetts Birth Book. Each year with the release of the Birth Book, MDPH creates Community Packets which provide city/town specific data on the proportion of VLBW infants among infants born to teen mothers and among infants who died in the first year of life. Data on percent VLBW and preterm infants born at each maternal and newborn care facility in MA are also used to monitor adherence to new perinatal regulations, implemented in March 2006, to ensure that infants are born at birth hospitals licensed at a level of care that is appropriate for their anticipated level of need. This HSI also enables MDPH to monitor disparities in VLBW by race/ethnicity and other socio-demographic factors (e.g., Medicaid vs. non-Medicaid). //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	1.0	1.0	0.9	0.9	0.9
Numerator	740	701	687	693	
Denominator	74677	73258	74146	74498	
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
2008 birth data are not available. We have estimated the same rate as that for 2007. See 2007 for the most recent actual data and see the Note for 2007 for data sources and other comments.

Notes - 2007
Data for both the numerator and denominator are taken from MDPH Vital Records for calendar year 2007. This is the most recent year of data available. The denominator is all resident singleton births for the year.

Notes - 2006
Data for both the numerator and denominator are taken from MDPH Vital Records for calendar year 2006. The denominator is all resident singleton births for the year.

Narrative:
/2010/ The percentage of VLBW infants among multiple births is much larger than among singletons. In addition to monitoring the overall prevalence of VLBW infants (as described under HSI#02A), MDPH stratifies trends in VLBW by plurality. This allows an estimation of what proportion of the increase in VLBW births can be accounted for by the increase in multiple births. Data are analyzed by plurality and maternal age. These data are published annually and widely disseminated in the Massachusetts Birth Book. //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	3.1	3.2	3.4	2.9	3
Numerator	38	39	41	34	
Denominator	1222774	1214584	1202482	1188128	
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
2008 death data are not available. We have estimated a similar rate to that for 2007. See 2007 for the most recent actual data and see the Note for 2007 for data sources and other comments.

Notes - 2007
Data on deaths are taken from MDPH Vital Records for calendar years 2005-2007. Rates are calculated as rolling 3-year averages. (I.e. the 2006 numerator is the sum of the 2005, 2006, and 2007 numbers of deaths (37,41, and 23 respectively) and the denominator is the sum of the most recent Massachusetts population estimates for the age group for the same years, as provided by the MDPH Bureau of Health Information, Statistics, Research and Evaluation. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere.

Notes - 2006
Data on deaths are taken from MDPH Vital Records for calendar years 2004 - 2006. Rates are calculated as rolling 3-year averages. (I.e. the 2006 numerator is the sum of the 2004, 2005, and 2006 numbers of deaths (44, 37, and 41 respectively) and the denominator is the sum of the Massachusetts population estimates for the age group for the same years, as provided by the

MDPH Bureau of Health Information, Statistics, Research and Evaluation. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere.

Narrative:
/2010/ The six Health Status Indicators dealing with unintentional injuries to children and adolescents are core MCH and public health indicators used on a regular basis for a number of purposes. Massachusetts has been a leader in the development of injury prevention and control programs based on data analysis. We have dedicated epidemiology resources and provide leadership using injury surveillance data, expanding data utilization and applying data to public health policy. Surveillance of unintentional injuries utilizing statewide death and hospital discharge data and dissemination of findings to DPH program staff as well as state and local audiences continues.

Unintentional injuries are the leading cause of death among MA children aged 1-14 years of age. From 1990 to 2007 the unintentional injury death rate for children 0 to 14 yrs declined from 6.2 to 2.0 per 100,000 (N=71 and N= 23, respectively). Our ongoing surveillance of these deaths includes examination of data by age subgroups (<1, 1-4, 5-9 and 10-14 years), sex, race/ethnicity, and by injury cause. The data indicate that the cause of unintentional injury deaths among children in MA varies by age subgroup, with suffocation the leading cause among infants, drowning the leading cause among children 1-4 years, and motor vehicle traffic (including occupant, bicyclists and pedestrian) the leading cause among children 5-14 years. These data, derived from our Vital Records, are used in conjunction with population-based data sources containing information on the magnitude, causes and risk factors for nonfatal injuries in MA, providing us with a rich and comprehensive picture of the injury problem within the Commonwealth.

Unintentional injury death data for MA children 0-14 years have been disseminated in our annual comprehensive state death report (the injury epidemiologist assists in the analysis and written presentation of the injury chapter of this report and conducts additional analyses targeted more specifically on children and youth), as well as in a variety of injury specific reports, presentations, in numerous custom data requests from a variety of public and private organizations, and in MassCHIP, the MDPH's publicly accessible query-based web site. These data have also been shared with and utilized by state agency work groups (including an interagency group working on infant safe sleep), our state and child fatality review (CFR) teams (this data was presented by the injury epidemiologist at a statewide CFR conference in 10/08), and have been included in a number of grant applications aimed at securing resources to address this problem (including a CDC supplemental injury prevention grant aimed at the development of a child injury prevention policy plan and a State and Territorial Injury Prevention Directors Association (STIPDA) sponsored roundtable on pedestrian safety). //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	1.2	1.3	1.2	0.8	1
Numerator	15	16	14	9	
Denominator	1222774	1214584	1202482	1188128	
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
2008 death data are not available. We have estimated a similar rate as that for 2007. See 2007 for the most recent actual data and see the Note for 2007 for data sources and other comments.

Notes - 2007
Data on deaths are taken from MDPH Vital Records for calendar years 2005 - 2007. Rates are calculated as rolling 3-year averages. (I.e. the 2006 numerator is the sum of the 2005, 2006, and 2007 numbers of deaths (10, 12, and 5 respectively) and the denominator is the sum of the most recent Massachusetts population estimates for the age group for the same years, as provided by the MDPH Bureau of Health Information, Statistics, Research and Evaluation. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere.

Notes - 2006
Data on deaths are taken from MDPH Vital Records for calendar years 2004 - 2006. Rates are calculated as rolling 3-year averages. (I.e. the 2006 numerator is the sum of the 2004, 2005, and 2006 numbers of deaths (19, 1, and 12 respectively) and the denominator is the sum of the Massachusetts population estimates for the age group for the same years, as provided by the MDPH Bureau of Health Information, Statistics, Research and Evaluation. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere.

Narrative:
/2010/ See general comments under Health Status Indicator # 03A. Subsequent analyses on this HSI enable us to examine the proportion of motor vehicle-related deaths by person type (occupant, motorcyclist, MV-pedestrian, and MV-bicyclist) and by age group. Our child booster seat law went into effect June 8, 2008 and this HSI will be used to evaluate the impact of this law.

We have also used our pedestrian death and nonfatal data to understand the magnitude of the pedestrian injury problem around MA by age subgroup and geographic region. In the spring of 2009 we utilized our MV-pedestrian data to apply for, and were subsequently awarded, an opportunity to attend a national roundtable on pedestrian safety sponsored by STIPDA. We also assisted the SAFEKIDS coalition with their annual Safe Routes To School project in the city of Holyoke, a poor community in western MA. This data will be used to evaluate the impact of that project.

We have used data on occupant injuries extensively in our work to promote a primary seat belt law in MA, incorporating the data findings into a fact sheet which has been used widely by policy makers. //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	15.0	13.0	13.3	14.2	14.2
Numerator	128	111	119	129	
Denominator	851425	851856	895707	906161	
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
2008 death data are not available. We have estimated the same rate to that for 2007. See 2007 for the most recent actual data and see the Note for 2007 for data sources and other comments.

Notes - 2007
Data on deaths are taken from MDPH Vital Records for calendar year 2007 (the most recent year available). The 2007 denominator is from the most recent population estimates for Massachusetts, as provided by the MDPH Bureau of Health Information, Statistics, Research and Evaluation. The resulting denominator and age-specific rate may differ from those previously reported or published elsewhere.

Notes - 2006
Data on deaths are taken from MDPH Vital Records for calendar year 2006. The 2006 denominator is from population estimates for Massachusetts, as provided by the MDPH Bureau of Health Information, Statistics, Research and Evaluation. The resulting denominator and age-specific rate may differ from those previously reported or published elsewhere.

Narrative:
/2010/ See general comments under Health Status Indicator # 03A and HSI #03B. Recent examples of using data on unintentional injuries due to motor vehicle crashes among adolescents and young adults to influence policy and practice are partnering with the Injury Community Planning Group, known as the Massachusetts Prevent Injuries Now Network (Mass PINN) and the MA Coalition for Adolescent Road Safety to create an educational and marketing campaign on risky teen occupant behaviors (which have already been affected by recently toughened junior operator regulations). In the spring of 2008, in collaboration with Emerson College Graduate Program in Health Communication, we completed the development of social marketing materials aimed at improving the rate of seat belt use among young drivers.

Data was also used to inform a state report to the MA legislature, issued in 2009, on the risks of drowsy driving. Young adults, particularly medical residents and college students were found to be at high risk for injury due to drowsy driving. Recommendations included increased awareness at college campuses on the risks of drowsy driving. //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	225.2	212.4	210.0	215.1	215
Numerator	2727	2570	2491	2512	
Denominator	1210811	1210179	1186455	1167750	
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
Hospitalization data for 2008 are not yet available from the Massachusetts Uniform Hospital Discharge Data System (UHDDS), Division of Health Care Finance and Policy. We have estimated the same rate as that for 2007. See 2007 for the most recent actual data and see the Note for 2007 for data sources and other comments.

Notes - 2007
Hospitalization data are from Massachusetts Uniform Hospital Discharge Data System (UHDDS), Division of Health Care Finance and Policy, 2007. Data are for Fiscal Years, not Calendar Years. The 2007 denominator is from the most recent population estimates for Massachusetts, as provided in MassCHIP. The resulting denominator and age-specific rate may differ from those previously reported or published elsewhere.

Notes - 2006
Hospitalization data are from Massachusetts Uniform Hospital Discharge Data System (UHDDS), Division of Health Care Finance and Policy, 2006. Data are for Fiscal Years, not Calendar Years. The denominator is from population estimates for Massachusetts, as provided in MassCHIP. The resulting denominator and age-specific rate may differ from those previously reported or published elsewhere.

Narrative:
/2010/ See general comments under Health Status Indicator # 03A and #03B. In addition to the detailed surveillance of injury deaths to children and adolescents, we utilize the statewide hospital and emergency department databases to monitor the magnitude, trends of nonfatal injuries and to describe the demographic groups at greatest risk. In late 2008, after several years of planning, the MDPH began receiving data into its statewide trauma registry. This database contains information on seat belt use, child safety seat use, and other protective devices used by the injured patients, alcohol and drug involvement, as well as information on injury severity. Once analyzed, this data will be incorporated into reports, materials used to inform policy, and used to evaluate policies and programs aimed at reducing injuries.

Data on nonfatal injuries among children ages 14 years and younger is currently primarily derived from the MA statewide inpatient hospital, observation stay and emergency department databases, which have traditionally had excellent external cause of injury coding (E coding) rates. The E code quality (completeness) of the observation stay data for FY2007 was significantly reduced from previous years (from 80% in FY2006 to <40% in FY2007). Due to the tremendous importance of these E codes in our surveillance work, we are currently working with our state partner, the MA Division of Health Care Finance and Policy, to improve E coding completeness in these data sets back to their previous levels.

Despite the E code problems with the FY2007 observation stay data, we have been able to use our nonfatal injury data to inform our work on reducing window fall injuries

(identifying high risk communities, evaluating the Boston intervention program and for legislation to replicate the Boston intervention statewide), bicycle and pedestrian injuries, playground injuries, and traumatic brain injury prevention (distribution of CDC tool kits aimed at youth sports concussion prevention, hosting trainings for coaches and parent volunteers). We are sharing our nonfatal injury data with the MA Department of Children and Families to identify priority injuries for prevention and to identify communities with the highest rates of nonfatal injury. This data is also being incorporated into a CDC grant proposal for the development of a state plan for child injury policy. //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	20.2	15.5	17.0	16.2	16
Numerator	244	188	202	189	
Denominator	1210811	1210179	1186455	1167750	
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
Hospitalization data for 2008 are not yet available from the Massachusetts Uniform Hospital Discharge Data System (UHDDS), Division of Health Care Finance and Policy. We have estimated the same rate as that for 2007. See 2007 for the most recent actual data and see the Note for 2007 for data sources and other comments.

Notes - 2007
Hospitalization data are from Massachusetts Uniform Hospital Discharge Data System (UHDDS), Division of Health Care Finance and Policy, 2007. Data are for Fiscal Years, not Calendar Years. The 2007 denominator is from the most recent population estimates for Massachusetts, as provided in MassCHIP. The resulting denominator and age-specific rate may differ from those previously reported or published elsewhere.

Notes - 2006
Hospitalization data are from Massachusetts Uniform Hospital Discharge Data System (UHDDS), Division of Health Care Finance and Policy, 2006. Data are for Fiscal Years, not Calendar Years. The denominator is from population estimates for Massachusetts, as provided in MassCHIP. The resulting denominator and age-specific rate may differ from those previously reported or published elsewhere.

Narrative:
/2010/ See general comments under Health Status Indicator # 03A and comments specific to MV injuries in children in Health Status Indicator #03B. //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	136.2	123.1	113.3	108.8	109
Numerator	1160	1049	1015	986	
Denominator	851425	851856	895707	906161	
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
Hospitalization data for 2008 are not yet available from the Massachusetts Uniform Hospital Discharge Data System (UHDDS), Division of Health Care Finance and Policy. We have estimated the same rate as that for 2007. See 2007 for the most recent actual data and see the Note for 2007 for data sources and other comments.

Notes - 2007
Hospitalization data are from Massachusetts Uniform Hospital Discharge Data System (UHDDS), Division of Health Care Finance and Policy, 2007. Data are for Fiscal Years, not Calendar Years. The denominator is from the most recent population estimates for Massachusetts, as provided in MassCHIP. The resulting denominator and age-specific rate may differ from those previously reported or published elsewhere.

Notes - 2006
Hospitalization data are from Massachusetts Uniform Hospital Discharge Data System (UHDDS), Division of Health Care Finance and Policy, 2006. Data are for Fiscal Years, not Calendar Years. The denominator is from the population estimates for Massachusetts, as provided in MassCHIP. The resulting denominator and age-specific rate may differ from those previously reported or published elsewhere.

Narrative:
/2010/ See general comments under Health Status Indicator # 03A and comments specific to MV injuries in adolescents and young adults in #03C //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	17.4	18.3	17.9	18.3	18.9
Numerator	3565	3823	3955	4116	4249
Denominator	204745	208824	221338	224406	224406
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 sources:
Cases of chlamydia: Massachusetts Department of Public Health. Sexually Transmitted Diseases Program, 2008 (calendar year data).
The 2008 denominator is estimated to be the same as 2007 (see previous year's note). The resulting denominator and age-specific rate may differ from those previously reported or published elsewhere.

Notes - 2007
Data sources:
Cases of chlamydia: Massachusetts Department of Public Health. Sexually Transmitted Diseases Program, 2007 (calendar year data).
The 2007 denominator is from population estimates for Massachusetts, as provided by the MDPH Bureau of Health Information, Statistics, Research and Evaluation. The resulting denominator and age-specific rate may differ from those previously reported or published elsewhere.

The denominator has been updated, resulting in a revised 2007 rate.

Notes - 2006
Data sources:
Cases of chlamydia: Massachusetts Department of Public Health. Sexually Transmitted Diseases Program, 2006 (calendar year data).
The 2006 denominator is from population estimates for Massachusetts, as provided by the MDPH Bureau of Health Information, Statistics, Research and Evaluation. The resulting denominator and age-specific rate may differ from those previously reported or published elsewhere.

The numerator was updated in June 2008 with final data from the STD Program and the denominator was updated as well, resulting in a revised 2006 rate.

Narrative:
/2010/ Chlamydia trachomatis is a common cause of urethritis and cervicitis, and sequelae include pelvic inflammatory disease, ectopic pregnancy, and tubal factor infertility. MDPH uses this HSI to monitor trends in diagnoses of chlamydia infections among youth and to identify racial/ethnic disparities in diagnoses. Compared to older adults, sexually active youth (aged 15--19 years) and young adults (aged 20--24 years) are at higher risk for acquiring STDs. This higher risk is due to a combination of behavioral, biological and cultural factors, accessibility to quality health care, and concerns about confidentiality. The majority of reported chlamydia infections in Massachusetts are in youth and young adults. According to the MDPH Bureau of Communicable Disease Control surveillance data, among the 15, 276 cases of chlamydia infection reported in 2006, 4,836 (32%) were in youth aged 15--19 years. Dramatic racial/ethnic differences in STD rates exist among youth and young adults in Massachusetts. Among persons aged 15--24 years, when compared to non-Hispanic whites, the rate of reported chlamydia infection was 15 times higher in Blacks and 10 times higher in Hispanics. The reasons for these racial and ethnic differences are unclear and complex. Possible explanations for these differences include socioeconomic status, variability in access to and utilization of health care and screening, reporting differences, differences in sexual behavior, and varying risk of STDs among sexual networks. Since chlamydia infection is often asymptomatic and diagnosis is

dependent on laboratory testing, increased screening for chlamydia infection is one cause of increased reports of cases. Periodic screening is now recommended for all sexually active young women and successful implementation of these screening recommendations leads to increases in reported cases. //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	5.0	5.6	5.9	6.6	7.0
Numerator	5912	6539	6759	7524	7927
Denominator	1184601	1168750	1144172	1133164	1133164
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
Cases of chlamydia: Massachusetts Department of Public Health. Sexually Transmitted Diseases Program, 2008 (calendar year data).
The 2008 denominator is estimated to be the same as 2007 (see previous year's note). The resulting denominator and age-specific rate may differ from those previously reported or published elsewhere.

Notes - 2007
Cases of chlamydia: Massachusetts Department of Public Health. Sexually Transmitted Diseases Program, 2007 (calendar year data).
is from the most recent population estimates for Massachusetts, as provided by the Bureau of Health Information, Statistics, Research and Evaluation. The resulting denominator and age-specific rate may differ from those previously reported or published elsewhere.

The denominator has been updated, resulting in a changed rate.

Notes - 2006
Data sources:
Cases of chlamydia: Massachusetts Department of Public Health. Sexually Transmitted Diseases Program, 2006 (calendar year data).
The 2006 denominator is from population estimates for Massachusetts, as provided by the Bureau of Health Information, Statistics, Research and Evaluation. The resulting denominator and age-specific rate may differ from those previously reported or published elsewhere.

The numerator was updated in June 2008 with final data from the STD Program and the denominator was updated as well, resulting in a revised 2006 rate.

Narrative:
/2010/ Women are more likely than men to experience complications from sexually transmitted infections (STIs) because they are biologically more likely to be infected after

exposure and because infections are more likely to remain undetected, leading to delayed diagnosis and treatment and ultimately more untreated infections. Untreated chlamydia infections in women can lead to serious health consequences, including pelvic inflammatory disease, infertility, and ectopic pregnancy. MDPH uses this HSI to monitor trends in diagnoses of chlamydia infections among women and to identify racial/ethnic disparities in diagnoses. In 2006, women accounted for almost 75% of diagnosed chlamydia cases in Massachusetts. The greater number of cases in women is also a result of increased screening in women compared with men. //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	75370	53394	6774	179	4837	0	0	10186
Children 1 through 4	301478	213574	27098	714	19349	0	0	40743
Children 5 through 9	384722	283543	32130	945	21749	0	0	46355
Children 10 through 14	407300	306963	31646	1031	20181	0	0	47479
Children 15 through 19	453947	344734	36186	1329	21860	0	0	49838
Children 20 through 24	453334	341839	35078	1447	26759	0	0	48211
Children 0 through 24	2076151	1544047	168912	5645	114735	0	0	242812

Notes - 2010
Total Population, all ages:
Data Source: National Center for Health Statistics. Estimates of the 7/1/2000-7/1/2007, population from the Vintage 2007 postcensal series by year, county, age, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Bureau; released August 7, 2008. As prepared and reported by the MDPH Bureau of Health Statistics, Information, Research and Evaluation.

These detailed estimates by age group and race/ethnicity do not break out the standard census age group of 0 – 4 into separate groups for infants 0 - 1 and for children 1 – 4. Since these are otherwise the only reasonably current estimates available by age and race/ethnicity, we have placed 20% of the 0 – 4 estimated numbers in the 0 – 1 row and the remaining 80% in the 1 – 4 row.

Also note that these estimates are for combined race/Hispanic ethnicity and thus the more accurate column headings are White, non-Hispanic, Black non-Hispanic, Native American, non-Hispanic, Asian non-Hispanic, and Hispanic (all counted under “Other and Unknown” in Table 06A).

Narrative:

/2010/ Massachusetts publishes estimated tables equivalent to HSIs #06A and 06B annually with Vital Records reports on births and deaths, using the sources as noted above. Data are presented for mutually exclusive categories of race and Hispanic ethnicity (i.e. White Non-Hispanic, Black non-Hispanic, Native American Non-Hispanic, Asian Non-Hispanic, and Hispanic) and also by all age groups and by gender. These estimates are used to calculate state-wide population-based rates, both in those reports and for this application.
New, more detailed population numbers will be available after the 2010 Census.
Since the 2000 Census, the Massachusetts population ages 0 -- 24 appears to have declined slightly and Hispanic and Black Non-Hispanic children and youth have increased as a percentage of the total population. //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	65184	10186	0
Children 1 through 4	260735	40743	0
Children 5 through 9	338367	46355	0
Children 10 through 14	359821	47479	0
Children 15 through 19	404109	49838	0
Children 20 through 24	404563	48211	0
Children 0 through 24	1832779	242812	0

Notes - 2010
See Note for #06A for data source and further information.

Narrative:
/2010/ See text for Health Status Indicator # 06A. //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	49	13	11	0	4	0	0	21
Women 15 through 17	1543	661	202	3	63	0	0	614
Women 18 through 19	3401	1824	435	7	116	0	0	1019
Women 20 through 34	55215	37499	4687	130	4249	0	0	8650
Women 35 or older	17726	13836	1220	25	1340	0	0	1305

Women of all ages	77934	53833	6555	165	5772	0	0	11609

Notes - 2010
Data Source: MDPH Vital Records, Births for calendar year 2007 (the most recent year available). 2008 birth data are not yet available.

The race category labeled "Asian" also includes persons of Other Pacific Islander races. Birth certificate reporting of race does not include the category of "more than one race reported."

The "Other" race category has a large number of women who selected Hispanic ethnicities as their race.

Narrative:
/2010/ MDPH uses HSI#07A to understand the trend in number of births to MA mothers by age and race and to monitor the changing demographics of the birth population. The overall number of live births to MA women declined by approximately 1% per year from 2000 through 2006. However, in 2007 and 2008 the overall number of births increased slightly. Another important indicator is the age distribution of mothers giving birth in MA. Compared with 1990, birth rates have increased among mothers aged 30 years and older, and decreased among mother aged 30 or younger. The largest increases in birth rates have been observed among the older age groups (40-44, 45-49, and 50-54 years), while the largest decreases have been observed among the youngest groups (10-14 and 15-19 years). MDPH also examines mean maternal age at first birth by race/ethnicity. Hispanic mothers have the youngest average age at first birth (23.0 years) whereas Asian (29.1) and non-Hispanic white (28.5) mothers have the highest. The percentage of MA births to minority women (including all mothers who were not non-Hispanic white) increased from 22% in 1990 to 32% in 2007.

The percentage of total births to White Non-Hispanic women continues to decline (an overall decrease of 14% since 1990), while the percentages to Asian, Hispanic, and black Non-Hispanic mothers have risen 106%, 53%, and 8% respectively during that time period. The percentages to non-white mothers remained stable from 2006.

Massachusetts has one of the lowest teen birth rates in the country. Teen birth rates have declined for all race and ethnicity groups compared with 1997 rates, but the rate for Hispanics is still 5 time higher than that for white teens.

MA continues to closely follow these changing trends and the data are published annually and widely disseminated in the Massachusetts Birth Book. //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	24	25	0
Women 15 through 17	885	646	12
Women 18 through	2320	1060	21

19			
Women 20 through 34	46300	8040	875
Women 35 or older	16291	1090	345
Women of all ages	65820	10861	1253

Notes - 2010
Data Source: MDPH Vital Records, Births for calendar year 2007 (the most recent year available). 2008 birth data are not yet available.

Hispanic ethnicity is derived from the "mother's ancestry" question on the Parent (mother) Worksheet. There is no "Hispanic" question. Therefore, the "Hispanic" category was populated by combining the count of all women who selected an Hispanic ancestry: Puerto Rican, Dominican, Mexican, Cuban, Colombian, Salvadoran, Other Central American, Other South American, and Other Hispanic. The "Non-Hispanic" group is made up of those who selected any ancestry other than the Hispanic choices. There are no women who did not report Hispanic ethnicity according to this method. The "Ethnicity not reported" group is those who did not select an Hispanic ancestry or any other of the 39 choices.

Narrative:
/2010/ HSI#07B is also used to understand the changing demographics of the population of mothers giving birth in MA. The proportion of births to Hispanic mothers increased from 9% in 1990 to 14% in 2007. In 2007, there was substantial ethnic diversity among women giving birth with only 41% of mothers classifying themselves as American. The next largest ethnic groups were European (19%), Puerto Rican (6%), African-American (4%), Brazilian (3%) and Dominican (3%). MDPH also analyzes birth data by maternal nativity. The percentage of MA births to foreign-born mothers has been growing steadily in recent years. In 1990, one out of seven births was to a foreign-born mother whereas in 2007 more than one in four births was to a foreign-born mother. MA continues to closely follow these changing trends to identify emerging populations and the data are published annually and widely disseminated in the Massachusetts Birth Book. //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	385	232	85	0	18	0	0	50
Children 1 through 4	44	31	2	0	3	0	0	8
Children 5 through 9	36	23	5	0	2	0	0	6
Children 10 through 14	48	28	11	0	3	0	0	6
Children 15 through 19	198	148	31	0	3	0	0	16
Children 20 through 24	307	230	49	0	3	0	0	25
Children 0	1018	692	183	0	32	0	0	111

through 24								

Notes - 2010
Data Source: MDPH Vital Records, Deaths for calendar year 2007 (the most recent year available). Mortality data for 2008 are not yet available.

The race category labeled "Asian" also includes persons of Native Hawaiian or Other Pacific Islander races. Death certificate reporting of race does not include the category of "more than one race reported."

The category “Other and Unknown” includes only persons who selected “Hispanic” as a race.

Narrative:
/2010/ Massachusetts has death rates for children and young adults that are well below national rates for all age sub-groups and that have already met Healthy People 2010 targets for age groups 1-4, 5-9, and 10-14 and are within 25% of those targets for ages 15-19 and 20-24. Rates are highest among black Non-Hispanic and Hispanic youth of all ages, with the lowest rates for ages 1-14 for white Non-Hispanics but for Asians for ages 15-24.

As with births, these data, with many additional analyses by gender, geography, underlying causes, etc. are published annually by the Commonwealth and actively used to guide policy and program services. //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	303	82	0
Children 1 through 4	35	8	1
Children 5 through 9	30	6	0
Children 10 through 14	37	11	0
Children 15 through 19	172	26	0
Children 20 through 24	267	39	1
Children 0 through 24	844	172	2

Notes - 2010
Data Source: MDPH Vital Records, Deaths for calendar year 2007 (the most recent year available). Mortality data for 2008 are not yet available.

Narrative:

/2010/ See comments above for Health Status Indicator #08A. //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	1621137	1202208	133834	4198	87976	0	0	192921	2007
Percent in household headed by single parent	29.0	21.0	60.0	0.0	21.0	0.0	0.0	65.0	2007
Percent in TANF (Grant) families	3.9	0.0	0.0	0.0	0.0	0.0	0.0	3.9	2008
Number enrolled in Medicaid	505517	0	0	0	0	0	0	505517	2008
Number enrolled in SCHIP	100853	0	0	0	0	0	0	100853	2008
Number living in foster home care	6632	3017	993	7	91	0	0	2524	2008
Number enrolled in food stamp program	192000	0	0	0	0	0	0	192000	2007
Number enrolled in WIC	147170	64835	27484	169	8100	0	0	46582	2008
Rate (per 100,000) of juvenile crime arrests	79.0	0.0	0.0	0.0	0.0	0.0	0.0	79.0	2005
Percentage of high school drop-outs (grade 9 through 12)	3.4	2.2	5.8	7.3	2.0	6.7	3.5	8.3	2008

Notes - 2010

Data Source for All Children 0 through 19: National Center for Health Statistics. Estimates of the 7/1/2000-7/1/2007, population from the Vintage 2007 postcensal series by year, county, age, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Bureau; released August 7, 2008. As prepared and reported by the MDPH Bureau of Health Statistics, Information, Research and Evaluation.

Note that these estimates are for combined race/Hispanic ethnicity and thus the more accurate

column headings are White, non-Hispanic, Black non-Hispanic, Native American, non-Hispanic, Asian non-Hispanic, and Hispanic (all counted under “Other and Unknown” in Table 09A).

Data source for % in Household headed by singe parent: 2007 data. Population Reference Bureau, analysis of data from the U.S. Census Bureau, 2007 American Community Survey (ACS). As reported in Kids Count Data Center, Annie E. Casey Foundation. http://datacenter.kidscount.org/data/bystate/. The 2008 Kids Count report has not yet been released.
Data are reported for children under 18. Break-outs are not available by race or ethnicity.

Data Source for % in TANF families: Administration for Children and Families; Office of Family Assistance, Data Reports. Data are for Fiscal Year 2008 (Oct. 2007 - Sept. 2008); Table: “Average Monthly Number of Recipients, Adults and Children.” (http://www.acf.hhs/gov/programs/ofa/data-reports/caseload/2008/2008_children_tan.htm)

The % calculation is based on the ACF number of child recipients (62,583) divided by the estimated 2007 child population 0 – 19 of 1,621,137 (see above). Data are not available by race or Hispanic ethnicity.

Data Source for number enrolled in Medicaid: HHS, CMS, “FY2008 Medicaid Children Annual Enrollment Report.” Data are the unduplicated number of children (defined as under age 19) ever enrolled in the Medicaid program in FY 2008, as reported by the state into the CHIP Statistical Enrollment Data System (SEDS). Data are not available by race/ethnicity. www.cms.hhs.gov/NationalCHIPPolicy/CHIPER.

Data Source for number enrolled in SCHIP: Federal Centers for Medicare and Medicaid Services (CMS). Federal CMS SCHIP Statistical Enrollment Data System (SEDS). FY2008 Separate Child Program Enrollment. Children enrolled through the state’s Medicaid expansion options are counted in the previous row of Form 21. Data are not available by race/ethnicity. (http://www.cms.hhs.gov/NationalSCHIPPolicy/SCHIPPolicy/downloads/FY2008StateTotalTable012309FINAL.pdf)

Data Source for number enrolled in food stamp program: USDA, Food and Nutrition Service, FY2007 Food Stamp Program Quality Control sample, as reported in “Characteristics of Food Stamp Households: Fiscal Year 2007, Final Report, September 2008.” Table B-11. Data on child participants are not available by race or Hispanic Ethnicity. However, other 2007 data for Massachusetts participants by households report that 49.1% of SNAP households were White, 15.7% were African-American, 19.6% were Hispanic, and 13.7% were other race/ethnic origin. The distribution of child participants by race/ethnicity would be similar. (www.fns.usda.gov/oane/menu/Published/SNAP/SNAPPARTHH.htm)

Data Source for number enrolled in WIC: Massachusetts WIC Program, MDPH. Enrollment as of 12/31/08. Note that this is lower than the total number of children who are served by WIC over the course of a year.
Data are reported by combined race/Hispanic ethnicity categories only. Therefore, the columns labeled “White,” “Black,” etc. are in fact reported as “White, non-Hispanic,” “Black, non-Hispanic,” etc. In Section 09A, Hispanics are included in the “Other and Unknown” column; they are reported separately in Section 09B. This limitation on the data means that the number of persons with known race is underreported.

Data Source for rate (per 100,000) of juvenile crime arrests: FBI Uniform Crime Reports. As reported in Crime in the United States, Persons Arrested. (Tables 69 and 41) The data are for 2005, the most recent available. Arrest data are for juveniles under the age of 18. The Massachusetts rate is less that half the juvenile arrest rate in the US; rates for both Massachusetts and the US decreased significantly from 1995 to 2005. Data are not available by race/ethnicity.

Data Source for % of high school dropouts (grade 9 through 12): Massachusetts Department of Elementary and Secondary Education. "High School Dropouts 2007-08: Massachusetts Public Schools;" released April, 2009.
Data are reported by combined race/Hispanic ethnicity categories only. Therefore, the columns labeled “White,” “Black,” etc. are in fact reported as “White, non-Hispanic,” “Black, non-Hispanic,” etc. In Section 09A, Hispanics are included in the “Other and Unknown” column; they are reported separately in Section 09B. This limitation on the data means that the percent of persons with known race is underreported.

Data Source for number living in foster home care: Massachusetts Department of Social Services, 2008, as available in MassCHIP. Data are a snapshot for Calendar Year 2008.

Narrative:
/2010/ Current data with the level of detail by age and race/ethnicity as indicated for Health Status Indicator #09A are not consistently available, as can be noted in the disparity among data years and details shown above. Some -- including WIC and drop-out rates -- are routinely available in standardized reports. Others are only periodically available, sometimes from estimates that do not provide details by race/ethnicity. Such national data books as Kids Count (published by the Annie E. Casey Foundation from a wide range of data sources) have proven helpful, although not all data elements are available each year.

It is interesting to note that the most current state information for a number of items is available on either federal agency or private organization websites (e.g. Kaiser Family Foundation, Annie E. Casey, etc.) but not on the state's own website.

However, regardless of these specific data points, the Department participates in the preparation of analyses examining these and other demographic indicators related to the well-being of mothers and children and promotes policies and programs based on the factors. For example, many of these data items, along with others, are being used in the preparation of a document that is a collaborative effort of MDPH and the Governor's Adolescent Health Council entitled "A Shared Vision for Massachusetts Youth and Young Adults," which is due to be released in FY10. //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	1428216	192921	0	2007
Percent in household headed by single parent	0.0	65.0	0.0	2007
Percent in TANF (Grant) families	0.0	0.0	3.9	2008
Number enrolled in Medicaid	0	0	505517	2008
Number enrolled in SCHIP	0	0	100853	2008
Number living in foster home care	4412	1690	530	2008
Number enrolled in food stamp program	0	0	192000	2007
Number enrolled in WIC	100588	46582	0	2008
Rate (per 100,000) of juvenile	0.0	0.0	79.0	2005

crime arrests				
Percentage of high school drop-outs (grade 9 through 12)	2.6	8.3	0.0	2008

Notes - 2010
See data source notes for corresponding 09A categories.

Narrative:
/2010/ See comments above for Health Status Indicator #09A. //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	1621137
Living in urban areas	1481719
Living in rural areas	139418
Living in frontier areas	0
Total - all children 0 through 19	1621137

Notes - 2010
Data Source: U.S. Bureau of the Census. According to the most recent alignments of Standard Metropolitan Areas, all of Massachusetts is included in an SMA. Therefore we have entered the entire child population as noted in the urban/rural categories listed below.

For total number of children: Data Source: National Center for Health Statistics. Estimates of the 7/1/2000-7/1/2007, population from the Vintage 2007 postcensal series by year, county, age, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Bureau; released August 7, 2008. As prepared and reported by the MDPH Bureau of Health Statistics, Information, Research and Evaluation.

For Urban/Rural/Frontier distribution: U.S. Census Bureau. Census 2000 Summary File (SF 4) for Massachusetts. Massachusetts has no “Frontier” areas. The “Urban” and “Rural” numbers of children are estimates that use the percentage distribution of the entire population as reported in the SF 4 file (Table PCT2) multiplied by the 2000 Census count of children in the state (91.4% and 8.6% respectively for urban and rural residents). We have no reason to believe that children are significantly more or less likely to live in rural areas than are adults. These remain the most recent comprehensive data available on living location.

Narrative:
/2010/ Massachusetts is a primarily urban environment with several rural areas but no frontier areas. The Department supports an active Office of Rural Health and geography is a variable used frequently in analyses of maternal and child health, particularly in identifying areas of high need and in tailoring programs, outreach and training opportunities, and funding formulas to different populations. //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	6449755.0
Percent Below: 50% of poverty	5.0
100% of poverty	10.1
200% of poverty	24.7

Notes - 2010
Data Source: National Center for Health Statistics. Estimates of the 7/1/2000-7/1/2007, population from the Vintage 2007 postcensal series by year, county, age, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Bureau; released August 7, 2008. As prepared and reported by the MDPH Bureau of Health Statistics, Information, Research and Evaluation. These estimates are not available by poverty status.

Narrative:
/2010/ Monitoring changes in poverty status -- and in the concentrations of greatest need across communities and population groups -- is an on-going process that influences virtually all programs and needs assessments. While the percentage of the overall population in poverty and near poverty is less in Massachusetts than in the country as a whole, it remains a significant problem and one that is expected to rise until the economic crisis is resolved. Massachusetts is expected to recover more slowly than other parts of the country from the current economic downturn. //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	1622817.0
Percent Below: 50% of poverty	6.0
100% of poverty	13.0
200% of poverty	26.0

Notes - 2010
Data Source: The most recent 2007 population estimates for Massachusetts by age, as provided by the MDPH Bureau of Health Information, Statistics, Research and Evaluation. These updated population estimates are not available by poverty level.
The ages reported here are 0 – 19.

Narrative:
/2010/ Monitoring changes in poverty status -- and in the concentrations of greatest need across communities and population groups -- is an on-going process that influences virtually all programs and needs assessments. While the percentage of children in poverty and near poverty is less in Massachusetts than in the country as a whole, it remains a significant problem and one that is expected to rise until the economic crisis is resolved. Massachusetts is expected to recover more slowly than other parts of the country from the current economic downturn. //2010//

F. Other Program Activities

In addition to activities contributing to performance measures, a majority of Bureau programs conduct one-time and/or on-going activities directly focused on meeting one or more of the State's currently defined Priority Needs. A description of these activities is attached to this section of the application. Plans for FY06 are included for Priority Needs that will continue as a result of our Five-year Needs Assessment. Also in the attachment is a comprehensive list of MCH-related programs and service numbers for FY04, by MCH population categories. /2007/ The 2007 attachments include updated information about Program Activities related to Priority Needs not otherwise covered by the NPM and SPM narratives and an updated listing of MCH-related programs and service numbers for FY05, by MCH population categories. //2007//
/2008/ The 2008 attachments include updated information about Program Activities related to Priority Needs not otherwise covered by the NPM and SPM narratives and an updated listing of MCH-related programs and service numbers for FY06, by MCH population categories. //2008//

/2009/ The 2009 attachments include updated information about Program Activities related to Priority Needs not otherwise covered by the NPM and SPM narratives and an updated listing of MCH-related programs and service numbers for FY07, by MCH population categories. //2009//

/2010/ The 2010 attachments include updated information about Program Activities related to Priority Needs not otherwise covered by the NPM and SPM narratives and an updated listing of MCH-related programs and service numbers for FY08, by MCH population categories. //2010//

An attachment is included in this section.

G. Technical Assistance

Massachusetts is again making a specific request for Technical Assistance to assist in undertaking a CAST 5 Assessment. After significant changes in state resources and restructuring of the Department into larger Centers, CAST 5 would provide a better understanding of current resources and needed rebuilding or enhancements to assure strong MCH/CSHCN services. Although this was our original planned request for FY05, it was deferred as we joined the other Region I states in obtaining Technical Assistance support for a regional poison control symposium and meeting.
/2007/ Massachusetts expects to make a request for assistance with planning a process for priority setting and team building. This will assist us in continued staff and program integration across previously separate bureaus in an era of shrinking federal funds and a changing health insurance and services system in the Commonwealth. In particular, we wish to identify and address the short and long-term impacts on Title V from the comprehensive Massachusetts health care reforms that are just getting underway. A formal request will be made through the web-based system at a later date.

The Commonwealth also is prepared to join other Region I states in a joint request for one or more regional technical assistance projects or events, as we have done in the last two years. No specific request has been determined at this time. //2007//

/2008/ The Commonwealth has already submitted and been approved for one technical assistance request, to contribute funding to a New England Knowledge to Practice Project for Region I Title V Programs: Enhancing knowledge and capacity of Title V MCH leaders to identify program priorities and influence policy using evidence-based models for improving MCH health at the state level. The first meeting of the regional leadership/advisory group will take place in Boston, MA on October 2, 2007. Neal Halfron and Holly Grason will be presenting their research

and paradigm on a lifecourse and multiple determinant framework to improve maternal health. Because Massachusetts will not need to request TA funds for our participants to travel out of state, we are using our TA request to cover the travel and lodging expenses for the two presenters. //2008//

/2009/ As part of the NICHQ CSHCN leadership activity, MA would like to request funding to contract with National Initiative for Children's Healthcare Quality (NICHQ) staff to work directly with MA CYSHCN staff to begin the implementation of the Roadmap Action plan which is currently under development. A special focus will be on the expansion of the medical home model to additional pediatric primary care practices. //2009//

/2010/ For FY10, MA will be requesting supplemental funding for a consulting team with which we have been working on strategic planning. Specifically, the Title V Children and Youth with Special Health Care Needs program has been involved in a strategic planning process over the past year and a half and has moved to an action team/implementation mode. We are seeking assistance to continue this effort and will seek TA to continue this process with areas of focus including Medical Home, Youth Transition, Stakeholder Engagement, and Capacity Building. The Ripples Group, Inc. is a Boston based consulting firm with whom we have worked extensively in the past. They are high skilled, focused and efficient in their consulting role.//2010//

V. Budget Narrative

A. Expenditures

See the FY06 Expended columns in Form 3 (State MCH Funding Profile), Form 4 (Budget Details by Types of Individuals Served), and Form 5 (State Title V Programs Budget and Expenditures by Types of Services). The Form and Field Notes for the Forms provide additional details and explanations about the amounts shown, including differences between budgeted and expended amounts, changes in the levels of funding categories across years, and the sources of state Partnership funds and other Federal funds.

It is important to note that throughout these changes and variations from original budgets, the distribution of expenditures from the federal portion of the Title V Partnership remained much more stable. Due to the increasingly categorical nature of much of our state funding, we are not always able to shift it to moderate secular changes in funding levels or to target our highest MCH priorities. Because the ratio of total state funding is so much higher than our federal allocation (almost 5 to 1 in FY06), patterns in state funding drive the patterns seen in the total Partnership budget and expenditures.

Two aspects of the Expenditures warrant narrative discussion:

1. The difference between the FY06 Unobligated Balance originally budgeted and the amount expended.
2. Several differences between the amounts budgeted for FY05 and final expenditures by MCH Population Group (Form 4) and by Level of the Pyramid (Form 5)

The final Unobligated Balance Expended for FY06 is less than the original budget estimate by more than 10%. The reason for this apparent discrepancy is that the original unobligated balance estimate was too high, as it did not account for a portion of the MCH Block Grant which is transferred to CDC for direct assistance in the form of an MCH Epidemiologist assigned to Massachusetts. In fact, the two amounts are virtually identical.

Form 4 (Budget by MCH Population Groups). Final FY06 Expended totals are significantly different from FY06 Budgeted totals for Administration. The overall decrease in administrative expenditures in FY06, compared to budgeted amounts reflect the fact that the Bureau continued to be successful in both reducing overall administration costs and in shifting a number of them to other state and federal accounts that are not part of the Partnership budget.

Form 5 (Budgets by Level of the Pyramid). Final FY06 Expended totals are more than 10% higher than FY06 Budgeted totals for Infrastructure Building. In fact, final expenditures for FY06 were higher than budgeted amounts for Total Expenditures and for each level of the Pyramid except Enabling Services. Only the Infrastructure amount reached the 10% threshold for endnotes. The main reason for this is that there were substantial Supplemental state budgets in FY06 (particularly in the areas of Family Planning and Early Intervention). In addition, approximately $400,000 was originally not budgeted because it was thought to be needed for state match for other accounts. However, that need did not arise, so the funds were added back into the Expended category. Spending from the MCH Block Grant itself was not higher than budgeted.

It may appear from Forms 4 and 5 that Massachusetts distributes our funding among MCH Population groups and service types in a variable manner from year to year. This picture is misleading, however, because these Forms present the entire MCH Federal-State Partnership budget, which in our case has been around 80% and is now about 86% state funds for FY08. We have flexibility in allocating federal Block Grant funds, while the populations to be served by state appropriations are usually closely controlled by the more categorical or earmarked nature of state budget language. A more accurate picture of our commitment to the MCH Populations and Types of Services may be seen in the tables attached to Part V, Section B, which presents data with federal funds and state funds separately over several years. These tables illustrate that virtually all of the year to year variation in the relative distribution of funds across population

groups is due to variations in state funding.

In addition, the target populations for the state funds, as well as the types of services specified by the Legislature, shape the overall percentage distribution of funds across the MCH Pyramid and MCH population groups.

/2009/ See the FY07 Expended columns in Form 3 (State MCH Funding Profile), Form 4 (Budget Details by Types of Individuals Served), and Form 5 (State Title V Programs Budget and Expenditures by Types of Services). The Form and Field Notes for the Forms provide additional details and explanations about the amounts shown, including differences between budgeted and expended amounts, changes in the levels of funding categories across years, and the sources of state Partnership funds and other Federal funds.

It is important to note that throughout these changes and variations from original budgets, the distribution of expenditures from the federal portion of the Title V Partnership remained much more stable. Due to the increasingly categorical nature of much of our state funding, we are not always able to shift it to moderate secular changes in funding levels or to target our highest MCH priorities. Because the ratio of total state funding is so much higher than our federal allocation (over 5 to 1 in FY07), patterns in state funding drive the patterns seen in the total Partnership budget and expenditures.

Total state expenditures in FY07 are higher than our original FY07 budget. This is due to a decision to include expenditures for the Catastrophic Illness in Children Relief Fund trust account in the final FY07 accounting, even though we had not included this account in our annual budgets for state match until our FY08 Application. This change will bring FY07 expenditures more in line with those for future years for trend analysis.

It may appear from Forms 4 and 5 that Massachusetts distributes our funding among MCH Population groups and service types in a variable manner from year to year. This picture is misleading, however, because these Forms present the entire MCH Federal-State Partnership budget, which in our case has been around 80% and is now approximately 87% for FY09. We have flexibility in allocating federal Block Grant funds, while the populations to be served by state appropriations are usually closely controlled by the more categorical or earmarked nature of state budget language. A more accurate picture of our commitment to the MCH Populations and Types of Services may be seen in the tables attached to Part V, Section B, which presents data with federal funds and state funds separately over several years. These tables illustrate that virtually all of the year to year variation in the relative distribution of funds across population groups is due to variations in state funding. In addition, the target populations for the state funds, as well as the types of services specified by the Legislature, shape the overall percentage distribution of funds across the MCH Pyramid and MCH population groups.

The year to year variation within state funds has leveled off in the last three years, so that even the total percentage shares have remained very consistent. This pattern remains susceptible to change each year due to changes in the state budget and relative budget priorities at the state level. //2009//

/2010/ See the FY08 Expended columns in Form 3 (State MCH Funding Profile), Form 4 (Budget Details by Types of Individuals Served), and Form 5 (State Title V Programs Budget and Expenditures by Types of Services). The Form and Field Notes for the Forms provide additional details and explanations about the amounts shown, including differences between budgeted and expended amounts, changes in the levels of funding categories across years, and the sources of state Partnership funds and other Federal funds.

It may appear from Forms 4 and 5 that Massachusetts distributes our funding among MCH Population groups and service types in a variable manner from year to year. This picture is

misleading, however, because these Forms present the entire MCH Federal-State Partnership budget, which in our case has been as high as 89% and is now approximately 82% for FY10. We have flexibility in allocating federal Block Grant funds, while the populations to be served by state appropriations are usually closely controlled by the more categorical or earmarked nature of state budget language. A more accurate picture of our commitment to the MCH Populations and Types of Services may be seen in the tables attached to Part V, Section B, which presents data with federal funds and state funds separately over several years. These tables illustrate that virtually all of the year to year variation in the relative distribution of funds across population groups is due to variations in state funding. In addition, the target populations for the state funds, as well as the types of services specified by the Legislature, shape the overall percentage distribution of funds across the MCH Pyramid and MCH population groups.

The year to year variation within state funds leveled off for several years through FY09, so that the total percentage shares have remained very consistent. However, this pattern remains susceptible to change each year due to changes in the state budget and relative budget priorities at the state level. //2010//

B. Budget

The budget proposed for FY08 in Forms 2, 3, 4, and 5 contains some differences with those of previous years. Overall, state funding, which had dropped for several years has now stabilized and is experiencing some gains, including some new areas of support from the state.

The total Partnership budget of $88,044,275 is made up of $11,596,681 of MCH Block Grant funds (including carry-forward funds) and $76,447,594 in state funds. Massachusetts continues to commit funds above our statutory maintenance of effort level from FY1989 of $23.5M and the state funding represents a FY08 State Match ($3 state for every $4 federal) of $8,697,511 and State Over Match of $67,750,083. The total state funds represent all or portions of 10 state accounts (Family Health Services, Early Intervention (2 accounts), Teen Pregnancy Prevention, Universal Newborn Hearing, Domestic Violence and Sexual Assault Prevention and Treatment, Dental Health, School Health (including School-Based Health Centers), one Interagency account with Medicaid, and state administration). In addition, there is a new account in FY08 for Shaken Baby Syndrome Prevention, and funds from the state Suicide Prevention account are contributing to the Regional Poison Control Center. Within the Family Health Services account, there are new funds for the Regional Poison Control Center, the Massachusetts Birth Defects Monitoring System, and the Massachusetts SIDS Center; all of these are the first state funds for these MCH priorities in many years.

Details on the budgeted amount from each account are given in the Notes to Form 2.

Massachusetts continues to budget at least 30% of our federal MCH funds for Preventive and Primary Care for Children (30.17% in FY08) and for Children with Special Health Care Needs (31.09% in FY08). The proportion of federal funds used for Title V Administrative Costs is at the allowable 10% for FY08. As the amount of MCH Block Grant has decreased over the last several years, we have continued to be successful in sharing those costs with other state and federal sources in an equitable manner.

The state revenue picture is generally positive in FY08, continuing the restoration of several MCH-related accounts that began in FY05. A new state administration and the legislature have both provided increased support for public health, including some MCH priority areas. While state partnership funding continues to be below FY03 or earlier levels for some accounts, funding appears more stable. The impact of Health Care Reform -- both on our clients and programs and on our budgets (if costs exceed expectations) will be closely watched. In FY07 and FY08, substantial funding has been identified for health promotion and disease prevention across the

lifespan as a complement to universal health insurance coverage. Cuts, changes, and restorations have not been uniform and certain types of services and population groups served have been affected more than others.

Our oldest and core MCH state account, Family Health Services, the one that most closely resembled the federal block grant and was created originally as the state match, was initially cut by almost 70% in FY04. This account had contained the only state funding for family planning services, rape crisis centers, the poison control center, MCH primary care wrap-around services, and prenatal/infancy home visiting. After the FY04 cuts and modified budget language, it only funded family planning services, rape crisis centers, and a small amount of MCH primary care wrap-around services in FY06. In FY07 budget, the rape crisis center funding was moved to a new domestic violence and sexual assault prevention and treatment account that consolidates funding from a number of accounts. While this new account is a very appropriate and exciting opportunity for better coordination of these critical services, the removal of the RCC funds made the Family Health account very narrow, with primarily categorical funding. New earmarking (without additional funding) and reductions to the funding allocated for Family Planning left us with even less funding than FY06 for core MCH programs supported in part by this account. Combined with the reductions in federal MCH funds, this was a very serious situation, which we had hoped may be remedied in the state FY08 budget.

The FY08 budget for the Family Health Services account is a very mixed bag, however. The entire account is now earmarked for specific programs -- or vendors. The good news is that the Family Planning Program received a $1M increase and the account includes new funds specified for the Regional Poison Control Center and the Massachusetts Birth Defects Monitoring System (both of these were priorities for the Department). It also includes $100,000 for the Massachusetts SIDS Center, which currently receives only federal MCH funds. However, the total dollar amount of the earmarks (including these positive ones) completely subsumes the entire account, leaving no funds for MCH contracts for services for women of reproductive age and adolescents that were contributed from this account last year. It is expected that those programs will absorb cuts of about 11%.

Details on the budgeted amount from each account and the amount that it has changed (if relevant) are given in the Notes to Form 2.

The $120,535,869 of other Federal funds shown on Forms 1, 2, and 3 comes from approximately 25 different grants, which cover all of the categories of the categories on Form 2 except federal Healthy Start and Abstinence Education. [Massachusetts has declined to reapply for ACF Abstinence Education funds for the coming year.] It is important to note that we include all of our WIC funds, state and federal, as they are budgeted in a seamless manner at the state level. Massachusetts funds WIC (both directly and with an infant formula retained revenue account) at over $34M, which is included in the $106.8M. The Bureau continues to have good success in obtaining a wide range of federal categorical grants. These grants are of great importance in maintaining the breadth of the Bureau's MCH efforts and in continuing our history of innovation and integrated service delivery model development.

Not included in the budget forms is a substantial amount of state funding administered by the Bureau for MCH programs, but which cannot be listed as match by us because the funds are used for match for other federal programs (e.g. TANF) or which originate in other state agencies that wish to maintain their options to use the funds for match. As we have a substantial amount of over-match, this is not a budget issue for the Bureau, but it does undercount the level of state support for key MCH services. The programmatic efforts supported by the funds continue to be fully described in our annual reports and plans. Some of the accounts involved are fully MCH-related; the largest of these have been the bulk of the Teen Pregnancy Prevention Challenge Fund and FOR Families; both of these accounts are funded with state TANF funds. In FY07, a new state account for Pediatric Palliative Care was funded, but is being used 100% for Medicaid-related match. Other accounts include both MCH-related and other activities that are difficult to

identify precisely or that are needed for potential match for other purposes. These include several state-funded accounts that address sexual assault and domestic violence, batterer intervention, violence and injury prevention, and two that support community health center operations and initiatives.

It may appear from Forms 4 and 5 that Massachusetts distributes our funding among MCH Population groups and across types of services in a variable manner from year to year. This picture is misleading, however, because Forms 4 and 5 present the entire MCH Federal-State Partnership budget, which in our case is over 86% state funds in FY08. While we have flexibility in allocating federal Block Grant funds, the proportion of the total State Partnership budget that comes from "categorical" state accounts continues to increase and the total, as noted above, can fluctuate significantly from year to year. A more accurate picture of our commitment to the MCH Populations may be seen in the tables in the Excel file that is the attachment to this Part 5, Section B (Budget). These tables present budget data for the federal and state portions of the Partnership budget separately over several years. A comparison of Forms 4 and 5 with these tables illustrates that much of the year-to-year variation in the total and relative distribution of funds across population groups is due to changes (up and down) in state funding. Based on the categorical nature of our state funding stream (and the disproportionate cuts in some accounts), the impact of the state funding cuts is not always felt equally across all of MCH population groups.

These trends continue to place enormous pressure on the MCH Federal funds as the only source of flexible funding for many key MCH activities. This strain has previously been felt primarily in the area of Infrastructure Building, as state accounts rarely include funds for systems development, data management, or evaluation. In addition, with caps (or complete prohibitions) on the number of personnel that can be hired on state accounts, a disproportionate number of our total MCH Partnership staff are funded from the Block Grant.

A noticeable change in FY07 that continues for FY08 is the level of federal funds budgeted and the portion of the Partnership budget from federal MCH funds. Only with the FY07 budget was the impact of federal cuts to the MCH Block Grant itself fully reflected in the annual budgets. Modest cuts -- and the lack of any increases to cover payroll costs rising annually due to union settlements, COLAs, and changes to fringe benefit and indirect cost rates -- for several years were managed by spending down some substantial carry-over savings.

However, with the substantial federal cut of over $500,000 in FY06 that continues to the present, the federal share of the annual budget has been reduced significantly, and the annual total federal funding projected is much closer to the new annual award with little carry-over expected to be available. The reduction in federal MCH funding comes at the same time when inexorable increases in personnel costs have exhausted our previous carry-over cushion. Due to these factors and their particular impact on personnel costs, the number of FTE staff paid directly by the MCH Block Grant has been reduced, from approximately 107 in FY06 to 94 for FY08, and they now represent approximately 70% of all Partnership FTEs (down from 75% in FY06). A higher percentage of staff working in MCH-related areas is being funded from either state or other federal grant sources. With caps (or prohibitions) on state-funded positions and limitations on the types of staff that can be supported on our other categorical federal grants, our ability to hire and retain highly qualified professional staff is increasingly threatened.

In summary, the FY08 budget, although generally very good on the state side, continues to strain our ability to assure core direct, enabling, and population-based services and is altering the shape of many of our programs. These potential changes are discussed throughout our Narrative in the "Current Activities" and "Plans for the Coming Year" segments.

/2009/ The budget proposed for FY09 in Forms 2, 3, 4, and 5 continues to reflect several trends discussed in previous applications. Overall, state funding, which had dropped for several years has now stabilized and is experiencing some gains, including some new areas of support from

the state. Of particular importance for maternal and child health services are state accounts supporting a Shaken Baby Syndrome program, pediatric palliative care, and youth violence prevention. In addition, state funding for Early Intervention services continues to keep pace with increased demand for these services.

The total Partnership budget of $88,010,176 is made up of $11,743,816 of MCH Block Grant funds (including carry-forward funds) and $76,266,360 in state funds. Massachusetts continues to commit funds above our statutory maintenance of effort level from FY1989 of $23.5M and the state funding represents a FY09 State Match ($3 state for every $4 federal) of $8,807,862 and State Over Match of $67,458,498. The total state funds represent all or portions of 13 state accounts. These include continuation of the first state funds in many years for poison control, birth defects surveillance, and SIDS, along with the continuation of a new account for shaken baby syndrome. Details on these accounts and the budgeted amount from each are given in the Notes to Form 2.

In addition, 3 state accounts that are considered part of the Partnership programmatically are not included, as their funds are used for other FFP matching purposes: Early Intervention Retained Revenue ($6.5M), Pediatric Palliative Care ($1M) and Youth Violence Prevention (3.5M). The latter two were new in FY08 and have been expanded for FY09. Removing these accounts from the state funds included in the official Partnership budget (and Forms 2, 3, 4, and 5) makes it appear that state support for the Partnership has decreased in FY09. In fact, total state support (including the $11M that is no longer included in the forms) has increased in FY09 and the Commonwealth continues its strong overall support for targeted MCH services.

Massachusetts continues to budget at least 30% of our federal MCH funds for Preventive and Primary Care for Children (30.05% in FY09) and for Children with Special Health Care Needs (31.85% in FY09). The proportion of federal funds used for Title V Administrative Costs is within the allowable 10% for FY09 (9.8%). As the amount of MCH Block Grant has decreased over the last several years, we have continued to be successful in sharing those costs with other state and federal sources in an equitable manner.

The state revenue picture has deteriorated since the initial submission of our FY09 application in July, although the restoration of several MCH-related accounts that began in FY05 is still in place. Emergency funding restrictions are being put into place in several areas and their full impact on Partnership activities is somewhat unclear. The new state administration and the legislature have both provided increased support for public health, including some MCH priority areas. The impact of Health Care Reform -- both on our clients and programs and on our budgets (if costs exceed expectations) continues to be watched closely.

Again in FY09, the entire Family Health Services account has been earmarked for specific programs -- or vendors. The good news is that the Family Planning Program has received a significant increase again (up to nearly $6.0M in FY09) and the account continues to include funds specified for the Regional Poison Control Center, the Massachusetts Birth Defects Monitoring System, and the Massachusetts SIDS Center. However, the total dollar amount of the earmarks (including these positive ones and others targeting some other high-risk youth) completely subsumes the entire account, leaving no flexible funds for MCH services. It appears that this situation will continue on this account.

The $132,462,710 of Other Federal funds for FY09 comes from approximately 20 different grants, which cover all of the categories on Form 2 except federal Healthy Start and Abstinence Education. [Massachusetts no longer applies for ACF Abstinence Education funds.] We continue to include all of our WIC funds, state and federal, as they are budgeted in a seamless manner at the state level. Massachusetts funds WIC (both directly and with an infant formula retained revenue account) at over $35M. The Bureau continues to have good success in obtaining a wide range of federal categorical grants. We are hopeful that several pending grant applications will be added during FY09.

As noted previously, not included in the budget forms is a substantial amount of state funding for MCH programs that is used for match for other federal programs (TANF and Medicaid FFP). As we have a substantial amount of over-match, this is not a budget issue, but it does undercount the level of state support for key MCH services. The programmatic efforts supported by the funds continue to be fully described in our annual reports and plans.

For a more detailed picture of the different distribution of federal and state funds across the MCH Populations and the MCH Pyramid, see the updated tables in the Excel file that is the attachment to this Part 5, Section B (Budget). Historically, much of the year-to-year variation in the total and relative distribution of funds across population groups (or the pyramid) is due to changes (up and down) in state funding. Based on the categorical nature of our state funding stream (which is over 87% of the MCH Federal-State Partnership budget), the impact of the state funding cuts is not always felt equally across all of MCH population groups and while the patterns of funding have stabilized greatly for the last three years, they could begin to fluctuate again at any time.

State-level trends continue to place enormous pressure on the MCH Federal funds as the only source of flexible funding for many key MCH activities. This strain has previously been felt primarily in the area of Infrastructure Building, as state accounts rarely include funds for systems development, data management, or evaluation. In addition, with caps (or complete prohibitions) on the number of personnel that can be hired on state accounts, a disproportionate number of our total MCH Partnership staff are funded from the Block Grant. But reductions in federal MCH funding have come at the same time when inexorable increases in personnel costs have exhausted our previous carry-over cushion. Due to these factors and their particular impact on personnel costs, the number of FTE staff paid directly by the MCH Block Grant has been reduced, from approximately 107 in FY06 to 92 for FY09, and they now represent approximately 70% of all Partnership FTEs (down from 75% in FY06). A higher percentage of staff working in MCH-related areas is being funded from either state or other federal grant sources. With reduced federal MCH funds, state position caps and limitations in our other categorical federal grants, our ability to hire and retain highly qualified professional staff is increasingly threatened.

In summary, the FY09 budget, although generally good on the state side, continues to strain our ability to assure core direct, enabling, and population-based services and is altering the shape of many of our programs. The worsening economic climate and state revenue picture are increasingly worrisome, affecting available funding at a time of increased demand for critical services. Restoration of federal funding levels and of flexible state funds, along with changes to personnel funding options are essential to the long-term richness and stability of the Title V Federal-State Partnership in Massachusetts. These potential changes are discussed throughout our Narrative in the "Current Activities" and "Plans for the Coming Year" segments.//2009//

/2010/The FY10 budget in Forms 2, 3, 4, and 5 reflects a new and concerning budget situation at the state level. Federal MCH funds remain steady and we have been able to achieve some cost-savings to stretch them further programmatically, as fringe benefit costs are rising again. However, like almost all states, Massachusetts is experiencing a budget crisis of unprecedented proportions. The just-signed FY10 state budget is significantly lower than FY09 across the board. Our state funds will be at least $25M less than our original FY09 budget. So after stabilizing and experiencing some gains over the previous several years, including some new areas of support from the state, the shape and scope of virtually all state programs will be changing in FY10. Some new initiatives will disappear altogether and further cuts during FY10 are very likely.

The total Partnership budget is made up of $11,606,462 of MCH Block Grant funds (including carry-forward funds) and $51,448,647 in state funds (down from an initial $76,266,360 in FY09.) Massachusetts continues to budget at least 30% of our federal MCH funds for Preventive and Primary Care for Children (30.96% in FY10) and for Children with Special Health Care Needs (35.63% in FY10). The proportion of federal funds used for Title

V Administrative Costs is within the allowable 10% for FY09 (9.71%). Massachusetts continues to commit funds above our statutory maintenance of effort level from FY1989 of $23.5M and the state funding still includes Over Match of over $42M. See the Notes to Form 2 for details.

The $147,646,533 of Other Federal funds for FY10 comes from approximately 21 different grants and some ARRA funds for EI. The Bureau continues to have good success in obtaining a wide range of federal categorical grants.

The budget forms do not include substantial amounts of state funding for MCH programs that are used for match for other federal programs (TANF and Medicaid FFP). The programmatic efforts supported by the funds continue to be fully described in our annual reports and plans.

For a more detailed picture of the different distribution of federal and state funds across the MCH Populations and the MCH Pyramid, see the attachment to this Section. Due to its categorical nature, the impact of changes in state funding (now about 82% of the Partnership budget) is not always felt equally across all MCH population groups. Patterns of funding stabilized for several years, but the impact of major budget cuts is causing them to fluctuate again. //2010//

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.