Maternal and Child Health Services Title V Block Grant

State Narrative for Maryland

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

The required assurances and certifications have been signed by Ms. Bonnie S. Birkel, Director of the Center for Maternal and Child Health and housed in the Center for Maternal and Child Health's central offices. The assurances and certifications will be made available to the Maternal and Child Health Bureau upon request.

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

Flyers we distributed at many state and local meetings involving the Center for Maternal and Child Health Programs explaining Title V and asking to log into our online survey to provide comments and input suggestions. The public is invited to review a summary MCH plan for 2008 and to comment on the State's current MCH priorities and performance measures through a web based survey. The survey tool will remain available for public comment throughout the coming year. Survey results will be reviewed and compiled bi-monthly to assist in identifying emerging MCH needs. Comments and recommendations generated by the survey will be considered for incorporation into MCH needs assessment and planning efforts over the next two years. Comments will be summarized and included in next year's application. Links to both the needs assessment and the 2009 application will be available on both the CMCH and OGCSHCN Web sites.

Parents of CSHCN from The Parents' Place of Maryland were participants in preparation and review of the CSHCN portions of the block grant application.

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

Updates to Needs Assessment for CYSHCN

There are a number of new data sources available related to CYSHCN since the 2005 needs assessment. Some interesting/important findings from selected data sources are described below.

Health Care Transition Survey of Pediatricians
Kennedy Krieger Institute, in partnership with the Office for Genetics and Children with Special Health Care Needs (OGCSHCN), conducted a brief survey by mail of pediatricians to assess their current practices and needs related to supporting the health care transition process for CYSHCN in their care. The survey was inadvertently sent to Maryland family practitioners as well as pediatricians, with no way to distinguish the responses from the two groups. This obviously limits the data somewhat, as we would not expect that family practitioners would transition their YSHCN. The overall response rate was 12.5% out of 2500 surveys mailed. Key findings:

- Areas of relative self-reported strength for pediatric primary care providers were in the areas of keeping comprehensive medical summaries, meeting privately with adolescents for part of the visit, and providing age-appropriate and developmentally-appropriate anticipatory guidance
- Some of the areas of greatest weakness were found in creating a written health care transition plan, ability to direct patients and their families to resources that facilitate transition, and assisting families with identifying health care providers who are comfortable caring for adults and collaborating with those providers
- Knowledge of health care resources, knowledge of educational and vocational resources, and time were the top 3 issues reported to impact pediatric primary care providers' ability to facilitate health care transition planning

Medical Home Survey of Respite Recipients
The local health departments, in partnership with OGCSHCN, distributed a brief survey by mail or in person to families of CYSHCN receiving funding for respite supported by OGCSHCN monies. The survey asked questions primarily about the quality of different aspects of care provided by the child's primary care provider. There were 455 responses with an unclear number of surveys distributed. Key findings:

- Very few families had ever heard the term "medical home"
- Areas of parent-reported strength for their child's PCP: accessibility, components of compassionate and culturally competent care
- Areas of parent-reported weakness in their child's PCP were in aspects of health care transition, shared decision-making, provision of information about public resources, care plan development, and coordination/communication with other providers

Survey of Adult Primary Care Providers Regarding Sickle Cell Disease
Transition planning for children identified with sickle cell disease (SCD) through newborn screening has been complicated by the paucity of services for adult SCD patients and the scarcity of physicians willing to accept new patients with SCD. The OGCSHCN distributed a survey to 3520 internists, family practitioners and general practitioners to ask what would help them to see more SCD patients. The overall response rate was 12.9% but only 22% (97 responses) were informative. Key findings:

- 24% said they did not want to see SCD patients.
- Of those willing to see SCD patients: 38% asked for free case management services, 30% for higher reimbursement, 28% for a 24/7 on call SCD specialty consultant, 27% for convenient relevant CME, 27% for an SCD center within reach, 24 % for a pain management specialist on call and 17% for a day hospital within reach.

Updates to the Needs Assessment for the Maternal and Child Health Programs

Babies Born Healthy Initiative
The Center for Maternal and Child Health initiated the Babies Born Healthy Program to improve perinatal health through a comprehensive approach. The design and implementation of activities for the Babies Born Healthy program were completed after thorough quantitative and qualitative data analysis. Vital statistics data were analyzed by maternal characteristics, including race, educational attainment, and maternal age. Leadings causes of infant death also were analyzed. Causes of infant mortality include premature birth, congenital anomalies, Sudden Infant Death Syndrome, and maternal complications.

Maternal behaviors also are known to be associated with poor pregnancy and birth outcomes. An increasing percentage of women in Maryland receive late (after 20 weeks gestation) or no prenatal care. Additionally, pre-pregnancy health is important for good pregnancy outcomes, yet approximately 42 percent of births in Maryland are not planned. Furthermore, 47 percent of Maryland women of childbearing age are overweight or obese, and 20 percent of Maryland women of childbearing age smoke.

Qualitative data also were used to provide insights into the factors associated with infant mortality. Specifically, Fetal and Infant Mortality Review (FIMR) and Key Informant Interviews have yielded information for targeting interventions. Fetal and Infant Mortality Review are a confidential and anonymous review of individual cases of fetal and infant loss to identify needs and opportunities for change in community systems that will improve perinatal outcomes. Through this process, needs related to preconception and reproductive health, preterm labor prevention, infant care, healthy pregnancy behaviors, substance abuse cessation, and bereavement support have been realized. Additionally, MCH conducted a needs assessment of the leadership and programmatic concerns in Maryland related to infant mortality through interviewing experts from obstetrics, pediatrics, nursing, social work, and public health, which became known as Key Informant Interviews. The Key Informants' revealed the need for improved data, emphasis on preconception health, and attention to racial health disparities.

/2009/ CMCH funded a needs assessment to determine the need for expansion of Baltimore City Healthy Start Inc. outreach and family support services in Baltimore City. The federally funded Baltimore City Healthy Start project provides a range of enabling services to reduce adverse birth outcomes in high risk areas of the City. The results of the needs assessment that included both qualitative and quantitative components demonstrated the need for expanded services in four neighborhoods in Baltimore City. The State is now partnering with Healthy Start Inc. to provide these services. //2009//
/2010/ The Title V Program is continuing to work to complete the 2010 Needs Assessment using the steps and methodologies as suggested by MCHB. Other needs assessment activities are discussed under State Performance Measure 10. //2010//

III. State Overview

A. Overview

According to the U.S. Census Bureau, Maryland was home to 5,558,058 residents in 2004. This included 374,578 young children under the age of five; 368,612 elementary school aged children between the ages of five to nine; 806,368 adolescents between the ages of ten to nineteen; and 366,452 young adults ages 20-24. Maryland is comprised of 23 counties and the City of Baltimore and is characterized by mountainous rural area in the Western part of the State, densely populated urban and suburban areas in the central and southern regions and flat rural areas on the Eastern Shore. The State borders West Virginia, Pennsylvania, Washington, D. C., Delaware and the Atlantic Ocean. Maryland has 9,837 square miles of land area, 623 square miles of inland waters and 1,726 square miles that constitute the Chesapeake Bay, the world's largest estuary. In 2004, Maryland ranked 19th in population and 6th in population density among the states (including the District of Columbia) with 541.9 persons per square land mile.

Maryland's population grew by 4.9% as compared to an overall U.S. growth rate of 4.3% between 2000 and 2004. Montgomery and Prince George's counties, both part of the Washington D.C. suburbs, accounted for the majority of this population growth. Conversely, the population of Baltimore City continued to decline, decreasing by 14% during this same time period. The majority of Maryland residents (75%) live in the two major metropolitan areas surrounding either Baltimore City or Washington D.C., while 11% live in Baltimore City and 14% reside three more outlying rural areas: Western Maryland, Southern Maryland and the Eastern Shore. The Baltimore-Washington D.C. combined Metropolitan Statistical Area constitutes the nation's fourth largest retail market.

/2010/According to the MD Vital Statistics Annual Report 2007, the estimated population of Maryland in 2007 was 5,618,344, with a distribution as follows: White (64.2%), Black or African-American (30.0%), Asian or Pacific Islander (5.3%) and American Indian (<1%). Over 6% of the population is comprised of individuals of Hispanic origin. This includes 376,745 under the age of five; 358,840 elementary school aged children between the ages of five to nine; 784,451 adolescents between the ages of ten to nineteen; and 378,650 young adults 20-24. //2010//

/2007/ In 2005, Maryland's total population grew to 5,600,338. Since 2000, Maryland's population has grown by nearly 304,000 persons. Foreign immigration, particularly in the Washington, D.C. metropolitan area, accounts for a significant percentage of population growth. Population size within Maryland's 24 jurisdictions ranged from a low of 19,899 in Kent County to a high of 927,583 in Montgomery County. Many local health departments are directing increasing percentages of resources to address the increasing linguistic and cultural diversity of the State's population. In several instances, county budgets for translators and interpreters increased in recent years. / /2007//

The State's 1,549,558 children and adolescents ages 0-19 represented 27.8% of Maryland's population in 2004. Senior citizens, aged 65 and over, represented 11.4% of the population. The median age was 36.9 years. An estimated 1.2 million women of childbearing age (ages 15-45) lived in Maryland in 2004. Between 1999 and 2004, an average of 73,463 babies were born each year. The state's birth rate has been declining overall as well as for most racial and ethnic groups.

Maryland is a diverse State and one that is becoming more diverse over time. With the exception of Western Maryland, the State's minority racial and ethnic populations are rapidly increasing and comprise a significant portion of the population of each geographic area. Racially, Maryland's population was distributed as follows in 2004: 64.5% were Caucasian, 29.1% were African American, 4.6% were Asian, 1.4% represented two or more races and less than one percent were American Indian or Native Hawaiian. As a whole, racial minorities comprised an estimated

35.5% of Maryland's population in 2004, up from 28% in 1990. Of the 2.0 million racial minority residents in Maryland, African Americans represented 82% in 2004. Hispanics, the fasting growing ethnic minority in Maryland, represented 5.4% of the total State population in 2004. Compared to the national average, Maryland has a greater proportion of African-Americans (two times of the national average) and a lower percentage of Hispanics (one third of the national average).

/2009/ The number of minorities in Maryland continues to grow as the State's white population decreases. Minorities represented 42% of the State's 2007 population of 5.6 million. Latinos continue to be the fastest growing racial/ethnic group, representing over 6 percent of the State's 2007 population. Racial/ethnic minorities (52% in 2006) now represent a majority of the babies born in Maryland. //2009//

Maryland's undocumented immigrant population has continued to increase. Between 2000 and 2004, the numbers of undocumented immigrants in Maryland are estimated to have doubled from 120,000 to approximately 250,000 (Pew Hispanic Center, Estimates of the Size and Characteristics of the Undocumented Population). A large percent of undocumented residents are women, and about one in six are children. While nationally, 57% of this population migrates from Mexico, Maryland's Hispanic immigrants are predominantly from the South and Central Americas and the Caribbean Islands. The increasing numbers of undocumented women and children, coupled with state budgetary constraints, has strained the ability of local health departments to provide and maintain services for uninsured MCH populations.

/2009/ The 2008 Maryland Legislature passed a bill establishing a Commission to study the Impact of Immigrants in Maryland including a demographic profile of the population as well as an analysis of the fiscal impact of immigration on the State. A report is due to the Governor by January 2011. //2009//

U.S. Census data for Maryland indicate that both the total number of poor persons and the poverty rate rose between 1990 and 2000. The Census reported that 438,700 Marylanders (8.3% of the total population) lived in poverty in 1999, however Maryland's poverty rate for 2003 was 10.4%. Still, Maryland is comprised of some of the wealthiest communities and jurisdictions in the nation. Maryland continues to be one of the wealthiest states in the nation with per capita, median and mean household incomes that consistently rank within the top five nationally. Maryland ranked as the nation's second richest state with a median household income of $57,218 in 2003 according to the Census Bureau's American Community Survey.

Nationally, Maryland's poverty rate placed it at the sixth lowest in the nation in 2004 (American Community Survey). Poverty rates vary by race/ethnicity and jurisdiction in Maryland. For example, the poverty rate for African Americans is two to three times higher than the rate for Caucasian Americans. The 2003 Governor's Commission on Poverty noted that the state has several "areas of concentrated poverty" particularly in Baltimore City, in Western Maryland and on the Eastern Shore. These areas are characterized by high unemployment, high crime and violence, teen parenting, a lack of father figures, low performing schools and deteriorating and physical environments. Children living in these communities are increased risk for a host of poor health outcomes.

/2007/ Nationally, according to the American Community Survey for 2004, child poverty rates in the states ranged from a high of 33.9% in Washington, D.C. to a low of 9.7% in New Hampshire. Maryland had the fifth lowest child poverty rate (11.4%) in 2004. //2007//

While the majority of regions in Maryland experienced an economic boom during the 1990's, the Eastern Shore and Western Maryland experienced a decrease in their economic prosperity that has continued in the new millennium. By jurisdiction, the poverty rate for individuals ranged from a low of 3.8% in Carroll County to a high of 22.9% in Baltimore City in 1999. The poverty rate for children under the age of 18 stood at 10.3% statewide in 1999 and ranged from a high of 30.6%

in Baltimore City to a low of 3.8% in Howard County.

Among all states, Maryland's workforce is one of the best educated. Over a third of Maryland's population aged 25 and older held a bachelor's degree or higher in 2003. More than 146,455 businesses employ 2.29 million workers. Seventy two percent of people employed were private wage and salary workers; 23% were federal, state or local government workers; and 5 percent were self-employed in 2003. Health care represents a $26.5 billion industry in Maryland with per capita spending on health care reaching $4,811 in 2003.

In spite of Maryland's affluence and many positive attributes, health indicators for the State remain mixed. In the latest (2005) Annie E. Casey Foundation ranking of states on child well-being, Maryland ranked 19th on 10 indicators of child well-being. On the positive side, as the state's latest needs assessment report shows, fewer women are smoking during pregnancy and more are initiating breastfeeding in the early postpartum period. Teen birth as well as child and adolescent death rates continue to decline. More children are being screened for lead exposure and fewer are being found with elevated blood lead levels. There are fewer uninsured children and more young children are being fully immunized. Fewer adolescents are smoking and juvenile arrests for violent crimes are down.

/2007/ In the 2006 Kids Count Report, Maryland's ranking slipped to 23rd. A rise in the infant mortality rate and a high teen death rate partially accounted for the slippage. On the positive side, the Report noted improvements in five of the ten survey areas including decreases in child deaths and high school dropout rates. //2007//

/2009/ Maryland's ranking improved to 19th in the 2008 Kids Count Report. Between the 2006 and 2007 Reports, improvements were reported in infant, child and adolescent death rates. //2009//

One area of continuing concern is the state's infant mortality rate. Maryland's infant mortality rate at 8.1 infant deaths per 1,000 live births in 2003 remains one of the highest in the nation. The state's infant mortality rate increased by 7% between 2002 and 2003 and current projections are that the rate has risen even higher in 2004. The Title V Program is currently conducting a review of infant deaths in the state and will report the findings in next year's application. Significant racial disparities remain in state with African Americans continuing to have significantly poorer perinatal outcomes than mothers and babies in other racial and ethnic groups. Maryland has identified the elimination of health disparities as a priority.

/2007/ The State's infant mortality rate rose again in 2004 to 8.5 deaths per 1,000 live births. The Title V Program used a linked dataset to investigate a statistically significant increase in deaths among African American infants in the Baltimore Metropolitan area between 2002 and 2003. The review revealed that need to improve access to preconception and interconception health services. For the seventh year in a row, the State's percentage of women receiving early prenatal care declined, lowering to 82.3% in 2004. Continuing concerns about the State's worsening perinatal outcomes led to the appropriation of funding for a new legislative initiative in 2006. The Babies Born Healthy Initiative will expand existing public health partnerships to reduce infant mortality. //2007//

/2008/ Infant mortality declined to a rate of 7.3 deaths per 1,000 live births in 2005. However, the racial gap in rates continued to worsen. The 2007 Legislature appropriated an additional 1.0 million to address infant mortality; however, part of this increase was lost during recent budget cuts brought on by a State fiscal crisis. //2008//

/2009/ Infant mortality increased to a rate of 7.9 deaths per 1,000 live births in 2006. Additional funding was appropriated by the 2008 General Assembly to support the Babies Born Healthy Initiative. This was done in spite of the State's tight fiscal situation. //2009//

/2010/ Infant mortality rate was 8.0 per 1000 live births in 2007, slightly higher than the 2006 rate of 7.9. The infant mortality rate was 4.6 among whites, 14.0 among blacks and 3.0 among Hispanic. The 2009 General Assembly continues to support Babies Born Healthy with level funding in spite of the State's tight fiscal situation.//2010//

Another area of concern is the growing number of uninsured Marylanders, particularly within the adult population. Over 740,000 Marylanders lacked health insurance coverage in 2002-2003. An estimated 140,000 of the state's uninsured were children between the ages of 0-18. Between 2001-2002 and 2002-2003, the state's uninsured non-elderly population increased by 60,000 while the numbers of uninsured children declined by 10,000. The state's MCHP program which provided insurance coverage to 150,643 children at some point during FY 2004 is partially credited with the decline in uninsured children. Black (13%), Hispanic (24%) and Asian (15%) children were three to six times more likely than White children (4%) to be uninsured.

The non-elderly uninsured rate was 15.3%, approximately two percentage points below the national average of 17.4% in 2002-2003. Fewer Maryland employers are offering insurance coverage as a benefit. The State's employment based coverage rate is estimated to have declined from 77 to 75 percent during 2000-2002 and continued falling to 72 percent in 2002-2003. Uninsured rates for non-elderly adults varied by race/ethnicity and were lowest for Whites (10%), followed by Blacks (17%), Asians (22%) and Hispanics (48%). Hispanics comprised 23% of the state's uninsured, but only 7% of the state's non-elderly population. Uninsured rates varied by poverty level and were highest for persons in families with incomes below the poverty level (39%). Only half of poor persons were enrolled in Medicaid.

/2009/ Maryland's average annual uninsured rate among the nonelderly (under age 65) remained at approximately 15% in 2005-2006, with an average of 750,000 uninsured nonelderly residents. During a special session held in late 2007, the Maryland Legislature voted to enact legislation to expand Medicaid coverage for uninsured parents/caretaker relatives in households with incomes up to 116% of the federal poverty level, to expand coverage incrementally over a three year period to childless adults with incomes up to 116% of the federal poverty level and to establish a Small Employer Health Insurance Premium Subsidy Program. These provisions are expected to provide coverage for an additional 100,000 adult Marylanders. //2009//

/2009/ Nearly 12 percent of Maryland children were uninsured in 2005-2006. Several bills were introduced during the 2008 Legislative Session to facilitate increases in Medicaid and MCHP enrollment; however, none passed. //2009//

/2010/ During the 2007 Special Legislative Session, Senate Bill 6 was passed, which provides for Medical Assistance to parents and other family members caring for children with incomes up to 116% of the Federal Poverty Level. In Fiscal Year 2009, the Medical Assistance for Families initiative was launched. On July 1, 2008, Medical Assistance benefits expanded to include comprehensive health care coverage for many more parents and other family members caring for children. Eligibility depends on family size and income. The income limit is about $21,200 for a family of three. There is no asset limit when applying, no face-to-face interview is required and there are options to apply online, by mail or by fax. The number of families now on the new program has exceeded 45,000. //2010//

/2010/ For 2006-2007, 15.4% of Maryland's non-elderly population was uninsured, with an average of about 760,000 non-elderly uninsured per year. The uninsured rate for all residents, 13.9% is lower because it includes the elderly, who are nearly all insured by Medicare. Compared to 2004-2005, the demographic composition of Maryland's uninsured is relatively unchanged, as are the coverage rates for most subgroups of the State's nonelderly population. The demographic composition of Maryland's uninsured shifted slightly by income (relatively poor, race/ethnicity (relatively more Hispanics), and employment relatively fewer from families lacking an employed adult. Compared to 2002-

2003 the uninsured rate is significantly higher. Conversely the Medicaid rate rose 6% (2000-2001), 7% (2002-2003), and 9% (2004-2005). Unfortunately, the growth in Medicaid coverage was too small to compensate in losses in private coverage. //2010//

/2009/ Funding was appropriated this year for the Oral Health Safety Net Program. This Program is designed to improve access to dental care for low income children. Inadequacies in access to dental care became more apparent following the death of a young Prince George's County boy who developed complications due to an untreated dental problem. Based on the recommendations of a Dental Action Committee convened by Secretary Colmers, DHMH will receive funding to increase Medicaid dental reimbursement rates, provide oral health services in targeted communities, and to support school based dental health services. //2009//

/2010/ Beginning July 2009, EPSDT medical providers including pediatricians, family medicine physicians and nurse practitioners will be reimbursed by the Medicaid Program for assessing and applying a preventative fluoride varnish agent to very young children not currently being seen by dentists; Efforts began to institute a dental sealant demonstration project to assess and evaluate the most efficient and cost-effective means to develop statewide dental sealant initiatives. //2010//

Injuries remain as the leading cause of child and adolescent deaths. Two major environmentally linked health conditions - asthma and lead poisoning -- continue as major causes of childhood morbidity. An estimated 153,000 Maryland children and adolescents have asthma. In 2003, 3,349 children were diagnosed with elevated blood lead levels (defined as a venous or capillary blood lead level >= 10 ug/dL). Obesity and obesity related illnesses such as type 2 diabetes are documented to be increasing among children and adolescents. The 2005 needs assessment reports that health providers and school health personnel are increasingly identifying depression and mental health disorders as problems among adolescents.

/2009/ In 2007, the Maryland Legislature passed the Clean Indoor Air Act which prohibits smoking in most workplaces and resultantly reduces exposure to second hand smoke, a contributing factor to asthma for some Marylanders. //2009//

Twenty of Maryland's 24 jurisdictions are currently either entirely or partially federally designated as medically underserved areas for primary care services. This occurs even though the ratio of primary care physicians to the population is higher in Maryland than the national average. Part of this higher representation is based on the high number of physicians employed by government research facilities, military and medical schools, in non-direct health care positions. Four of Maryland's twenty-four jurisdictions are currently classified as being underserved for dental health services/manpower and six jurisdictions are classified as underserved for mental health services. Federally qualified community health centers are located in 17 jurisdictions.

The Medicaid Program, known in Maryland as the Medical Assistance Program, serves as the major source of publicly sponsored health insurance coverage for children and adolescents. The Maryland Children's Health Program (MCHP) began operating as a Medicaid expansion program on July 1, 1998. The MCHP program expanded coverage for comprehensive health insurance for children up to the age of 19 with family incomes at or below 200 percent of the Federal Poverty Level (FLP). In 2001 Maryland initiated a separate children's health insurance program expansion, MCHP Premium. In FY 2004, 397,060 children and adolescents were enrolled in the Medicaid Program at some point during the year, while 150,643 were enrolled in MCHP. MCHP also provides insurance coverage for pregnant women with incomes between 185% and 250% of the federal poverty level. In FY 2004, Medicaid covered hospital delivery costs for approximately one-third of Maryland births.

More detailed MCH-related health status indicators are reported on in the other Narrative Sections and/or the Health Status Indicator Section. Emerging health trends, problems, gaps and barriers are also identified in the 2005 Needs Assessment Report.

State Health Agency Priorities

The mission of the Maryland Department of Health and Mental Hygiene is to protect and promote the health of the public by creating healthy people in healthy communities; to strengthen partnerships between state and local governments, the business community and all health care providers in Maryland; and to build a world class organization grounded in the principles of quality and learning, accountability, cultural sensitivity and efficiency.

Mr. S. Anthony McCann and Dr. Michelle Gourdine were appointed Secretary and Deputy Secretary for Public Health Services, respectively in FY 2005. Secretary McCann has stated that improving quality within the health care system is his priority for the next 6 years. Dr. Gourdine, the former Baltimore County Health Officer, has indicated that two of her top priorities are succession planning (developing the next generation of public health leaders) and public health prevention.

/2008/In November 2006, Marylanders elected a new democratic governor, the former Mayor of Baltimore City, the Honorable Martin O'Malley. Anthony Brown was chosen as his running mate for Lietenant Governor. Governor appointed John M. Colmers, the former director of the Maryland Health Care Commission to replace S. Anthony McCann as the new Health Secretary. Dr. Gourdine remains as the Deputy Secretary for Public Health Serivces. Reforming the health care system and reducing the numbers of uninsured Marylanders are priorities for the current administration. //2008//

/2009/ Secretary Colmer's priorities include expanding health insurance coverage, improving the quality of health care services and controlling health care cost growth. Governor O'Malley recently created the Maryland Health Quality and Cost Council through an Executive Order. This Council which is co-chaired by Secretary Colmers and Lieutenant Governor Brown will facilitate collaboration and make recommendations on health care quality improvement and cost containment initiatives across the public and private sectors. //2009//

/2010/ Last state fiscal year, Governor O'Malley established a furlough and salary reduction plan for 67,000 State employees including MCH staff take up to five furlough days. Because of a $700 million dollar deficit in the current fiscal year additional furlough days or even layoffs may be forthcoming. //2010//

/2009/ Dr. Michelle Gourdine left State service in February 2008 and her replacment is currently being sought. The current acting Deputy Secretary is Ms. Arlene Stephenson who previously held this position under a different administration. //2009//

/2010/ Frances B. Phillips, RN, MHA, former health officer from Anne Arundel County became the new Deputy Secretary for Public Health Services. //2010//

The elimination of health disparities remains as a DHMH priority. Objectives to address health disparities within the State's Health Improvement Plan for 2010. The Maryland General Assembly passed legislation in 2003 requiring the DHMH to develop and implement a plan to reduce health care disparities based on race/ethnicity, gender and poverty. The 2004 Maryland General Assembly passed legislation establishing an Office of Health Disparities and Minority Health in the Department of Health and Mental Hygiene. This Office which is headed by Dr. Carleissa Hussein, sponsored the sponsored two statewide conferences on health disparities and is currently finalizing a state's health disparities plan.

/2007/ A bill (HB 851) was passed by the State legislature in 2006 requiring the OGCSHCN to work with the Office of Health Disparities and Minority Health (OMHHD), to formulate a plan for improving services for adult patients with sickle cell disease, drawing on the OGCSHCN's

experience with lowering the mortality from sickle cell disease in the pediatric population. This is a transition issue for the OGCSHCN since the oldest sickle cell disease patients identified through newborn screening will turn 21 years old this month. //2007//

/2008/ The plan to improve services for adults with sickle cell disease (SCD) was formulated and the required report submitted to the legislature. In response a bill, HB793, was introduced with the intent of providing funding to implement the plan. The plan included the development of a day hospital at the only clinic in the State (at Johns Hopkins) dedicated to adult sickle cell disease patients; the development of an outreach case management network with nurse practitioners/ physician assistants providing home visiting and consultative services in primary care provider's offices and emergency rooms; telemedicine and outreach clinics; a 24/7 on call consultation service; an abbreviated electronic medical record available on line for all patients; a voluntary patient registry; strengthening patient support groups; a provider education web site with standard treatment protocols for health maintenance, emergency room management and the use of hydroxyurea; and publicizing the Employed Individuals with Disabilities Medicaid buy-in program. Unfortunately, because of the State structural budget deficit, the bill, as passed, only provided for a steering committee to strengthen stake holder partnerships, do some provider and patient education and to seek grant or other funding to carry out the rest of the plan. The OGCSHCN will work with the steering committee to accomplish as much as possible. //2008//

//2009// The Statewide Steering Committee on Services for Adults with SCD was established with all the constituencies specified in the bill represented. The Committee has clearly succeeded in establishing institutional and community partnerships and a Statewide network of stakeholders. However, without funding, the other accomplishments are largely the accomplishments of individual groups of members, although these activities benefit from the support of the group. The Johns Hopkins Center for Adults with Sickle Cell Disease established a day infusion center through a creative partnership and sub-capitated funding arrangement with several MA managed care organizations. The Center opened in February 2008. Several grant applications were written. The NIH for a Comprehensive Sickle Cell Disease Center application submitted by the Johns Hopkins Medical Institutions was approved but not yet funded. MD Logix, a company specializing in electronic health information systems, developed a prototype sickle cell disease specific electronic health record/ workflow tracking system with funding from Small Business Innovative Research (SBIR) grants. Another MD Logix application to the NIH Institute of Nursing is pending. The Sickle Cell Disease Association of America submitted an unsucessful application for a Patient Registry to the Agency for Health Care Research and Quality. Support group activities and numerous educational/ awareness activities, targetted to legislators, parent, patients, health care providers and the public, are ongoing. A workgroup including Blue Cross / Blue Shield of Maryland is working on strategies for implementing the Medical Home model of coordinated care for adult sickle cell disease patients.//2009//

//2010//. The Statewide Steering Committee on Services for Adults with SCD continues to work. With a change in direction by the NIH, the Comprehensive Sickle Cell Disease Center award contained no funding for a patient services core. None of the other grant applications was sucessful. The day infusion center has decreased the admission rate of patients in SCD crisis compared to the emergency room. A report was submitted to the Secretary in December of 2009, outlining the ongoing needs of this population with an emphasis on finding ways to assure that all SCD patients can access primary care. The OMHHD and the OGCSHCN submitted an application for one of the CDC cooperative agreements for SCD surveillance. //2010//

For the past three years, Department of Health and Mental Hygiene, the Family Health Administration and the Maternal and Child Health Offices have dealt continuously with budget, personnel and resource reductions. The state's public health system has faced severe budget reductions and other federal and state priorities, including Medicaid and emergency preparedness expenditures. Recently, programs within DHMH have been permitted to request and are receiving freeze exemptions for recent vacancies that have occurred because of

employees' retirement. While improvement in hiring is beginning to occur, past fiscal decisions have slowed the Department's ability to sustain and develop public health programs. It is anticipated that progress will be made but at a very slow rate.

/2008/ With the new gubernatorial administration and its concern for the structural budget deficit - $1.4 billion in FY 2008, additional budget cuts are being made and freeze exemption requests are again being carefully scrutinized and sparingly granted, slowing the replacement of positions vacated by retirements.//2008//

The Family Health Administration's priorities will continue to focus on strengthening programs, as well as revitalizing public health data; building public health partnerships (with the academic centers, professional and advocacy groups, and others); and strengthening operational aspects of public health administration (e.g., budget, personnel, procurement, legislation, information technology). In addition, a major FHA focus will be on leadership development with special attention on developing and mentoring the next generation of public health leaders.

MCH/CSHCN Program Priorities

The Center for Maternal and Child Health Program priorities for the next four years are identified here:

Assuring access to family planning services continues as a priority. This includes assuring that the program maximizes resources, and minimizes costs while continuing to offer convenient no-cost/low-cost services through a diverse network of providers, to reach more women in need. This is to be done without sacrificing the current level of comprehensiveness or quality of services. Family planning services is one of the strategies for reducing infant mortality because women will be healthier and pregnancy will occur within a planned period to time.

Improving key indicators for the health of women and children (i.e., decreasing unintended pregnancy and fetal and infant mortality; and sustaining and increasing progress in teen pregnancy prevention). Reducing maternal, infant and child mortality and improving health outcomes will be achieved through the implementation of maternal mortality, fetal and infant mortality and child fatality review processes; the implementation of the Pregnancy Risk Assessment Monitoring System (PRAMS); and the continuation of local health department based home visiting and care coordination programs.

/2009/ Further refinement of and implementation of the Babies Born Healthy Initiative will be a priority focus for the coming year. A Babies Born Healthy Summit is being planned for the Fall of 2008 to heighten awareness of the problem of infant death and sickness. The target audience includes legislators, health care providers, community groups and other key stakeholders. //2009//

/2010/ A Babies Born Healthy Forum was held in October 2008. This call to action's purpose was to develop a plan to ensure that all babies in Maryland are born healthy and to explore the multifaceted issues of infant mortality in Maryland. //2010//

The state has developed a plan to eliminate elevated blood lead levels in children by 2010. CMCH will continue to work on activities to promote blood lead screening and collaborating with other agencies to reduce elevated blood lead levels in children under age 6.

Another priority focus will be on advancing new prevention priorities in the areas of environmental health (i.e., asthma) and healthy nutrition/physical activity to address obesity and overweight across the life span. CMCH is the recipient of a CDC asthma intervention grant and also is responsible for administering the legislatively mandated Asthma Control Program.

CMCH is also administering a MCHB funded early childhood grant. The Program will focus on developing a comprehensive approach to early childhood health that is fully integrated with broader, more comprehensive efforts aimed at healthy child development. The same approach will be used to develop a plan for improving adolescent health.

During the coming year, CMCH will also focus on refining the five year MCH strategic plan with input from local health departments, health providers, family groups, community based organizations, advocacy groups and other MCH stakeholders. This will be done in conjunction with the Office for Genetics and Children with Special Health Care Needs. Finally, enhancing the Center's data and epidemiological capacity is an ongoing priority.

The Office for Genetics and Children with Special Health Care Needs will be dealing with a number of significant issues in the next few years. In general, the structural State budget deficit and resulting cuts to the Departmental budget and an increasingly conservative political climate create challenges for all public health programs, including MCH programs. More specifically, on the genetics front, these include the fragmentation of the newborn bloodspot screening program by the licensure of a private laboratory in competition with the State Public Health Laboratory, obtaining the legislative changes needed to bring the birth defects program up to the new CDC standards, and the closure of the AFP/Quadruple Marker Screening laboratory in the State Public Health Laboratory.

//2009// See below for OGCSHCN issues) //2009//

On the CSHCN front, the issues include the creation of a cabinet level Office of Disabilities, major changes to the REM (Rare and Expensive Disease Case Management) Program in Medicaid, the transition of the CMS (Children's Medical Services) program to electronic bill paying, the elimination of Medicaid coverage for legal immigrants, new legislation mandating a pilot autism screening project and overcoming barriers to collaborating with partners outside State government such as professional organizations, like the Maryland Chapter of the AAP.

/2007/ An additional priority focuses on implementation of the medical home state plan developed over the past year. This plan incorporates strategies that target CYSHCN and their families, pediatric health care providers/practices, and state and local agencies to optimize the care of Maryland CYSHCN through medical home partnerships. //2007//

/2009/ The development of a Maryland plan for CYSHCN, that will engage diverse partners in shared planning, implementation, and evaluation of strategies to achieve six core components of a system of services for CYSHCN built on evidence-based practices, is a priority for the coming year. Maryland sucessfully applied to MCHB for a State Implementation Grant to build an Integrated Community System of Services for CSHCYN. Under the project, a Community of Care Consortium will be created. The Consortium will be kicked off with a Community of Care for CYSHCN Summit to be held in November 2008. //2009//

//2010// The Community of Care Consortium Summit meeting was well attended and a detailed work plan was constructed. The COC meets quarterly and has awarded its first set of mini grants. This effort is severely hampered by the loss of 2 key OGCSHCN staff members: Dr. Jamie Perry, Deputy Medical Director of OGCSHCN, and Rachael Hardegree, the medical home project coordinator. Parents' Place of Maryland has shouldered an increased share of the work of the project. The Maryland Chapter of the AAP has undertaken a greater share of the work of the medical home and developmental screening projects.//2010//

In 2000, NeoGen Screening, a commercial newborn screening laboratory, appealed the denial of a license to conduct newborn screening in Maryland. NeoGen had previously been granted a license as a molecular diagnostic laboratory, but had been denied a license to do newborn screening. In May of 2002 NeoGen Screening received a license to perform newborn screening

tests as part of a settlement agreement. Under the terms of the settlement, Neo Gen was to report abnormal test results to the Newborn Screening Follow-Up unit in the OGCSHCN who would continue to provide follow up services. NeoGen was also to provide data on all Maryland babies screened to the Follow-Up unit and to provide data on the babies it screened for required reports, such as the MCH Block Grant and the National Newborn Screening and Genetics Resource Center' s annual report. NeoGen Screening was then acquired by Pediatrix. The new leadership was much less experienced with newborn screening and the mechanics of comprehensive state newborn screening programs.

Despite the best efforts of all concerned, the difficulties of running a comprehensive State newborn screening program with two laboratories have proven much greater than anticipated. Meshing the 2 data systems has been much more difficult than expected. This has been further complicated by differing interpretations of HIPAA compliance requirements and the expectations of all parties. Consequently, Maryland's newborn screening data may be incomplete. Maryland continues to address these issues and anticipates that as the "learning curve" evolves a significant number of these concerns will be resolved. This affects both blood spot screening and hearing screening because Maryland collects the results of hearing screening performed in the hospital before discharge on the newborn blood spot screening lab slip. This issue is will increase in significance as more Maryland hospitals use Pediatrix.

In CY 2004, Pediatrix screened about 5% of the babies. By the beginning of 2005, Pediatrix had contracts in place to cover approximately one third of babies born in Maryland. (Maryland has a routine 2 specimen system and some babies, for instance premies or babies with mildly abnormal results, may have more specimens.) Work on database issues and negotiations on reporting are ongoing.

/2007/ The above issues continue to evolve. Meshing the databases has proven beyond our capabilities and the program maintains 2 separate databases, only importing abnormal results from Pediatrix into the follow up database to form a single abnormal follow up database. Maryland implemented newborn screening for cystic fibrosis in 2006. Pediatrix has always used the IRT/DNA method but the Maryland Advisory Council decided that the State lab should use the IRT/IRT method. The settlement agreement under which Pediatrix is licensed requires them to use the method selected by the Advisory Council for Maryland babies. This has resulted in Pediatrix reporting only IRT results to the OGCSHCN's follow up unit and reporting the DNA results separately to the hospital or physician. This confuses physicians and makes it difficult to intelligently conduct follow up. Pediatrix has medico legal concerns about not doing DNA testing on a subset of the babies it screens. Clearly this new data exchange impass must be resolved. //2007//

/2008/ Operating a Statewide newborn screening follow up program with 2 laboratories remains a challenge but progress is being made. The problem with cystic fibrosis screening has been largely resolved. Pediatrix now reports complete abnormal results, including the DNA analysis, to the OGCSHCN for follow up. This means that the follow up protocol differs slightly depending on which lab is used but this is preferable to confusing primary care providers. The newborn screening follow up program is also facing a manpower crisis. The veteran nurse in follow up program retired due to ill health. This required the OGCSHCN director, an ABMG certified medical geneticist, to step in to do the follow up until additional personnel could be recruited. Dr Ngozi Nwokoro was reassigned from the adult sickle cell disease project and a genetic counselor, Lucy Talbot, was recruited through the University of Maryland. However, this is a temporary arrangement and the genetic counselor is relocating this fall, again leaving the program with insufficient manpower. A combination of factors requires the reorganization of the newborn screening follow up program. These factors include the rapid expansion of the program and the follow up workload, additional expansions expected in the near future (lysosomal storage disorders, SCID, ALD, fragile X, etc), the need for a new follow up database, the difficulty of recruiting and retaining qualified personnel willing to take night and weekend call, the promotion of the labor intensive PEAS quality assurance protocol and changing culture of the Family Health

Administration away from clinical programs. A number of possibilities are under consideration but the reorganization will most likely consolidate the lab and follow up components under the auspices of the Laboratories Administration and procure personnel and expert back up through an MOU with the University of Maryland.//2008//

//2009//Obstacles to operating the Newborn Screening (NBS) Program with two labs proved insurmountable. Legislation, HB 216,was introduced, hotly contested but eventually passed to restrict first tier newborn screening (NBS) to the State Public Health lab. HB 216 takes effect January 1, 2009. Restoration of a single laboratory should result in better data and better follow up since all abnormals will be reported. The NBS fee will be raised to cover a new data system, replacement of aging equipment and follow up costs. The NBS program will be reorganized with the follow up unit moving to the Laboratories Administration, which will assume administrative responsibility for the entire program. A report on the policy of informed consent for newborn screening is being prepared in response to a group wishing to change that policy. A new follow up nurse, Johnna Watson, and a new genetic counselor, Carolyn Dinsmore, were recruited. All research (usefullness of the second screen) and test development (SCID, ALD) continues and a project to estimate the birth prevalence of a variant gene for osteogenesis imperfecta, that seems to occurr only in African Americans, was initiated with Dr Joan Marini from the NIH. //2009//

//2010// HB 216 took effect. New regulations were written and promulgated. The new lab data system with electronic reporting was finished. Hospitals are sending all specimens to the State Lab. The short term follow up unit moved to the lab. Carolyn Dinsmore left and recruitment of an new genetic counselor is underway. The practioner's manual was updated. The new follow up data sysytem is not yet ready and the old one is still in use. A new part time clinical biochemical geneticist, Dr Julie Kaplan, was recruited, to serve as medical director of the newborn screening program. Two new tandem mass spectrometers were purchased and the number of false positives continues to decline. Maryland had a long standing policy of informed consent for NBS. HB216 (2008) required the OGCSHCN to write a report on whether NBS should be mandatory. The conclusion was that it should not be mandatory but that written informed consent need not be required. The Advisory Council on Hereditary and Congenital Disorders, the body empowered by current law to make such policy decisions, adopted a policy of informed dissent like the overwhelming majority of other states. However a group in favor of mandatory NBS introduced SB160 (2009). SB 160 would make NBS mandatory for "treatable" disorders with no exceptions, prosecute parents who refused screening (Nebraska model) and require Maryland to adopt a Massachusetts style split screening panel with some disorders mandatory and others requiring informed consent. Using a split panel would have required the lab to reprogram its new data system, which had just been finished to accommodate the current protocols and change the tandem mass spectrometry protocol to MRM, which takes longer in the instrument. This would have required another tandem mass spectrometer, since the current equipment is at capacity. The bill failed. Some advocates complained to the Secretary's Advisory Council on Heritable Disorders and Genetic Diseases in Newborns and Children alleging that the DHMH lied to the legislature. The bill is expected to resurface in the 2010 legislative session. //2010//

The Maryland Birth Defects Reporting and Information System (BDRIS) currently receives a grade of C from the Trust for America's Health. While praising the timeliness of Maryland data, Maryland's use of the data it collects, and the information and referral services it provides, the Maryland system is marked down because it does not collect data on all birth defects and because it does not have clear-cut authority to access medical records. These deficiencies will have to be corrected for the Maryland system to meet the newly published CDC standards.

A bill was introduced in the 2005 legislative session to correct these deficiencies. It was amended in the House of Delegates because the parents of children with facial clefts felt that it was discriminatory to allow hospitals to release information about babies with birth defects to the

Department without the informed consent of their parents while asking for informed consent to release information about possible control babies to the Department, so that the program could invite possible controls to participate in case/ control studies. (Informed consent is always obtained before including babies with or without birth defects in studies that are purely research and not investigations necessary to protect the public health.) The amended bill allowed the hospitals to provide initial information, contact information only on control babies, without informed consent. This was felt by the parents to treat cases and controls the same way. The bill passed the House but failed in the Senate because some Senators thought it was unacceptable for even contact information on infants without birth defects to be released to the Department without explicit informed consent, even though the information would only be used to contact the families to get informed consent.This impasse will have resolved.

/2007/ The bill is being rewritten and will be re-introduced in 2007, probably with independent sponsorship. //2007//

/2008/ The birth defects bill was again not included in the Departmental legislative package because of higher priority issues and permission to seek independent sponsorship was not granted. The bill is being rewritten to meet the requirements of the O'Malley administration and will again be considered for inclusion in the Departmental legislative package for 2008. The birth defects program lost its veteran data manager because of ill health and is being operated solely by the birth defects nurse. A new database for the program has been under construction. Fortunately, the new system can match birth defect reports with vital records and produce some of the reports previously produced by the data manager. A freeze exemption will be sought to fill the data manager position. The program has enjoyed a closer relationship to the environmental health section of the Community Health Administration with the arrival of Dr Clifford Mitchell to head that program. Funding from the Environmental Public Health Tracking grant has made database enhancements possible and will enable the program to post statistics as part of that effort.//2008//

//2009// HB 438/SB 828 were passed, providing the birth defects program with clear cut authority to review medical records without individual informed consent for data gathering, validation and QA, and for service provision. The bills also provide authority for the collection of data on all significant birth defects rather than just the 12 WHO "sentinel defects". An Advisory Committee will update data collection forms and educational materials. The data managers position is being reclassified and the work is being done by and intern, Barbara Do from Emory University. The relationship with the Environmental Public Health Tracking continues and the database is live and being modified to accept the new data allowed by the law. //2009//

//2010// The new data base has been adapted to accommodate data on all significant defects. The Maryland Tracking Network (Environmental Public Health program) went live and included birth defects program data. The data managers position was reclassified but was lost to a series of PIN cuts resulting from the economic downturn. As soon as another position became vacant it was reclassified to a more advanced database administrator's position for the birth defects program. Mr Francis Sammanasu was recruited and the reports for 2005 and 2006 have been sent to the CDC. Reports for 2007 and 208 are in progress. Revision of the data collection forms are ongoing.//2010//

In the early 1980s the State Public Health Laboratory began to provide maternal serum AFP testing. When AFP testing began to be available in the private sector, the State decided not to establish AFP testing as a State program for all pregnant women. The State left the provision of this test to the private sector and only provided it as a service to low income women who could otherwise not access the test. The number of women utilizing this service declined dramatically after 1997 when medical assistance patients were transitioned to MCOs. The State AFP/ Quadruple Marker Laboratory was closed in February 2004 since only approximately 3,000 women/yr were tested. A short term contract to serve this patient population was established with the genetics laboratory at the University of Maryland. OGCSHCN continues to assess ways to

continue funding this genetic test new that the interim funds have been depleted. None of these low income women are eligible for any public insurance program.

/2007/ The OGCSHCN continues to support this contract on a yearly basis as long as funds are available but a long term solution has not yet been found. //2007//

/2008/ Funding was again found to keep this service operating but a long term solution is still not in sight.//2008//

//2009//AFP/Quadruple Marker screening continues to be available through an arrangement with the AFP Lab at the University of Maryland which is funded by a small grant from the OGCSHCN. //2009//

//2010// AFP/Quadruple Marker screening continues to be available through an arrangement with the AFP Lab at the University of Maryland which is funded by a small grant from the OGCSHCN but no long term solution has been found//2010//

The Department of Disability was elevated to cabinet level in 2004. The Department of Disability was charged with writing a Statewide disability plan. All State programs providing services to persons with disabilities were required to report their activities to the new Department of Disability every year and to configure their programs to achieve the plans goals. The plan has just been released. The Department of Disability is granted very broad authority to implement the plan. It is not yet clear what the impact on the programs of the OGCSHCN will be. The programs of the OGCSHCN serve some children with disabilities and some who are not considered disabled.

/2008/ The Department of Disabilites has incorporated items related to medical home and health insurance for children and youth with disabilities into its state plan. Although the OGCSHCN has been designated as lead on the medical home efforts, is is not clear what will be accomplished beyond current activities without the development of new state/local agency collaborative partnerships and the input of additional resources targeted towards medical home improvement. //2008//

The future of the REM program has been a prominent issue this year and will continue to be a highly visible issue in the next year. The REM (Rare and Expensive Disease Case Management) Program was created in 1997 at the time that Medicaid transitioned its patients into managed care (HealthChoice). Only a few special populations remained in fee for service Medicaid. Among these were a small number of patients with rare, expensive, complex disorders who were judged very likely to do poorly in the managed care setting. A major concern was that the MCOs had not yet developed adequate networks of specialty providers, especially pediatric specialty providers. The REM patients receive case management and remain in fee for service Medicaid. They are allowed to assemble their own group of specialists, free of network constraints, and to have access to services not ordinarily covered by Medicaid if these are required for their care.

The REM population contained many CSHCN; 2850 (85%) of the approximately 3,300 patients enrolled in the program were CSHCN. Since diagnosis was the major criterion for eligibility for REM, there was a broad spectrum of severity for each diagnosis. Fewer than 6% of the REM patients accounted for over 40% of total REM expenditures. Approximately 20% of the highest cost patients are in their terminal year of life. Due to the total cost of the REM case management and its impact on the total Medicaid budget, in 2004, case management was eliminated for approximately two thirds of REM patients and retained only for the most severely affected third.

Various committee reports found that, with more developed specialty provider networks and improved case management, MCOs were now successfully handling many patients as complex as REM patients whose diagnoses were too common for eligibility in REM. The elimination of REM and transition of REM patients into HealthChoice MCOs was proposed as an additional cost containment measure. However, budget language in the FY 2006 budget retains the program for

another year while requiring a number of reports including a study of the utilization of durable medical equipment (DME), the development of cost containment strategies and the consideration of alternatives to the program.

/2007/ As as result of the studies of DME utilization, the REM program now requires the case managers to use a standard DME request assessment tool in deciding whether to request specific DME. In addition, REM case managers are provided patient specific cost and utilization data on a quarterly basis to assist them in managing their patients. //2007//

Changes to REM or the elimination of REM may have a substantial impact on the CSHCN program. The CMS program historically provided "underinsured" low income CSHCN with specialty care services that are not covered by Medicaid or private insurers. Many benefit packages in the private sector do not cover care or services needed by CSHCN with complex problems. In 2004, 56% of the calls received by Parent's Place of Maryland (funded by OGCSHCN) are from families with private insurance whose insurance does not cover items needed by their children.

To comply with HIPAA, the CMS program is working on a system to pay bills electronically and proving to be more difficult than anticipated. /2007/ The difficulties with the electronic bill paying system proved insurmountable and the program returned to manual bill paying for the moment. Other alternatives are being explored. //2007//

The FY 2006 State budget eliminates Medicaid eligibility for approximately 3,000 children who are legal immigrants but who have not lived in Maryland for a minimum of 5 years. It is anticipated that some of the children with special health care needs in that group will seek fee for service coverage for their specialty care from the CMS program. This could potentially increase the caseload in the CMS program by 450 children, which is approximately 3 times the number of patients currently in the program. /2007/ The Governor has included an Immigrant Health Initiative in his budget to assist families losing Medicaid in accessing needed services through ther means. The funding will go primarily to local health departments, but the CMS program budget will also be increased to absorb the specialty care needs of the CSHCN in the affected population. //2007//

/2008/ Fortunately, the past year saw reinstatement of Medicaid eligibility to many Maryland legal permanent resident children who previously lost coverage. With this reinstatement, however, additional monies that had been put in the public health budget to shore up the public health infrastructure to assist uninsured Marylanders were lost, including funds to pay for additional services through the CMS Program. While CMS has seen a leveling off of its enrollment, overall enrollment in the program continues to exceed previous years.//2008//

Autism will also be a prominent issue in the near future. A bill to establish a pilot program of screening for the early identification of autism was passed in the 2005 legislative session. The project is based in the Maryland Department of Education but the Department of Health and Mental Hygiene is collaborating and the Associate Director of the OGCSHCN, who is a developmental pediatrician, serves on the advisory board for the project. In addition, the Director of the OGCSHCN serves on the Advisory board of the Center for Autism and Developmental Disabilities Epidemiology based at the Johns Hopkins School of Public Health. /2008/ The state's focus has expanded to general developmental screening with Maryland's selection to participate in the ABCD Screening Academy. The Maryland Medicaid program, the OGCSHCN, and the Maryland AAP are leading this effort aimed at policy and practice changes needed to support improvements in developmental screening.//2008//
//2010// The pilot program of screening for the early identification of autism initiated the use of electronic work sheets and is expanding. The OGCSHCN was represented at the Autism Spectrum Disorders summit sponsored by the Milbank Foundation.//2010//

OGCSHCN staff will work to overcome the barriers to collaborating with partners outside State

government on an increasing number of grants that require such collaboration. Both the Champions for Progress Grant and the Medical Home Work Group require collaboration with the Maryland Chapter of the American Academy of Pediatrics. The State procurement system makes it almost impossible for a State agency to provide such a professional organization with the funding for its part of the grant. In addition, the Maryland AAP Chapter lacks the staff and organization to do its part. This is an increasing concern since many new initiatives require such collaboration.

//2010// The Parent's Place of Maryland (PPMD),the Maryland Family Voices program, in partnership with the OGCSHCN, was awarded a State Implementation Grant for Integrated Community Systems for CYSHCN from MCHB. Block grant funded staff from the OGCSHCN provided critical leadership and staff support to develop the Community of Care (COC) Maryland Consortium CYSHCN. An inaugural summit was held in November 2008; over 100 stakeholders from across the state including physicians, other professionals, and families attended. Summit participants worked in small groups,and a detailed plan, addressing each of the MCHB objectives for CSHCN, was drafted. The workgroups continue to meet and the COC holds quarterly meetings. The first quarterly meeting focused on medical home and the second on families feeling like partners. The family Voices Self Assessment tools for parents and providers were introduced and will be disseminated. PPMD and the MD -AAP have had to take on more responsibility for the project because of the loss of several key OGCSHCN personnel.//2010//

B. Agency Capacity

B. Agency Capacity

Both the Center for Maternal and Child Health (CMCH) and the Office for Genetics and Children with Special Health Care Needs (OGCSHN), hereafter referred to as the MCH Program, share responsibility for MCH Block Grant development and implementation. The mission of the Maryland's MCH Program is to protect, promote and improve the health and well-being of women, children and adolescents, including those with special health care needs. Major goals include improving pregnancy and birth outcomes, improving the health of children and adolescents, including those with special health care needs, assuring access to quality health care services, eliminating barriers and health disparities, and strengthening the MCH infrastructure.

The MCH Program is responsible for addressing several federal (e.g., Title V and Title X) and state mandates for improving the health of women and children. State statutes relevant to Title V program authority include the following:

Child Fatality Review Teams (HEALTH GENERAL, Article 5, SS701) -- Establishes multi-disciplinary, multi-agency State and local child fatality review teams for the purpose of preventing child deaths. Administrative support is to be provided by the CMCH.

Hereditary and Congenital Disorders Program (HEALTH GENERAL, Article 13, SS101) -- Establishes an Advisory Council and programs to address hereditary and congenital disorders. Administratively placed within the OGCSHCN.

General Regulations For Hereditary Diseases (COMAR 10.52.01) (several programs related to genetic disorders are mandated in regulation rather than statute)- Establishes quality assurance standards for hereditary and congenital disorders services procured by the State. These regulations are administered by the OGCSHCN.

Program for Hearing Impaired Infants (HEALTH GENERAL, Article 13, SS601) -- Establishes a program for universal hearing screening of newborns and early identification and follow-up of

infants at risk for hearing impairment. This Program is administratively placed in OGCSHCN.

Sickle Cell Anemia (HEALTH GENERAL, Article 18, SS 501) -- Establishes a program for screening newborns for sickle cell anemia, monitoring each affected infant's health and providing prenatal education regarding sickle cell anemia. Informed consent is required for screening. This program is part of the bloodspot newborn screening and follow up program administered by the OGCSHCN.

Screening for Treatable Disorders in the Newborn Child (COMAR 10.52.12)-- Establishes a voluntary program to offer newborn screening for treatable metabolic disorders. Informed consent is required for screening. This program is administered by the OGCSHCN. /2007/ These regulations are being updated to encompass the new technology and expanded panel of disorders. //2007// //2009// New legislation (HB 216, 2008)was passed restoring a single newborn screening (NBS) lab. This is the first time that NBS has been put in statute. New regulations are being drafted. ***/2010/ These regulations were modernized to reflect the reorganization of the NBS program and were promulgated.//2010//***

Screening for Sickle Cell Disease, Thalassemia and Related Conditions (COMAR 10.52.13)-Establishes a voluntary program for population based carrier screening for these conditions. This program does not include newborns or those thought to be at risk on clinical grounds. This program is administered by the OGCSHCN.

Screening for Neural Tube Defects in the Fetus (COMAR 10.52.14)-Establishes a program to offer biochemical maternal serum screening to identify mothers at increased risk for carrying a fetus with a neural tube defect or a chromosomal anomaly. This program is administered by the OGCSHCN.

/2008/ All of the regulations of the OGCSHCN pertaining to genetics have been revised. The revision of COMAR 10.52.12., the newborn screening follow up regulations, was carried out in conjunction with the regulations for newborn screening laboratories, COMAR 10.10.13. The entire package of revised regulation is currently under study by the Chief Council for the Department of Health and Mental Hygiene in the Office of the Assistant Attorney General. //2008// //2009// Because of new legislation (HB 216, 2008) putting the NBS program in statute for the first time, new regulations are being drafted.//

Maryland Asthma Control Program (HEALTH GENERAL, Article 13, SS701) -- Establishes the Maryland Asthma Control Program within DHMH. The Program is administratively housed within CMCH.

Maternal Mortality Review Program (HEALTH GENERAL, Article 13, SS1201)-Establishes a program to review maternal deaths and develop strategies to prevent deaths. Support is provided by the CMCH.

Children's Environmental Health Advisory Council (HEALTH GENERAL, Article 13, SS501) -- Creates a Council which is charged to identify environmental hazards that may affect children's health and to recommend solutions. CMCH chairs and staffs the Council.

Lead Poisoning Screening Program (HEALTH GENERAL, Article 18, SS106) -- Establishes a Lead Screening Program to assure appropriate screening of children. This Program is administratively placed within CMCH.

Disease Prevention (HEALTH GENERAL, Article 18, SS107) -- Directs the Secretary to devise and institute means to prevent and control infant mortality, diseases of pregnancy, diseases of childbirth, diseases of infancy, and diseases of early childhood as well as to promote the welfare and hygiene of maternity and infancy. This mandate applies to programs administered within

CMCH and OGCSHCN.

Sentinel Birth Defects (HEALTH GENERAL, Article 18, SS206) -- Requires hospitals to report sentinel birth defects to the Secretary. Also requires the Secretary to monitor birth defects trends. OGCHSN is administratively responsible for the program. The program unsuccessfully sought to change this statute in the 2005 legislative session. Legislative change was sought to authorize the collection of data on all significant birth defects rather than just a few "sentinel " defects, bringing the program in line with CDC standards. The proposed change would also have clarified and strengthened the language allowing the program to access medical information related to the birth defect from medical records, again bringing the program up to CDC standard. Passed in the House of Delegates, the bill failed in the Senate because of a disagreement regarding the need for informed consent to access the names and addresses of possible controls for the purpose of informing them of a study and inviting their participation. Actual participation is always with informed consent and under IRB supervision. An amended bill will be proposed in the 2006 session.

/2007/ The bill was not included in the Departmental legislative package for 2006 but is being rewritten and will be introduced in 2007, probably by an independant sponsor. //2007//

/2008/ The birth defects bill was again not included in the Departmental legislative package because of higher priority issues and permission to seek independent sponsorship was not granted. The bill is being rewritten to meet the requirements of the O'Malley administration and will again be considered for inclusion in the Departmental legislative package for 2008.//2008//

//2009// New legislation (HB438/SB 428) modifying this statute was passed and gives expanded authority to access medical records and to collect data on all significant birth defects.//2009//

School Health (EDUCATION, Article 7, SS401) -- Requires the Department of Education and the Department of Health and Mental Hygiene to jointly (1) develop public standards and guidelines for school health programs; and (2) offer assistance to the county boards and county health departments in their implementation. School health activities are housed within CMCH.

Program for Crippled Children (HEALTH GENERAL, Article 15, 125) - Establishes a program to identify and to provide medical and other services to "children who are crippled or who have conditions related to crippling". Administratively placed within the OGCSHCN.

Fetal and Infant Mortality Review (HEALTH GENERAL, Section 18-107) This activity is administratively placed within CMCH.
/2008/A Deparment bill to place a State fetal and and infant morality review team in statute was withdrawn by the sponsor in 2007. CMCH is redrafting a bill for resubmission in 2008.//2008//

/2009/ In 2008, the General Assembly passed House Bill 535, mandating that the Department of Health and Mental Hygiene establish a Morbidity, Mortality and Quality Review Team to conduct case reviews and enact interventions to prevent and control mortality and morbidity associated with pregnancy, childbirth, infancy and early childhood (HEALTH GENERAL, Chapter 664). This law establishes a State Fetal and Infant Mortality Review Committee in statute, standardizes the review and information gathering processes and ensures the confidentiality of data collected. //2009//

/2010/ In 2009, the General Assembly passed House Bill 705, entitled "Child Fatality Review -- Child Death Review Case Reporting System." This bill authorizes the members and staff of the State Child Fatality Review Team to provide identifying information related to cases of child death in Maryland to the National Center for Child Death Review (NCCDR). The information transfer will occur in accordance with a data use agreement that requires the NCCDR to act as a fiduciary agent of the State and local Child Fatality Review Teams. The bill also outlines the confidentiality and discovery protections related to

information provided to the NCCDR.//2010

Lead Poisoning Screening Program - Implementation (COMAR 10.11.04) CMCH is administratively responsible for this Program.

Family Planning (Family Law Article, Section 2-405) The Family Planning Program is required to distribute a Family Planning brochure to all marriage license applicants.

CMCH is responsible for developing Perinatal Systems Standards which are incorporated in the following regulations:
COMAR 10.24.12 (State Health Plan: Acute Hospital Inpatient Obstetric Services)
COMAR 10.24.18 (State Health Plan: Specialized Health Care Services -- Neonatal Intensive Care Services)
COMAR 30.08.01 (MIEMSS -- Designation of Trauma and Specialty Centers)

Legislation passed during 2004 requires the Secretary of Department of Health and Mental Hygiene to establish and promote a statewide campaign on fetal alcohol syndrome and other effects of prenatal alcohol exposure. This activity is placed administratively in the Center for Maternal and Child Health.

MCH programs and services in Maryland are provided at each of the four levels of the MCH pyramid to protect and promote the health of women and children, including those with special health care needs. Both CMCH and OGCSHCN work collaboratively to ensure that Title V funds are administered efficiently and according to best practice standards in public health.

The mission of the Center for Maternal and Child Health is to improve the health and well-being of all women, newborns, children and adolescents in Maryland. Ms. Bonnie S. Birkel serves as the Center's director. As the attached organization chart shows, the Center is comprised of three major divisions: Operations, Policy Development and Program Managment. Program Managment includes Family Planning and Reproductive Health; MCH Systems Improvement and Community Partnerships. The Service System Development Initiative (SSDI), Asthma, and Early Childhood Systems Development, and Title X Family Planning grants are administered by CMCH. Administrative changes at the federal level resulted in the transfer of administrative responsibility for the Abstinence Education Program from DHMH to the Department of Human Resources (DHR). However, DHMH petitioned the Governor and was able to maintain fiscal and administrative control for the Program.

The goal of the Family Planning and Reproductive Health Program is to improve the health of women of reproductive age by assuring that comprehensive, quality family planning and reproductive health care services are available and accessible to citizens in-need. The target population includes clients in need of subsidized family planning services, with special attention to those who are uninsured and with incomes under 250% of federal poverty guidelines. The Program is consistent with federal and state mandates to lower the incidence of unintended pregnancy and promote the health of women of reproductive age (Health General, Article 18, Section 107 of the Annotated Code of Maryland, and Title X of the U.S. Public Health Services Act of 1970). Program efforts are designed to (1) assure that Maryland communities offer family planning and reproductive health services to clients in need; and (2) develop a coordinated approach for assuring quality patient care services, educational activities, and evaluation efforts in order to improve reproductive health outcomes.

The Family Planning Program administers the following services: Family Planning Clinical Services, Reproductive Health Services that include colposcopy, cancer screening program and sexually transmitted disease treatment, the Healthy Teens and Young Adults

program and the Adolescent Pregnancy Prevention Program. Program activities include the following:

1. Assuring reproductive health care to over 70,000 clients each year through a statewide network of over 80 ambulatory sites located in local health departments, outpatient clinics, community health centers, Planned Parenthood affiliates, and private provider offices;
2. Providing an array of preventive health care services including contraceptive care, colposcopy services, reproductive health education and counseling, sexually transmitted disease services, HIV/AIDS prevention services, breast and cervical cancer screening, cardiovascular risk screening, and referrals for indicated health and social services;
3. Developing community-based outreach strategies for reaching and serving young people, both males and females, who are at risk for unintended pregnancies;
4. Organizing workgroups of health professionals and community members to set standards for clinical care; and
5. Assuring compliance with Title X Federal Family Planning regulations and guidelines.

Maternal and perinatal health programs seek to prevent maternal and infant deaths and other adverse perinatal outcomes by promoting preconception health, assuring early entry into prenatal care, and improving perinatal care. In collaboration with local health departments, hospitals, private providers, professional organizations and community groups, these programs work to assure and improve the quality of services for the 70,000+ infants born each year in Maryland. Programs are consistent with federal and state mandates to reduce infant mortality and promote the health of women and children (Health General, Article 18, Section 107 of the Annotated Code of Maryland, and Title V of the U. S. Social Security Act of 1935). Activities include:

1. Assuring access to maternal health services, including medical care, risk assessment, prenatal education, case management, smoking cessation counseling, genetic screening, high-risk referral, home visiting, assistance in obtaining hospital-based services, and referral for family planning, and preconception health care;
2.Support of a Toll Free Maternal and Child Health Hotline (1-800-456-8900) that assists pregnant women seeking prenatal care;
3. Funding of regional perinatal improvement activities (Crenshaw Perinatal Health Initiative);
4. Perinatal systems building in each jurisdiction including Fetal and Infant Mortality Review, provider education, and public awareness efforts;
5.Development of perinatal standards and support for Perinatal Center Review and Designation;
6.Administration of the Pregnancy Risk Assessment Monitoring System (PRAMS), a statewide survey that identifies and monitors selected maternal behaviors;
7.Promotion of preconception health including the use of folic acid preconceptionally (Folic Acid Council);
8.Breastfeeding Promotion in cooperation with the Maryland Breastfeeding Promotion Task Force //2009/ Evolved into the Maryland Breastfeeding Coaltion in FY 2008 //2009//;
9.Maternal Mortality Review in cooperation with the Vital Statistics Administration and the State's Medical Society;
10.Funding for Sudden Infant Death Syndrome (SIDS) related educational and family support activities;
11.Supporting state activities to identify and address Fetal Alcohol Spectrum Disorders (FASD);
12.Supporting state activities to address postpartum depression; and
13.Sponsoring maternal and child health meetings and conferences.

Child and adolescent health programs seek to promote and protect the health of Maryland's 1.7 million children and adolescents, ages 0-21, by assuring that comprehensive, quality preventive and primary services are available and accessible. This

is accomplished through a comprehensive, integrated system of care that provides: (1) direct and enabling services to underinsured and uninsured children and (2) population based services to Maryland's children, adolescents and young adults who would be at risk if preventive public health measures and health messages were not available. Leadership, consultation, training and technical assistance are provided in several program areas including school and adolescent health, care coordination and home visiting, environmental health and child fatality review. The Program collaborates with numerous DHMH programs and other State agencies in the development of policies and programs. Activities include:

1.Assuring access to child health services including medical care, risk assessment for families and adolescents, case management and home visiting, screening, referrals and assistance obtaining a medical home;
2.Facilitating the development of regional/community child and adolescent health plans;
3. Providing medical consultation and technical assistance to school health programs;
4. Teen pregnancy prevention;
5. Administering the Maryland Abstinence Education and Coordination Program;
6. Promoting early childhood health initiatives including administering the Childhood Lead Screening Program and evaluating Maryland's Targeting Plan for Areas At Risk for Childhood Lead Poisoning to assure appropriate screening and testing of all children at risk for lead poisoning;
7.Implementing the Child Fatality Review (CFR) mandate including supporting the State Child Fatality Review Team;
8.Supporting the Children's Environmental Health Protection Advisory Council;
9.Administering the Maryland Asthma Control Program including implementation of both a statewide asthma plan and an asthma surveillance system;
10. Planning to prevent childhood overweight and obesity;
11. Supporting State activities to reduce child abuse and neglect; and
12. Working with the Medical Assistance Program to increase enrollment in MCHP and other Medical Assistance Programs.

The goal of the Women's Health Program is to assess and address health issues that commonly, uniquely, or disproportionately affect women throughout their life span. This Program partners with other program areas to facilitate access to comprehensive preventive and primary care services that incorporate the unique needs of women. The Women's Health Program was established by issuance of an Executive Order in 2001. Program activities include:

1.Administration of the Women Enjoying Life Longer (WELL) Project, a former demonstration project funded under the MCHB grant program,"Integrated Comprehensive Women's Health Services in State MCH Programs." The goal is to integrate and coordinate preventive health services to promote wellness among women enrolled in family planning programs. CMCH has made the commitment to sustain funding for the WELL Project
2.Publication of materials to promote and improve the health of women. Current publications include a booklet on postpartum depression (www.fha.state.md.us/womenshealth/pdf/postpartum_booklet.pdf) and a report on the health of Maryland women (www.fha.state.md.us/mch/pdf/WomensHealth-Publication.pdf.)

The Division of Community Partnerships is responsible for developing initiatives and strengthening community partnerships with community organizations, advocacy groups, universities and professional groups to improve maternal and child health. This Unit shares responsibility with other programs where community involvement, outreach and partnering are crucial to program success. Examples include Abstinence Education, Pregnancy Risk Assessment Monitoring System (PRAMS), and teen pregnancy prevention.

/2009/ This Division was reorganized as the Division of Federal State MCH Partnerships in FY 2008. This Unit is responsible for managing several federal programs including asthma and abstinence as well as Title V coordination and planning. //2009//

The mission of the Office for Genetics and Children with Special Health Care Needs (OGCSHCN) is: (1) to reduce death, illness and disability from genetic disorders, birth defects, chronic diseases and injuries and to improve the quality of life for these individuals, and (2) to protect and promote the health of Maryland's children with special health care needs by assuring a family-centered, community-based, comprehensive, coordinated and culturally appropriate system of specialty health care. As the organization chart shows, the OGCSHCN is comprised of six divisions: Newborn Blood Spot Screening and Follow-Up (including sickle cell disease), Newborn Hearing Screening Follow- Up, Birth Defects, Metabolic Disease Nutrition, Specialty Care and Regional Resource Development and Program Support. /2010/ The newborn screening program moved to the Laboratories Administration.//2010//

The Division of Newborn Screening and Follow-Up screens babies for 32 disorders. The disorders are: 3 amino acid disorders (PKU, homocystinuria, and tyrosinemia), 3 urea cycle disorders, 13 disorders of organic acid metabolism (including MSUD and Biotinidase Deficiency), 9 disorders of fatty acid metabolism, Galactosemia, Congenital Adrenal Hyperplasia, Hypothyroidism, and Sickle Cell Disease.

/2007/ The capacity of the newborn screening program increased over the last year. The State lab hired an ABMG certified biochemical geneticist from the University of Maryland as a part time consultant. The state lab continued to refine its MS.MS techniques and cut offs for various ananlytes. New standards were added allowing the quantitation of additional analytes and the use of ratios to identify abnormal profiles. The additional standards also allowed the addition of several disorders such as carnitine uptake disorder. This brought Maryland to 34 disorders. The Advisory Council worked on the details of adding cystic fibrosis to the screening pannel and chose the IRT/IRT method for Maryland. With the addition of CF to the screening panel, Maryland screens for 35 disorders including all those recommended by the AGMG and the AAP. //2007//

/2008/ The newborn screening program added malonic acidemia to the panel in 2007 bringing the total number of disorders to 36. Maryland screens for all the disorders recommended by the AGMG and the AAP and the March of Dimes. Maryland screens for all 29 primary target disorders and can pick up the 25 secondary target conditions. It should be remembered that many of these conditions are part of the differential diagnosis of an abnormality in the marker used for a core condition and some would be suspected because of an unusual profile even if a standard for the primary marker is not run. Maryland follows up all significantly abnormal profiles whether or not the profile is associated with a known disorder. //2008//

/2009/ The NBS program screens for all the disorders recommended by the ACMG, AAP and March of Dimes including the secondary targets. New legislation (HB216) restores a single newborn screening lab and reorganizes the program. A fee increase will make the program including follow up fiscally self sustaining.//2009//
All babies born in Maryland, (70,000+ per year), are eligible for service. This Division also includes Carrier Screening for sickle cell disease, Thalassemia and Tay-Sachs Disease as well as AFP/Multiple Marker Screening to detect neural tube defects.//2009//

/2010/ Maryland continues to screen for all the disorders including secondary targets, recommended by the ACMG, AAP and March of Dimes. //2010//

/2007/ The State lab closed their AFP/Multiple Marker lab because of low volume. However, the OGCSHCN continues to support AFP/Multiple Marker Screening for low income women unable to access the service any other way by funding the service at the University of Maryland. //2007//.

/2008/ Funding was again found to keep this service operating but a long term solution is still not in sight.//2008//

/2009/AFP/Quadruple Marker screening continues to be available through an arrangement with the AFP Lab at the University of Maryland which is funded by a small grant from the OGCSHCN. //2009//

/2010/ No long term solution has been found for financing AFP/Quadruple Marker screening for medically indigent women , however, funding was again found to keep this service operating. //2010//

The Division of Newborn Hearing Screening Follow Up is supported by a grant from MCHB. This Division has been severely short staffed for the last several years. The Division lost its Chief in 2003 and was unable to replace him because of a hiring freeze. The junior audiologist left in 2004. The Division was folded into the bloodspot screening program to assure continued service to the babies of Maryland. However, an exception to the hiring freeze was obtained, 2 audiologists are being recruited and the Division should be able to operate independently again.

/2007/ Two audiologist were hired and the program now has a director and is operating independantly again. Unfortunately, the junior audiologist soon left for a better position. The Department's payscale is simply not competitive for audiologists. In addition one of the follow up specialist positions has turned over twice for the same reason. These positions are contractual and do not have benefits. We are seeking to convert them to regular State positions in hopes of retaining staff with a better package. //2007//

/2008/ The infant hearing program has made great strides in the last year. Permission was received to make the positions for the second audiologist and one of the follow up specialists federally funded permanent positions with benefits. Although these positions will end when the infant hearing screening grant ends, unless other funding can be found for them, the benefits are a major asset in terms of employee retention. At the moment, the infant hearing screening program is fully staffed for the first time in its history. Procedures have been standardized and procedure manuals written, hospital site visits are being made, NICUs were targeted to improve reporting of screenings on NICU babies, a programmer was hired to improve the current data system and a new web-based system is in procurement. The improvements in the data system have made the de-duplication of records more efficient. As an artifact of this, the percentage of infants screened appears to have remained about the same or even declined, although we suspect the percentage screened has actually improved. //2008//

/2009/ The infant hearing screening program is fully staffed for the first time, although one position remains contractual. The program is still heavily dependant of the HRSA grant which covers the salaries of 2 staff persons. A new database (OZ) with online data entry from the hospitals was procured and is in the process of bringing the last half of the hospitals on board. //2009//

/2010/ All hospitals were on board with the new web-based eSP system by August 2008. Improved data tracking has improved our ability to follow up quickly and to document outcomes.The percentage of infants screned before discharge has increased to over 98%. In addition to the the renewal application submitted to MCHB, a grant application for database enhancements was submitted to CDC.//2010//

The Division of Metabolic Disease Nutrition follows patients with genetic metabolic disorders like PKU or MSUD and provides case management, dietary therapy, support groups and a summer camp. /2008/ The Division of Metabolic Disease Nutrition now also serves children with organic acidemias requiring dietary therapy.//2008//
/2010/ The Metabolic Disease Nutrition now serves 354 patients and has a growing number of adults in it's patient population. Over 50 patients have had a trial of KUVAN and

approximately 30 are now able to have better blood levels on less restrictive diets. //2010//

The Birth Defects Division includes the Birth Defects Reporting and Information System, which collects data on the number of babies born with any of 12 common birth defects and provides information on the defects and services available. The Chief of the Birth Defects Reporting and Information System in the OGCSHCN is also the mother of a child with a birth defect and adds a mother's perspective to that program. The Department will return to the Legislature in 2006 to seek legislative change to broaden the scope of the program's data collection and to strengthen and clarify its authority to access information from medical records.

/2007/ The bill was not selected to be in the Department legislative package for 2006 but it is being rewritten and and will be introduced in 2007 probably by an independant sponsor. //2007//

/2008/ The birth defects bill was again not included in the Departmental legislative package because of higher priority issues and permission to seek independent sponsorship was not granted. The bill is being rewritten to meet the requirements of the O'Malley administration and will again be considered for inclusion in the Departmental legislative package for 2008.//2008//

/ 2009/ New legislation (HB438/SB 428) modifying this statute was passed and gives expanded authority to access medical records and to collect data on all significant birth defcts.//2009//

/2010/ The new data manager and the new data base for the birth defects program have greatly increased the programs capacity to generate data. The program continues to provide information and referrals to the families of infants with birth defects.//2010//

The Division of Specialty Care includes the Children's Medical Services Program (CMS), the Regional Resource Development Program, the Medical Day Care Program, and the Genetic Services Program. The Children's Medical Services Program (CMS) had historically served as the payer of specialty services for a large population of children with special health care needs in the state, serving over 12,000 children at its peak. Over the last 8 years, the need and demand for this program has been quite variable and the program has undergone major changes. The expansion of Medicaid in the 1990s lessened the need for the program as most CMS patients became eligible for other programs. The program was redesigned and funds redirected to care coordination, other enabling services, systems development and the dissemination of information about the services available. In the last few years, the program served a small number of children (135 in FY 2004), most of whom were undocumented. However, the FY 2006 state budget eliminates Medicaid eligibility for approximately 3,000 children who are legal immigrants but who have not lived in Maryland for a minimum of 5 years. It is anticipated that the children with special health care needs in that group will seek fee for service coverage for their specialty care from the CMS program. This could potentially increase the caseload in the CMS program by 450 children or roughly a factor of four.

/2007/ CMS enrollment is currently up to 209 patients, with 18 applications pending and applications still coming in. In FY 2006 alone 137 new applications were received. A Governor's Immigrant Health Initiative will increase the CMS program's budget in view of the increased caseload. //2007//
/2008/ While CMS has seen a leveling off of its enrollment with reinstatement of Medicaid eligibility for many legal immigrant children, overall enrollment in the program continues to exceed previous years. //2008//
//2010// A new Spanish- speaking outreach coordinator had greatly increased the number of completed applications for Spanish- speaking families with CSHCN. With better communication the number of missed appointments has dramatically decreased and the compliance has increased. //2010//

The Regional Resource component of OGCSHN funds 21 of the state's 24 local health departments in FY 2005 for a variety of services including the provision of specialty clinics for

uninsured and underinsured children, care coordination, respite care, assessment of family and community needs and service capacity building. The scarcity of specialty providers willing to accept Medicaid rates in the outlying areas of the state and the failure of local hospital specialty clinics to break even, lead the Maryland Association of Local Health Officers to request a re-expansion of the old statewide system of outreach specialty clinics in 2004. Currently, six jurisdictions receive funds to partially support specialty clinics. Twelve (12) jurisdictions receive funds to support case management and care coordination. The need for respite care was mentioned in the needs assessment reports from most local health departments. Sixteen jurisdictions are currently (FY 2005) receiving funding for respite care.

/2007/ Prince George's County, one of the largest, most populous counties, is gearing up to apply for OGCSHCN funding for the first time in many years. Currently (FY 2006) 16 jurisdictions continue to be funded for respite care, 14 are funded for care coordination/case management and 5 jurisdictions are funded to provide 7 outreach specialty clinics. //2007// ***//2010// While Prince George's County did not apply, Kent County on the Eastern Shore applied for the first time and received funding for a needs assessment.//2010//***

/2008/ These numbers remained unchanged for FY 2007. //2008// /2009/ It is becoming increasingly difficult to maintain the infrastructure for outreach specialty clinics, care coordination, and respite care through the local jurisdictions with continued level funding of the Block Grant. Services are decreasing in most jurisdictions funded. //2009// ***/2010/ The local health departments received large budget cuts and are barely level funded through the Block Grant. Their capacity to operate outreach specialty clinics and provide care coordination and respite care is declining. Currently only 5 provide specialty clinics and 15 receive grants for respite care. Only 10 receive funding to prepare materials on local resources to assist primary care providers in providing a medical home. //2010//***

Two Medical Child Care Centers are funded to serve children ages six weeks to three years of age with complex medical conditions and medical needs that cannot be met in traditional child/day care programs. As part of the interagency collaboration with Maryland's Early Intervention System, staff are involved in interagency coordination and liaison activities.

Finally, the Genetic Services Program coordinates a statewide network of clinical genetic services at 3 centers, and 13 general genetics outreach clinics. The clinic system is constantly rearranged to better serve the population in accordance with changing demographics in the state. Special genetics outreach clinics for facial clefts, hemophilia and sickle cell disease are conducted when there is need for them.

/2009/ The clinical genetics program continues to operate as it has since 1981 but the State fiscal constraints see the Centers level funded at best. Thes grants have been level funded for years. With inflation, the fraction of operating costs born by the OGCSHCN is eroding. We are increasingly dependant on the Centers to bear an increasing fraction of the cost in oder to continue services. The ability of the Centers to do that is also eroding and services may have to be cut. //2009// ***//2010// The genetics centers are continuing to provide services although with the retirement of several key personnel the future of this service is unclear. //2010//***

The Community Health Administration also administers a portion of Title V State matching dollars that are allocated to the local health departments through targeted funding. Maryland's 24 local health departments provide the core public health functions of assessment, policy development and assurance to citizens at the local level. The 24 local health departments receive annual basic public health funding (including Title V funds) from the DHMH through a Unified Grant Award process. Local health departments are the major service delivery arm for the DHMH and provide MCH services such as school health, family planning, home visiting and care coordination, immunizations, lead screening, fetal and infant mortality review, child fatality review, oral health services and maternal health services. Health Officers in each of Maryland's 24 jurisdictions are responsible for administering state and local health laws and regulations. ***//2010// The local***

health departments received large budget cuts this year//2010//

C. Organizational Structure

The State of Maryland, Department of Health and Mental Hygiene (DHMH) is the designated Title V Agency. The Secretary of Health and Mental Hygiene, Mr. S. Anthony McCann, heads DHMH and reports directly to Governor Robert L. Ehrlich. Mr. McCann replaced Nelson Sabitini as the Secretary in September 2004. As the attached organizational chart shows, three Deputy Secretariats report to Mr. McCann: (1) Operations, (2) Public Health Services and (3) Health Care Policy, Finance and Regulations.

/2008/Mr. Martin O'Malley, the former Mayor of Baltimore City, was elected Governor in November 2006. Governor O'Malley appointed Mr. John M. Colmers as the Secretary of Health and Mental Hygiene in February 2007. An updated organization chart is attached.//2008//

/2009/ Effective July 1, 2008, DHMH gained a fourth deputy secretariat, Behaviorial Health and Disabilities as a result of legislation passed this year. Three Administrations that were formerly located under the Deputy Secretariat for Public Health - Alcohol and Drug Abuse, Mental Health and Developmental Disabilities - will comprise the new Deputy Secretariat. The aim of this reorganization is to enhance the Department's ability to coordinate these closely related programs. //2009//

The Title V Program is administratively housed under the Family Health Administration within the Deputy Secretariat for Public Health Services. This Deputy Secretariat is responsible for six other administrations: AIDS, Alcohol and Drug Abuse, Community Health (e.g., Immunizations, sexually transmitted diseases, and bioterriorism), Developmental Disabilities, Laboratories, and Mental Hygiene; as well as the Anatomy Board and the Office of the Chief Medical Examiner. Medical Assistance, the State's Medicaid Program, is located under the Health Care Policy, Finance and Regulation Secretariat. The Deputy Secretariat for Public Services is headed by Dr. Michelle Gourdine.

/2009/ Dr. Michelle Gourdine left State service in February 2008. Ms. Arlene Stephenson is currently serving as the Acting Deputy Secretary for Public Health Services. An updated organization chart is attached. //2009//

The Family Health Administration (FHA) was formed in July 2001 and has been headed by Dr. Russell Moy as its Director and Ms. Joan Salim as the Deputy Director since its inception. FHA oversees a diverse array of public health programs within eight offices and two chronic rehabilitative facilities. The target population includes Maryland's total population of 5.5 million people, covering the lifespan from pregnancy to adulthood. Within the total population, at risk and vulnerable populations including low income, uninsured and medically underserved populations, are programmatically identified and safety net services provided. Dr. Moy reports to the Deputy Secretary for Public Health Services.

All of the MCH related programs are located within the FHA. The Family Health Administration includes the Center for Maternal and Child Health, the Office for Genetics and Children with Special Health Care Needs, the Office of Primary Care and the WIC Office. Other offices within the Administration closely linked with the core MCH offices are the Center for Preventive Health Services which recently gained administrative responsibility for the Office of Oral Health; Health Promotion, Education and Tobacco Control; and the Office of Health Policy. Department organization charts identifying the programs at the Secretariat and FHA levels are attached.

/2009/ During 2008, the Family Health Administration has undergone several changes. First, the

Office of Oral Health was re-established as a separate unit reporting to the Director of the Family Health Administration and a new State Dental Director was hired. Second, the Center for Preventive Health Services (CPHS) was disbanded and an Office of Chronic Diseases was created. The Injury Prevention and Public Health Surveillance components of the CPHS were merged with other existing offices. //2009//

/2010/
An attachment is included in this section.

D. Other MCH Capacity

Maryland's MCH Program includes a highly skilled and diverse team of public health professionals representing a variety of disciplines. This team plans, manages, and monitors Title V activities for Maryland from the Downtown Baltimore offices of Maryland's State Office Complex. In addition, MCH staff in local health departments, including a cadre of community health nurses, physicians, program administrators and clerical personnel, are also supported by Title V funds.

The Center for Maternal and Child Health is headed by Bonnie S. Birkel, CRNP, MPH. Ms. Birkel is a trained nurse practitioner with a Master of Public Health degree and 25 years of experience in public health. She is responsible for MCH policy development and is official spokesperson for all MCH and family planning related areas. She has served as CMCH's Director since its inception in 2000.

Susan R. Panny, M.D., oversees the work of the Office for Genetics and Children with Special Health Care Needs. Dr. Panny is certified in both Pediatrics and Medical Genetics. She has 30 years of experience in pediatrics and genetics and 20 years of experience in public health. She is an internationally known figure in newborn screening and public health genetics. She has served as the Director of the OGCSHCN since 2000, and prior to that had served as Director of the Office for Hereditary Disorders since 1984.

Maureen Edwards, M.D., M.P.H., serves as Medical Director for CMCH. Dr. Edwards holds board certification in neonatology and a masters degree in public health. Her prime responsibility is to oversee and provide medical consultation on policy and assurance matters for various CMCH programs. She is also the Center's legislative liaison. Dr. Edwards supervises the Center's medical staff, including the Medical Director for School and Adolescent Health, Dr. Cheryl DePinto, who is board certified in pediatrics and adolescent medicine; the Medical Director for the Family Planning Program, Dr. Evan Mortimer, a board certified obstetrician/gynecologist; and the Medical Director for Women's Health, Dr. Diana Cheng, a board certified obstetrician/ gynecologist.
/2008/ Dr. Maureen Edwards retired as Medical Director in August 2006. A new Medical Director is expected to be hired by September 2007.//2008//

/2009/ Dr. S. Lee Woods, a neonatologist with a Ph.D. in genetics was hired as the new CMCH Medical Director in December 2007. Dr. Woods is the Center's chief spokesperson, and oversees the clinical and policy work of the Center. //2009//

Jamie Perry, M.D., M.P.H. serves as the Associate Medical Director of the OGCSHN. Dr. Perry is board certified in Pediatrics and Neurodevelopmental Disabilities and holds a Master of Public Health Degree. Dr. Perry assists Dr. Panny in overseeing the clinical and programmatic work of the OGCSHCN, with particular focus on programs in the Division of Specialty Care. ***//2010// Dr Perry returned to the Kennedy Krieger Institute in January 2009.//2010//***

Ngozi Nwokoro, PhD, MD was hired as a temporary consultant to the OGCSHCN to assist with the expansion of newborn screening. Dr Nwokoro has a PhD in biochemistry, is board certified in

Pediatrics and has completed fellowships in clinical genetics and biochemical genetics. /2007/ Dr Nwokoro remained to follow up babies failing newborn hearing screening when that program lost all but one of its staff. She will stay in 2006 to assist with the legislatively mandated report on improving care for adults with sickle cell disease.//2007//
/2008/ Dr Nwokoro was reassigned to the newborn screening follow up program when the newborn screening follow up nurse retired.//2008// ***//2010// Dr Nwokoro returned to Canada in July 2009. She is a Canadian citizen and will retire there.//2010//***

Donna Harris, BS, serves as Special Assistant to the Director and Associate Director. Ms Harris tracks service data for programmatic purposes, handles data requests and produces special reports. She is in charge of OGCSHCN internal policies and assuring that OGCSHCN is in compliance with Departmental, State and federal policies and prepares reports documenting OGCSHCN compliance with all policies. /2008// Ms Harris is the OGCSHCN web-site coordinator and has assumed Dr Nwokoro's responsibilities with the adult sickle cell disease services steering committee. //2008// ***//2010// Ms Harris is providing staff support for the Advisory Council on Hereditary and Congenital Disorders since the reassignment of the former co-ordinator. //2010//***

In the CMCH, Bernadette Albers, M.P.H., APRNCS, assists Ms. Birkel as the Assistant Director of CMCH. Ms. Albers holds a Master of Public Health degree and is board certified in community health nursing. She has over 25 years experience in the fields of public health and health administration. In addition to being responsible for CMCH's daily operations, she supervises a unit that includes a master's trained health policy/research analyst who serves as the SSDI Project Director and Title V Coordinator (Yvette McEachern); a database administrator (Debbie Walpole); a master's trained asthma program administrator (Audrey Regan); a master's trained early childhood administrator (Mary LaCasse) and support staff (Debbie Krome and Anita Goldman).

/2009/ Ms. McEachern now heads the Federal State MCH Partnership Unit that includes Title V coordination, SSDI, asthma and abstinence. //2009//

/2007/ CMCH is undergoing a reorganization. In addition to serving as the Assistant Director, Ms. Albers is now responsible for supervising and managing three program areas: family planning and reproductive health; MCH systems development; and Community Partnerships. Ms. Astria Boyd-Millner was appointed Chief Operating Officer. //2007//

/2009/ Ms. Boyd-Millner left CMCH in February 2008 and has been replaced by Ms. Sharon Houston. //2009//

/2008/Ms. Bernadette Albers retired in December 2006. Her duties are currently being divided among three Section Chiefs.//2008//
/2007/ Audrey Regan was promoted to a newly created position, MCH Policy Analyst, and now reports to Ms. Birkel. A new asthma administrator, Rachel Hess-Mutinda, began work in July 2006. //2007//
/2009/ Dr. Audrey Regan is now the Director of the Office of Chronic Disease Prevention. //2009//

Until recently, this unit included four master's trained nurse consultants; however, two of them retired in the past year. The remaining two nurse consultants, Jeanne Brinkley and Pamela Putman, are responsible for monitoring local health department MCH contracts and providing technical assistance and consultation to Title V grantees on MCH issues (e.g., lead, adolescent health, asthma, obesity, school health). Ms. Brinkley supervises the MCH Coordination unit and the Department's lead staff person for lead activities. Ms. Putman also serves as the state's adolescent health coordinator. CMCH recently lost its fiscal administrator due to retirement. The Office is currently considering several options for filling this crucial vacancy.

/2010/ Christine Evans, Coordinator of Special Programs and Teen Pregnancy Prevention

has been assigned as Maryland's Adolescent Health Coordinator under MCHB.//2010//

/2009/ Ms. Jeanne Brinkley retired and Pam Putman is now the Chief of MCH Systems Improvement. //2009//

/2010/ Ms. Pam Putman, Chief, MCH Systems Improvement, is currently the Title V Block Grant Adminstrator.//2010//

Planning, evaluation and data analysis activities are provided by a MCH epidemiologist, a MCH database specialist, a health analyst, the Assistant Director for MCH and the birth defects database specialist and nurse consultants in the OGCSHCN. Yvette McEachern, M.A. has served as the SSDI Project Director for the past three years and also oversees development of the Title V application including data collection, performance monitoring and needs assessment. Ms. McEachern has over 20 years experience as a health analyst/statistician. Debbie Walpole, B.S. serves the MCH database manager/specialist and oversees CMCH database development and linkages; and data generation using SAS and other software. Bernadette Albers leads strategic planning efforts for the MCH Program and supervises grant development, including Title V.

William Adih, M.D., Dr.P.H. is a senior MCH epidemiologist with the Title V Program. Dr. Adih is a public health physician with extensive domestic and international experience in maternal and child health and reproductive health epidemiology. He provides epidemiological and data analysis support for the Center's activities. /2007/ Dr. Adih resigned in July 2006 to accept a position with the CDC. CMCH is recruiting a physician epidemiologist and hopes to acquire a third epidemiologist through the CDC MCH Epidemiology Program. //2007//
/2008/Ms. Lee Hurt was hired as the new MCH Epidemiologist in 2007.//2008//
/2009/ A new full-time asthma epidemiologist, Linda Nwachukwu was hired in May 2008. //2009//

Debra Perry, MPH was hired for a newly created Title X funded position of Family Planning Epidemiologist. Ms. Perry received her MPH from the University of Michigan School in of Public Health in Epidemiology and has worked provided epidemiologic support to various state and local agenices in Virginia and Maryland.

In addition, data support and analysis is provided by the Vital Statistics Administration which is headed by an MCH epidemiologist, Dr. Isabelle Horon, and the Office of Injury Prevention and Public Health Assessment which is headed by Dr. Lori Demeter. Contractual services are also purchased when necessary to complete data, assessment and planning activities.

Andy Hannon, LCSW-C, supervises the Division of Community-Based Initiatives and Partnerships. Mr. Hannon has over 25 years experience in public health and in addition to his supervisory role, leads male involvement initiatives for CMCH. Other activities under his direction include implementation of the PRAMS Survey which is supported by three staff persons (Helen Espatillier, Laurie Kettinger and Jodi Shaefer); and the Abstinence Education Program. The Abstinence Education Coordinator position is currently vacant and interviews have been held to select a new coordinator. This position serves as the Teen Pregnancy Prevention Coordinator for CMCH. Ms. Mary Johnson provides staff support to the Maryland Breastfeeding Promotion Task Force, and the Children's Environmental Health and Protection Advisory Council (CEHPAC). Ms. Johnson also leads community outreach efforts for CMCH. Joan Patterson, LCSW-C, was hired by Mr. Hannon as the CFR/FIMR Coordinator. She provides staff support to the State Child Fatality Review Team, and monitors contracts that provide technical support to local CFR and FIMR teams.

/2008/ Patricia Jones was hired as the Abstinence Coordinator.//2008//
/2010/ With the ending of Title V-Section510 Abstinence Education program on June 30th, Patricia Jones has been appointed as CMCH Agency Grant Specialist II effective July 1st.//2010//

/2007/ Mary Johnson was appointed as the State FASD Coordinator in 2005 and her CEHPAC responsiblities were transferred to Audrey Regan. Andy Hannon is now the Acting Chief of Family Planning. //2007//
/2009/ Andy Hannon is currently on medical leave and Helene O'Keefe is the currently the acting director of Family Planning. //2009//

The Title X Maryland Family Planning Program links and overlaps with MCH on a number of issues including preconception health care, teen pregnancy prevention and infant mortality reduction. The Family Planning staff include a Program Chief, a Medical Director, several physicians, several nurse practitioners who provide direct medical services and monitor contracts and program quality, and a program administrator. Ms. Victoria Young, LCSW-C, was hired the Chief of Family Planning in January 2003. Ms. Young has worked extensively in the area of child abuse and neglect.

In the OGCSHCN, Lynne Kelleher is chief of Program Support. She is the Chief Fiscal Officer and the Procurement Liaison for the Office. Sharon Burke handles contracts and assists with procurement. Barbara Greer handles personnel issues in addition to her role in the CMS program. General support services are provided by Marie Sapp, Terri Smiley and Chevria Meekins. /2007/ Ms. Sapp retired and her duties were assumed by Ms Meekins. //2007// /2009// Ms Kelleher left. Laura Weber, a former staff member has come out of retirement to take this position. //2009//

The Division of Newborn Screening is directed by Karen L. Funk. BS, RN, MEd. Ms. Funk has 35 years of neonatal intensive care nursing experience. She provides the medically expert follow up for infants with abnormal blood spot screening results. She is also responsible for the major database of the OGCSHCN, which contains the linked data for the newborn blood spot and hearing screening programs, the long term follow up programs for sickle cell disease and metabolic disorders. Adi Bello, RN in the sickle cell disease program provides home visiting and clinical follow up and Marcia Diggs handles the sickle cell disease follow up database. /2008/ Sadly Ms Funk had to retire for health reasons and Dr Nwokoro assumed her responsibilities, assisted by Lucy Talbot, MA, a 2006 graduate of the University of Maryland Genetic Counseling program./2008// /2009// A new chief of the Newborn Screening Division , Johnna Watson, RN , and a new genetic counselor, Carolyn Dinsmore, MA have been recruited.//2009///***//2010// The NBS program was reorganized and moved to the Laboratories Administration. Ms Dinsmore left but a new genetic counselor Carrie Blout , MA, CGC will start in September. A new half time clinical biochemical geneticist, Dr Julie Kaplan , has been hired to be medical director of newborn screening and will also start in September.//2010//***

The Newborn Hearing Screening Program lost both its audiologists but two new audiologists are being recruited. The senior audiologist will serve as Chief of the Division of Newborn Hearing Screening Follow-Up. The junior audiologist will provide the expert audiological follow up of babies suspected of having hearing loss. Theresa Thompson, BA, MA and Carol Fernandez, BA provide initial follow up of hearing screening results and handle the educational aspects of the program. Eileen Cohen, BA, MA, CCC-SP, a speech pathologist who is the OGCSHCN Early Intervention specialist and the liaison with Medicaid, provides consultation to the hearing screening program. /2007/ Linda Vaughan, MA, CCC-A was recruited to direct the program but we were unsuccessful in retaining a junior audiologist. Ms Fernandez and her immediate sucessor both left. Recruiting continues. //2007// /2008/Erin Filippone, MA, CCC-A was recruited as second audiologist postion and Stephanie Hood, BA as a follow up specialist. The infant hearing screening program is fully staffed for the first time.//2008//

Elizabeth Emerick, BA, MS, RD, LN and Mary Kalscheur, BA, MS, RD, LN are expert metabolic nutritionists, each with over 20 years of experience, and provide the dietary therapy and long term case management for children with metabolic disorders.

Anne Terry, BSN, MA, RN, serves as the Chief of the Birth Defects program. /2008/Rosemary

Baumgardener, BA ,the database manager retired. /2008// /2009/. Barbara Do, an intern is covering this position. //2009////***2010// A new database manager Mr Francis Sammanasu, expert in Access, SQL and oracle has been hired.//2010//***

Patricia Williamson, BSN, RN, CCM provides the clinical expertise for Children's Medical Services, the fee for service portion of the CSHCN program. Ms Williamson has 15 years of experience working with CSHCN and their families. Barbara Greer is the CMS eligibility specialist and Terri Smiley provides clerical support to this program. Joanne Johnson handles billing and assists Ms. Kelleher with the fiscal management of the Office. /2008/ Allyson Burlson-Gibson, MS was recently hired as the CMS Outreach Coordinator to work with both families and providers. She has a Master's in Human Services and is bilingual in English and Spanish. //2008//

Mary Ann Kane- Breschi, BA is the CSHCN regional resources coordinator and the liaison with the teaching hospital "Centers of Excellence", the local health departments, Parent's Place and other CSHCN family support services. Eileen Cohen oversees this portion of the program and directs the medical day care program. /2009/ Both Mrs Breschi and Ms Cohen have left and we are recruiting./2009/

/2008/ Rachel Hardegree, MPH was recently hired as the Medical Home Projects Coordinator. She is coordinating the OGCSHCN's medical home efforts and related projects. /2008// //***2010//Mrs Hardegree has left and we are recruiting.//2010//***

Maryland's Title V program is committed to family involvement as an integral component of MCH planning and programming. This is exemplified by the well established parent support groups developed by the OGCSHCN and the continued grant support for Parents' Place to provide outreach, communication linkages (newsletters) and consultation to the MCH Offices on CSHCN. The OGCSHCN has two professional staff members who are mothers of CSHCN. Unfortunately, Mrs Breschi left but we are hoping she will be able return part time.

E. State Agency Coordination

State Agency Coordination

The attached organization charts identify the functions and staff that support Maryland's Title V Program. In addition, both MCH offices, CMCH and OGCSHCN, maintain strong collaborative relationships with other MCH serving agencies both within and outside of DHMH to support MCH service delivery and infrastructure. Within DHMH, strong partnerships and collaborations have been forged with key agencies directors and their staff. FHA partners include the Office of Health Policy (which now includes the federal Primary Care Cooperative Agreement), the Office of Primary Care and Rural Health, the Center for Preventive Health Services, the Women, Infants and Children's (WIC) Program, the Office of Health Program and Tobacco Use Prevention), the Center for Cancer Surveillance and Control and the Office of Oral Health.

Work on MCH issues and needs will continue to be coordinated with a number of key state agencies outside of DHMH either through collaboration on joint initiatives or through committees, task forces and advisory groups. These agencies include the Governor's Office for Children (formerly the Governor's Office for Children Youth and Families), the Maryland Department of Human Resources, the Maryland State Department of Education, the Department of Juvenile Services, the Maryland Institute of Emergency Medical Services, the Maryland Department of the Environment (MDE), and the Department of Housing and Community Development.

For example, several state agencies are responsible for planning and implementation of activities to eliminate elevated blood lead levels in Maryland children. MDE took lead responsibility for convening an Elimination Plan Working Group with representatives of state and local agencies (including DHMH), non-profits and community groups. A Maryland Plan to eliminate childhood lead poisoning by 2010 was developed. The Governor's Lead Commission on which CMCH is

represented will oversee progress on Plan implementation.

Intra-agency and interagency collaboration will also continue with the following DHMH agencies and programs: the State Medicaid Agency, the Mental Hygiene Administration, the Laboratories Administration, the AIDS Administration, the Community Health Administration (including the Center for Immunizations), the Developmental Disabilities Administration, and the Maryland Health Care Commission.

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

/2007/ and the Partnership for a Safer Maryland (Injury Prevention) //2007//

/2008/ Dr Panny from OGCSHCN was appointed to the Advisory Board of the Johns Hopkins Sickle Cell Center for Adults.//2008//

/2008/Dr. Audrey Regan is representing the MCH Program on BabyLAP, an Annie E. Casey Foundation supported initiative to reduce infant morality in Baltimore City.//2008//

/2009/ Dr Panny serves on the Statewide Steering Committee for Services for Adults with SCD.//2009//

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

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

MCH programs have strong collaborative partnerships with several teaching hospitals/universities in the state. Both JHU and UMAB have collaborated in the development of state and multi state conferences, and the design of research projects. The GWU School of Public Health and the Johns Hopkins School of Public Health have established an internship relationship where graduate preventive medicine fellows, MPH candidates and/or nurse practitioners have practicum experience in the MCH offices. In addition, the Chief of Clinical Nursing at GWU serves as the liaison to Ryan White Title II and IV committees. Johns Hopkins Hospital, the Kennedy- Kreiger Institute, the University of Maryland Medical Center and Children's National Medical Center partner with the OGCSHCN to deliver clinical genetic services as well as specialty care.

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

/2008/Dr. Diana Cheng, Medical Director, Women's Health, CMCH, chairs the Maryland March of Dimes Grant Review Committee and is also a member of the Board of the Directors. Dr. Cheng is also a member of the Baltimore City Domestic Violence Fatality Review Team, a group that reviews cases of women who have died as a result of partner violence. //2008//

The Latino Community Health Care Access Coalition is a project of various Latino community groups, Catholic Health Care Initiatives, St. Clare's Medical Outreach, and St. Joseph Medical Center. Coalition members include the Highlandtown Medical Center, Johns Hopkins Bayview, Johns Hopkins Hospital, numerous Spanish speaking physicians in private practice and the Department of Health and Mental Hygiene, represented by Dr. Susan Panny of OGCSHCN. The goal is to assure access to high quality culturally competent health care for the Latino Community.

Other examples of collaborative efforts follow:

Inter-agency efforts with the WIC Program include the Maryland Breastfeeding Task Force and the Folic Acid Council. WIC and CMCH jointly co-chairs each of these groups. The March of Dimes is also an active participant in the Folic Acid Council. A grant from the March of Dimes to the MCH Program allowed for the re-institution of the Folic Acid Council in 2003.

The Office of Oral Health (OOH) which was recently merged with the Center for Preventive Health Services has developed a strong collaborative relationship with the MCH Offices. The CMCH Assistant Director continues as an active consultant to the Statewide Oral Health Advisory Committee. This Committee is currently overseeing the completion of a study of Maryland's oral health infrastructure. The OOH works collaboratively with the Medicaid Program to complete an annual legislatively mandated assessment of use of oral health services.

/2007/ The Oral Health Advisory Committee was disbanded in 2005. CMCH and OGCSHCN participated in an Oral Health Institute sponsored by MCHB in May. One outcome of the Institute has been DHMH discussions around the need to establish a statewide Oral Health Coalition focused on the oral health needs of children. //2007// /2008/ A statewide Oral Health Coaltion formed in the fall of 2006 and includes Title V representation.//2008//

Collaboration has been strengthened between the MCH program and the Family Health Administration's Center for Preventive Health Services on the issues of asthma, childhood obesity and women's health. In addition, the CMCH and Center on Health Education and Tobacco Prevention continues to partner with MCH, ACOG, and local health departments on smoking cessation initiatives during pregnancy.

The Title V Programs collaborate with other DHMH agencies on a number of priority MCH issues and needs. Intra-agency and inter-agency collaboration will continue with the following DHMH agencies, and programs: the State Medicaid Agency, the Mental Hygiene Administration, the Laboratories Administration, the AIDS Administration, the Community Health Administration (including the Center for Immunizations), the Developmental Disabilities Administration, the Vital Statistics Administration, Children's Environmental Health and Protection Council, the Office of the Chief Medical Examiner, and the Maryland Health Care Commission.

Maryland's Medical Assistance Program provides all the resources and personnel necessary to implement HealthChoice and MCHP. A collegial and collaborative relationship exists between this

Program and the MCH Offices. A revised Memorandum of Agreement (MOA) was finalized in 2004. The MOA speaks to sharing of client databases between each unit, and access to information on Medicaid eligibility status. Examples of collaborative efforts include the drafting of the adolescent health section of the state's EPSDT Manual by two CMCH staff persons, the Medical Director for School and Adolescent Health, and the state's adolescent health coordinator. /2008/ The Maryland Medicaid program is currently collaborating with the OGCSHCN and the Maryland AAP in the ABCD SCreening Academy, with a goal of making changes within the EPSDT Program to support improvements in developmental screening. A Developmental Screening Advisory Group has also been convened to oversee the ABCD project, and includes representatives from Medicaid MCOs, private insurers, specialty medical centers, pediatricians and family practitioners, Early Intervention, mental health, and family advocacy. /2008//

The OGCSHCN Early intervention specialist, who is a speech pathologist, spends two days a week with Medicaid preauthorizing OT, PT, audiological services, speech therapy and hearing aids. The OGCSHCN, particularly the CMS program, and Medical Assistance cross- refer patients that may be eligible for each others programs. The Medical Assistance information management staff produces reports of expenditures per child in the CMS program, broken down by county of residence and category of expense.

The new Interagency Agreement for Part C between the Department of Health and Mental Hygiene and the Maryland Department of Education includes a section on the exchange of data between OGCSHCN ‘s Newborn Hearing Screening Follow-Up program and the Division of Special Education/ Early Intervention to improve the referral process of hearing impaired infants to the Infants' and Toddlers' Program and to obtain long term outcome data on hearing impaired children identified through the newborn hearing screening program.

/2007/ Despite this agreement, additional more specific agreements will be needed to achieve the desired free exchange of information between the Newborn Hearing Screening Follow-Up program and the Maryland State Department of Education, Division of Special Education/ Early Intervention. // 2007// /2009//. Efforts at an MOU to exchange long term follow up information on infants with hearing loss with the Maryland State Department of Education continue to be unsucessful. However, a reciprocal agreement was concluded with the Maryland School for the Deaf and we have ascertained that we can make direct refferrals to the Early Intervention program so they can follow up on families referred who do not follow through. Apparently the conflict between HIPAA and FERPA are a national problem and were discussed at several national meetings.Perhaps help will come down from the national levle.//2009// ***//2010// An agreement was concluded with Dr Carol Ann Baglin, Assistant Superintendant of Schools and chief of early intervention to exchange information on baies identified innewborn hearing screening. //2010//***

The Center for Immunization within the Community Health Administration developed a strong collaborative relationship with the Division of Child and Adolescent Health to improve childhood immunization rates. MCH is represented on the Maryland Immunization Partnership Committee.

Mental health related issues and concerns such as improving access to services are critical to health of women, children and families in Maryland. The Title V Program has grappled with its role in this area and continually seeks opportunities to partner with other state and local agencies, advocacy groups, and community based organizations to improve the mental health of Marylanders. Mental health partners including child and adolescent health professionals in the Mental Hygiene Administration and the Mental Health Association were strategically involved in the latest statewide MCH needs assessment.

In May 2004, the Center for Maternal and Child Health in collaboration with the Mental Health Association of Maryland, Inc. submitted an application for the HRSA Grant entitled - Perinatal Depression and Related Mental Health Problems in Mothers and Their Families. Recent Maryland PRAMS data for 2003 indicate that at least 18% of new moms report being moderately

or severely depressed following pregnancy. The state sought grant funds to implement a comprehensive public information and provider information campaign to increase understanding of perinatal depression and to address the stigma of mental illness which often discourages individuals from seeking treatment. Although the grant was not funded, educational materials including a postpartum depression brochure has been distributed widely throughout the state and requests for copies from other states have been honored. The MCH Program also partners with the State's Medical Society and the American College of Obstetricians and Gynecologists (ACOG) on postpartum depression.

/2007/ The Mental Health Association has received MCHB funding to implement - Healthy New Moms: Maryland's Campaign to End Depression During and After Pregnancy. Numerous outreach and education venues will be used to increase provider and consumer awareness of perinatal depression. Title V is collaborating with the Association and is an active participant on the Advisory Committee overseeing the Project. //2007//

The MCH Program continued as an active participant on the Early Childhood Mental Health Steering Committee. This inter-agency Committee was jointly convened by the Mental Hygiene Administration in DHMH and the Maryland Department of Education to develop a plan for incorporating mental health services into early childhood programs statewide. Both the Medical Director of CMCH and the Early Childhood Health Administrator are members. The state adolescent health coordinator is an active member of the planning committee for the Mental Hygiene Administration's annual statewide adolescent suicide prevention conference. CMCH is also an annual financial supporter of the conference.

Asthma is one the major causes of morbidity for Maryland children. Since 2001, CMCH has been administratively responsible for the state's CDC funded Asthma Grant which includes statewide asthma control planning and surveillance. With the completion of the Maryland Asthma Control Plan in 2004, the Maryland Asthma Planning Task Force evolved into the Maryland Asthma Coalition. The Coalition meets quarterly, and advises the state on implementation of CDC funded asthma control activities for both children and adults. Coalition membership includes representatives of the clinical community (e.g., Johns Hopkins and University of Maryland Schools of Medicine), public health agencies at all levels (e.g., DHMH Center for Preventive Health Services), health organizations (e.g., Maryland Lung Assocation), physician organizations (e.g., American Academy of Pediatrics) community health centers, and educational authorities.

/2007/ Maryland is participating in an AHRQ sponsored Learning Institute to address racial/ethnic disparities in pediatric asthma. A team including representatives of Medicaid, local health departments, asthma providers, and the American Lung Association have been meeting to develop and implement a plan with technical support from AHRQ. //2007//

In the area of early childhood health, the MCH Program has also been represented on the following interagency groups: the Healthy Child Care Maryland Steering Committee, the Maryland Girl's Commission, the Healthy Homes Initiative, the Early Childhood Mental Health Steering Committee, the Ready at Five Strategic Planning Committee, The Judy Center Advisory Committee, the Maryland Home Visiting Collaborative, and TAMAR's Children (an intervention program for incarcerated women and their children that addresses infant bonding and attachment issues).

Since 2003, the MCH Program has been an active participant on the Leadership in Action Program (LAP) Team. This Team was convened by the Maryland Partnership for Children (includes the Secretaries of Health, Education and Human Resources) to address collaboration on early childhood issues in Maryland. MCH was also represented on the Early Head Start Policy Council and the Head Start Health Collaborative. MCH is also represented on the Maryland Developmental Disabilities Council, the Governor's Caregiver Support Coordinating Council, the Taskforce on Inclusive Child and After-School Care, and the Special Needs Advisory Council for HealthChoice and the Latino Community Health Care Access Coalition.

Several bills introduced during the 2004 Legislative Session would have required Maryland hospitals to provide written information to new parents on postpartum depression and shaken baby syndrome. The bills failed, however, and the Maryland Hospital Association subsequently convened an Ad Hoc Committee to determine how best to distribute this information to families of newborns. Both the CMCH Director, Bonnie Birkel and the CMCH Medical Director, Maureen Edwards are members of this Committee along with representatives from local hospitals and the Mental Health Association. The Title V Program is also represented on a statewide group that is developing a plan to address Fetal Alcohol Spectrum Disorders (FASD).

/2007/ The Maryland FASD Coalition was formed in 2005 with lead support from CMCH. //2007//

/2008/ A bill, HB 197 was passed in 2006 requiring the DHMH to prepare and distribute a brochure to inform expectant parents about cord blood donation. This brochure was developed and is about to be distributed. //2008//

Maryland's Title V program is committed to family involvement as an integral component of MCH planning and programming. This is exemplified by the well established parent support groups developed by the OGCSHCN and their ongoing grant support of Parents' Place to provide outreach, communication linkages (newsletters) and consultation to the MCH Offices on CSHCN. The grants to Parent's Place also support a network of CSHCN parent representatives throughout the state. The OGCSHCN partnered with Wicomico County to establish a regional resource center in Wicomico County. The center serves the entire Eastern Shore and is a model for other regions. The center provides books, periodicals and internet access to information relevant to CSHCN and enables parents to access these resources and to link with other parents. /2009/ The OGCSHCN partnered with The Parents' Place of Maryland in an application for a State Implementation Grant for Integrated Community Systems for CYSHCN which was funded by MCHB for the coming year. Other major partners in this Project are the Maryland Chapter, American Academy of Pediatrics and the Johns Hopkins Bloomberg School of Public Health. //2009//
The OGCSHCN has two professional staff members who are mothers of special needs children and who bring the family perspective to the program. One serves as Chief of Regional Resource Development and the second is Chief of the Birth Defects Reporting and Information System.

Finally, the Title V Program will continue to chair and/or staff the following inter-agency advisory boards, councils and committees: the Perinatal Clinical Advisory Committee, the Perinatal Disparities Work Group, the Maryland Breastfeeding Promotion Task Force, the Early Childhood Health Advisory Committee, the Children's Environmental Health and Protection Advisory Council, the Asthma Coalition, the Women's Health/PRAMS Steering Committee, the State Child Fatality Review Team, and the Abstinence Education and Coordination Advisory Committee.

/2007/ The Breastfeeding Task Force has been reorganized into a statewide Breastfeeding Coalition. //2007//

/2007/ The Medical Director for Women's Health has published materials on the role of domestic violence in maternal mortality and represents Title V on the following groups: the Baltimore City Domestic Violence Fatality Review Team (reviewing homicides due to domestic violence; the Maryland Domestic Violence Advisory Board (coordinated by the Medical Society to promote domestic violence awareness); the AMCHP MCH Violence Prevention Advisory Group (promoting a learning lab in perinatal domestic violence). //2007//

/2007/ Title V is working with the Maryland Health Professional Education Committee, established by the Office of Minority Health and Health Disparities, to increase the cultural competency of the health professional work force. //2007//

/2009/ The Medical Director for Child and Adolescent Health has been asked to participate on a

Youth Development Learning Collaborative sponsored by the Governor's Office for Children (GOC) to promote positive youth development. She is also a member of the Ready by 21 Consortium being spearheaded by the GOC. //2009//

/2009/ CMCH is a member of the School Health Practice Committee that has been meeting recently to revise communicable disease guidelines for schools and child care. //2009//

/2009/ The OGCSHCN Director serves on the Statewide Steering Committee on Services for Adults with SCD.//2009//

F. Health Systems Capacity Indicators

Introduction

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	41.5	34.2	35.4	44.9	44.9
Numerator	1556	1303	1303	1681	1681
Denominator	374578	381487	368199	374133	374133
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 - 2007
Source: HSCRC Hospital data and ambulator data, NCHS Vintage 2007 Population File.

Notes - 2006
Source: Hospitalizations - MD Hospital Discharge Database, 2006; Population - MD Vital Statistics Population estimates for 2006.

Narrative:
The State's ability to address asthma from a public health perspective has been influenced by legislation mandating creation of a State Asthma Control Program and CDC funding to support asthma control activities. The MCH Program with the support of asthma stakeholders completed a planning process that resulted in the development of a State Asthma Plan that identifies strategies and action steps for improving asthma outcomes.

In 2002, the Maryland Legislature mandated that a Maryland Asthma Control be established within the Department of Health and Mental Hygiene and charged the Program to develop a statewide asthma surveillance system and an asthma control plan. The Program's goals are to: (1) decrease the prevalence of asthma and the occurrence of its complications in Maryland; and (2) decrease disparities in health outcomes related to asthma in all parts of the State. Since 2002, with the assistance of a CDC Asthma control grant, the Program has developed an asthma plan (with support from Asthma Coalition members), built a surveillance system, and begun to implement initiatives in an effort to address Program goals. Asthma Control Program funding is supplemented by the Maternal and Child Health Block Grant.

Surveillance is the cornerstone of the Maryland Asthma Control Program. Analysis includes prevalence, emergency department visit rates, hospitalization rates, mortality rates, health disparity assessment, asthma-related health behaviors, and asthma-related health care costs. To date, four annual asthma surveillance reports have been completed for the years 2002-2005. The 2005 Maryland Asthma Surveillance Report (most recent report available) indicates that statewide, an estimated 142,270 children have been diagnosed with asthma at some point in their lifetime. This represents 10.2% of children. An estimated 106,000 children (7.6%) currently have asthma. Children under the age of 5 had the highest hospitalization rate of any age group at 43.4 hospitalizations per 10,000 population in 2005. Maryland's rate was lower than the national average in 2003, but higher than Healthy People 2010 goal of 25 hospitalizations per 10,000. Hospitalization rates for African Americans in 2005 were three times that of Whites. The emergency department visit rate was four times higher for African Americans as compared to Caucasian Americans.

Maryland's SSDI Project Team works collaboratively with the State's asthma surveillance team to complete annual asthma surveillance reports and issue briefs. Future plans include using GIS mapping to identify asthma "hot spots" within the State and to further analyze BRFSS and other datasets to assist in addressing racial and ethnic disparities.

/2009/ A new full-time asthma epidemiologist began working with the Asthma Control Program in April 2008. The epidemiologist is currently working with Project staff and staff in the Department of Education to improve school based asthma surveillance in the State. The 2006 and 2007 Asthma Surveillance reports are currently being prepared. //2009//
/2010/ Maryland completed a 5 year statewide asthma plan in April 2009. A grant for five years of CDC funding to address asthma fro a public health perspective was submitted in May 2009.//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	85.7	85.9	86.0	87.9	84.1
Numerator	27838	28799	30488	32206	31844
Denominator	32491	33517	35450	36639	37842
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	Final

Notes - 2008
Source: Medicaid data for Federal Fiscal Year 2008

Notes - 2007
Source: Maryland Medicaid Program. Defined as those born between 1/1/7 - 9/30/07. Initial periodic screen defined as CPT code 99381; 99391; 99341 or diagnosis codes starting with v20.2; v77.0; v77.9; v78.0-v78.9.

Narrative:

Data for this indicator is provided by the Medicaid Program. Increasing percentages of infants enrolled in Medicaid are receiving at least one periodic screen. /2009/ In Federal Fiscal Year 2007, 88% of the 36639 infants enrolled received a screen; up from 75% in FFY 1999. //2009//

Maryland's EPSDT Program is known as the Healthy Kids Program. The Program's goal is to promote preventive health care services for children to promote early identification and treatment of health problems before they become medically complex and costly to treat. Standards for the Healthy Kids Program are developed in collaboration with the Title V Agency and other key MCH stakeholders such as the Maryland Chapter of the American Academy of Pediatrics, the University of Maryland Dental School, and the Maryland Department of the Environment. The "Maryland Schedule of Preventive Schedule of Preventive Health Care" closely correlates to the American Academy of Pediatrics' periodicity schedule.

Most infants are enrolled in HealthChoice, Medicaid's managed care program which began in 1997. Medicaid recipients enroll in a managed care organization of their choice and select a primary care provider to oversee their medical care. The HealthChoice Evaluation data for 2006 indicates that the percentage of infants (includes those enrolled in both traditional Medicaid and MCHP) receiving a well child visits increased between 2000 and 2003, from 69.2% to 79.4%. Well child visits were defined by Medicaid to include well child visits, EPSDT and preventive services.

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	73.3	73.3	52.6	83.9	85.3
Numerator	211	211	201	433	1119
Denominator	288	288	382	516	1312
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	Final

Notes - 2008
Source: Medicaid data for Federal Fiscal Year 2008.

Notes - 2007
Source: Maryland Medicaid program data for FFY 2007. Infants defined as those born between 10/1/07 to 9/30/07.

Narrative:
Maryland's SCHIP Program, the Maryland Children's Health Program (MCHP), provides full Medicaid health benefits to children up to age 19, and pregnant women of any age who meet the income guidelines. MCHP enrollees obtain care from Managed Care Organizations (MCOs) through the Maryland Health Choice Program.

/2009/ The Medicaid Program reports that in FFY 2007, 84% of the 516 infants enrolled received

at least one periodic screen. The Medicaid Program is currently investigating to determine if the decrease between 2004 and 2006 is real or the result of a change in the methodology used to determine progress on the indicator. //2009//

/2010/ The percentage receiving screening continued to increase in 2008.//2010//

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	70.1	70.1	69.4	69.7	69.7
Numerator	52224	52491	53712	54389	54389
Denominator	74500	74880	77430	78057	78057
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 data not available. Derived from Vital Statistics Administration data, 2007.

Notes - 2007
Derived from Vital Statistics Administration Data, 2007.

Notes - 2006
Derived from VItal Statistics Administration data, 2006

Narrative:
Maryland recently began to analyze the data to be able to monitor progress on this indicator. The data show that only 70% of Maryland moms are receving adequate prenatal care according to the Kotelchuck Index. Early prenatal care in Maryland have been declining for the past several years which is a cause of concern for the Title V Program in combination with the low score on the Kotelchuck Index. This year through both the Title V needs assessment and the new Babies Born Healthy Initiative, the MCH Program plans to explore in depth the slide in prenatal care rates and to develop an action agenda that includes both community based and institutional level strategies to address the problem. CMCH plans to hire a new MCH epidemiologist to aid in spearheading this effort.

/2009/ Under the Babies Born Healthy Initiative, in 2009, CMCH is planning to expand outreach and case management services to low income at risk women in Baltimore City. Funding is being awarded to Baltimore City's Healthy Start, Inc. (BCHSI), a community based group that provides enabling services to pregnant and post-partum women in at-risk communities. BCHSI will expand their preconception and interconception health services into four additional Baltimore City communities. They received support to conduct a needs and capacity assessment to determine where and what kind of services were most needed from the Title V Program.

Despite this expansion effort, cuts in Medicaid funding for home visiting and care coordination

services linking women to prenatal care and other resources are making it more difficult for Baltimore City and other at risk jurisidictions to promote access to prenatal care services. The Title V Program is working with Medicaid to monitor the effects of these cuts. //2009//

/2010/ A graduate student in the School of Nursing from John's Hopkins is currently reviewing data on prenatal car usage in Maryland for the Title V needs assessment. Her analysis will assst the Title V agency in developing stratesgies to improve these rates. //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	78.9	79.5	80.7	83.6	83.8
Numerator	317803	321369	324114	317571	333454
Denominator	402825	404286	401816	379937	397848
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
Source: Medicaid data for Federal Fiscal Year 2008.

Notes - 2007
Source: Medicaid data for Federal Fiscal Year 2007.

Narrative:
The Maryland Medicaid or Medical Assistance Program provides health insurance coverage for eligible low income Marylanders. In FY 2006, more than 400,000 eligible children and teens under the age of 20 were enrolled. MCHP, the State's SCHIP program, is also administered by the Maryland Medicaid Program. Eligibility requirements include living in families with incomes up to 300% of the federal poverty level. In FFY 2007, there were children144,751 enrolled.

The majority of children enrolled in either Medicaid or MCHP are required to participate in HealthChoice, Maryland's statewide mandatory managed care program which began in 1997. Eligible Medicaid recipients enroll in a Managed Care Organization of their choice and select a Primary Care Provider to oversee their medical care. Covered services for both Medicaid and MCHP include EPSDT and dental services for children.

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	48.7	48.7	51.6	46.7	50.7
Numerator	28071	28071	32065	44600	52569

Denominator	57589	57589	62166	95464	103645
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
Source: Medicaid data for Federal Fiscal Year 2008.

Notes - 2007
Source: Maryland Medicaid Program, calendar year 2007. Age as of 1/1/07.

Notes - 2006
Source: Maryland Medicaid Program. In calendar year 2006, there were 62,166 children enrolled in HealthChoice managed care organizations for at least 320 days. 32,065 of these children had at least one dental visit.

Narrative:
Many Marylanders were shocked in early 2007 when a 12 boy year died because he did not have access to good dental health care. The young boy died when bacteria from an abscessed tooth spread to his brain. His mother noted that his Medicaid coverage had lapsed, but even while on Medicaid she had experienced difficulty in finding a dentist willing to treat her son. The 2007 Maryland Legislature took note of this tragedy and in 2007 passed an Oral Health Safety Net bill to fund oral health delivery services in local health departments and community health centers. Unfortunately, the bill passed with no funding appropriated for implementation.

In 1998, Senate Bill 590 passed and established the Office of Oral Health within the Department of Health and Mental Hygiene's Family Health Administration. It required DHMH to develop a five year oral health care plan that set targets for Medicaid MCO enrollee's access to oral health services. The Bill also requires DHMH to annually report on the availability and accessibility of dentists participating in the Program, outcomes in reaching utilization targets, and how funds were used.

The latest report issued in October 2006 identified the following:
. As of July 2006, there were approximately 918 dentists enrolled as providers. This represents an improvement but still indicates that less than 20% of the State's dentists participate.
. Other enrolled providers include 12 local health department provider sites and 13 federally qualified community health center sites.
. In 2005, 46% of enrolled children received one or more dental services. Most received either diagnostic (43%) or preventive (40%) services; only 16% received restorative services.
. Medicaid Managed Care Organizations have attempted to increase oral health services use by:
-Sending reminders to members about the importance of dental care.
- Developing incentive programs to induce participation.
-Providing dental education awareness programs in schools.
-Meeting with providers to address and respond to concerns.

/2009/ Based on the recommendations of a Dental Action Committee convened by Secretary Colmers in 2007, the Maryland Legislature appropriated $16.1 in FY 2009 to implement a number of recommendations made by the Committee. These include increasing Medicaid dental reimbursement rates, providing grants to local health departments, federally qualified health centers and others to improve access to dental care and expanding school based dental services through use of a dental van. CMCH is working with the Medicaid Program to examine and

explain the dental in dental care use.//2009//

/2010/ These percentages continued to increase during 2009. //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	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	12246	14720	15275	13246	13575
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.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Final

Notes - 2008
This annual indicator is in fact zero. The Children's Medical Services Program (CMS) does not pay for care for SSI/ MA eligible children if the needed service is covered by Medicaid.

CMS will pay for needed specialty care services that are not provided by Medicaid.

The OGCSHCN is currently only able to track this data in the Children's Medical Services Program (CMS) and only two SSI benficiaries less than 16 years of age are on the CMS eligibility list , both received services from CMS in 2007 but neither received services from CMS in 2008. Denominator data is the number of Maryland SSI beneficiaries under 16 years of age as of December 2008 from the Social Security Administration.

Notes - 2007
This annual indicator is zero. The OGCSHCN is currently only able to track this data in the Children's Medical Services Program, and only two SSI benficiaries less than 16 years of age received services from this program in 2007. Denominator data is the number of Maryland SSI beneficiaries under 16 years of age as of December 2007 from the Social Security Administration.

Notes - 2006
This annual indicator is in fact zero. The Title V CSHCN program does not want to pay for care for SSI benficiaries when they can receive this care through Medicaid. Denominator data is the number of Maryland children ages 0-17 receiving SSI as of December 2006 from the Social Security Administartion.

Narrative:
According to the Social Security Administration, as of December 2006, there were 15,275 Maryland children ages 0-17 years receiving SSI. In 2006, none of these children received rehabilitative services from the Title V CSHCN Program. Maryland Medicaid provides comprehensive services, including rehabilitative services, and all of these children qualify for Maryland Medicaid programs. There is no mechanism for tracking SSI-eligible children who do apply for Medicaid. In addition, the Maryland Title V CSHCN program currently only provides rehabilitative services through Children's Medical Services (CMS), payer of last resort for

uninsured/underinsured CYSHCN. No SSI beneficiaries received services through CMS in FY06. /2009/ As of December 2007, there were 13,246 Maryland SSI beneficiaries less than 16 years of age. Only two Maryland SSI beneficiaries less than 16 years of age received services through the Children's Medical Services Program in 2007. //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	10.8	8.3	9.1

Narrative:
/2009/ In 2006, 11.3% of Maryland babies were born prematurely or too early (under 37 weeks gestation). Premature babies are more likely to die within the first year of life than full term babies. Premature babies are also more likely to be born at low birth weights putting them at risk for numerous medical and handicapping conditions. Prematurity and low-birth weight are the leading causes of infant deaths in Maryland. Risk factors for prematurity or low birth weight include medical conditions and complications as well as behavioral/social factors such as maternal smoking, maternal weight gain and late entry into prenatal care. The increase in the state's infant mortality rate between 2002 and 2004 was partially the result of an increase in the number of very low birth weight infants born. In 2006, 88% of very low birth weight infants born in Maryland were delivered at high-risk facilities.

In 2006, over 6,000 Maryland babies (10.3%) were born at low birth weights (less than 2,500 grams). That same year, 1,415 (1.9%) of babies were born at very low birth weights (less than 1,500 grams). Maryland has much work to do to reach the Healthy People 2010 goals for low birth weight (5%) and very low birth weight (0.9%). //2009//

Maryland's low birth weight rate has consistently been higher than the national average (9.4% for MD and 8.1% for U.S. in 2004). The percentage of infants born at low birth weight increased in Maryland and the U.S. throughout the nineties. Factors contributing to the increase include an increase in multiple births, which are more likely to be delivered preterm, and/or at low-birth weight. In 2005, 58.8% of multiple births included babies born at low birth weights as compared to 7.2% of live singleton births. However, low birth weight rates have also been increasing among singleton births.

The low birth weight rates for American Indians and African Americans in 2006 were significantly higher than that of other racial and ethnic group. African American (13.2%) babies were more likely than Caucasian (7.1%), Hispanic (7.2%) and Asian (8.1%) babies to born at low birth weights. Five jurisdictions had low birth weight rates considerably above the statewide average of 9.2% in 2006: Baltimore City (13.2%), and Dorchester (12%), Allegany (11.6%), Prince George's (10.5%), and Kent (10.5%) counties. Women enrolled in Medicaid were more likely to give birth to a low birth weight baby than women with other types of coverage.

The Title V Agency works with local health departments, the March of Dimes, state medical associations, advocacy groups, hospitals and community based organizations to improve births and reduce adverse outcomes such as low birth weight.

/2009/ In 2009, the Babies Born Healthy Initiative will work with health providers, local agenies

and community based groups to reduce the State's low birthweight rate. In April 2008, the Department of Health and Mental Hygiene reconvened the Perinatal Clinical Advisory Committee (PCAC). The Perinatal Clinical Advisory Committee is a multidisciplinary committee representing 20 Maryland professional organizations and is charged with reviewing and updating the Maryland Perinatal Systems Standards. The PCAC will review the current guidelines to ensure they are consistent with the Guidelines for Perinatal Care, 6th Edition, 2007 issued by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists. //2009//

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	8.7	7.3	7.8

Notes - 2010
Based on Vital Statistics Administration Linked Birth-Death File for deaths in 2007.

Narrative:
/2009/ Data for this indicator is derived from linked birth and infant death records for 2005 (2006 linked data is currently unavailable). As was true in previous years, the data indicate that Medicaid enrolled women as compared to women with other types of insurance are significantly more likely to have a baby die within the first year of life.

The Babies Born Healthy Initiative will buildson preventive health strategies for reducing infant mortality, as supported by the literature and Maryland's successful experience with reducing infant mortality in the 1990's.
Strategies include MCH-WIC Collaborative Projects in Baltimore City, and Baltimore, Charles, and Wicomico Counties where MCH services (including family planning, folic acid distribution, and others) are linked with WIC services to maximize women's health during the preconception and interconception period, which is key to positive birth outcomes. Another strategy is the Maryland Advanced Perinatal System Support (MAPSS) Project. This University of Maryland Program provides telemedicine linkages between high-risk obstetrical consultants and local providers and three hospitals. This is necessary because there is a shortage of obstetrical providers throughout the State, and MAPSS supports local providers, which enables them to stay in practice.

Patient safety has become a national priority as a result of the groundbreaking Institute of Medicine Report entitled "To Err is Human." Some infant deaths in Maryland are attributable to patient safety concerns. In partnership with the Maryland Patient Safety Center's (MPSC), the Perinatal Collaborative is bringing together 25 Maryland hospitals to advance patient safety. Hospitals are improving communication, enhancing education, and establishing safety-related protocols. All 25 hospitals are submitting data into a single database at the National Perinatal Information Center. This phase of the collaborative will end with a results congress in May. We have already begun discussing continuation of the collaborative with a focus on NICUs for FY 2010. //2009//

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	67.8	85.3	79.5

Narrative:
Data for this indicator is derived from birth records for 2006. Linked birth and Medicaid files were unavailable. As was true in previous years, the data indicate that Medicaid enrolled women as compared to women with other types of insurance are significantly less likely to receive early prenatal care. Early prenatal care rates have continued to decline for both Medicaid and non-Medicaid women over the past decade. National performance measure #18 discusses state activities directed at improving this situation.

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	60	76.2	69.7

Narrative:
Maryland recently began to analyze the data to be able to monitor progress on this indicator. The data show that only 70% of Maryland moms are receving adequate prenatal care according to the Kotelchuck Index. Early prenatal care in Maryland have been declining for the past several years which is a cause of concern for the Title V Program. This year through both the Title V needs assessment and the new Babies Born Healthy Initiative, the MCH Program plans to explore in depth the slide in prenatal care rates and to develop an action agenda that includes both community based and institutional level strategies to address the problem. CMCH plans to hire a new MCH epidemiologist to aid in spearheading this effort.

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	300
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
State FY 2009/2010

Coverage is based on a sliding scale covers 200% to 300% FPL.
Note: May include a fee for service.

Notes - 2010
State FY 2009/2010

Coverage is based on a sliding scale covers 200% to 300% FPL.
Note: May include a fee for service.

Narrative:
The Maryland Medicaid Program provides medical care coverage to low income infants, children and pregnant women. Pregnant women and infants are covered up to 185% of the poverty level. SHIP coverage extends to 300% of the poverty level for infants. Families of enrolled infants with incomes between 200% and 300% pay a premium based on a sliding scale.

/2009/ Maryland continues to have one of the most expansive Medicaid Programs in the country. //2009//

/2010/ During the 2007 Special Legislative Session, Senate Bill 6 was passed, which provides for Medical Assistance to parents and other family members caring for children with incomes up to 116% of the Federal Poverty Level. In Fiscal Year 2009, the Medical Assistance for Families initiative was launched. On July 1, 2008, Medical Assistance benefits expanded to include comprehensive health care coverage for many more parents and other family members caring for children. Eligibility depends on family size and income. The income limit is about $21,200 for a family of three. There is no asset limit when applying, no face-to-face interview is required and there are options to apply online, by mail or by fax. The number of families now on the new program has exceeded 45,000. //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 19) (Age range to)	2008	300

(Age range to)		
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2008	300

Notes - 2010
State FY 2009/2010

Coverage is based on a sliding scale covers 200% to 300% FPL.
Note: May include a fee for service.

Notes - 2010
State FY 2009/2010

Coverage is based on a sliding scale covers 200% to 300% FPL.
Note: May include a fee for service.

Narrative:
Medicaid eligibility coverage extends to pregnant women and infants with family incomes up to 185% of the poverty levels. Coverage for children and adolescents extends to families with incomes up to 100% of the federal poverty level (FPL).

/2009/ Maryland's MCHP Program is one the richest in the nation in terms of the types of services covered as well as income eligibility. //2009//

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	250
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2008	250

Notes - 2010
State FY 2009/2010

Coverage is based on a sliding scale covers 200% to 300% FPL.
Note: May include a fee for service.

Notes - 2010
State FY 2009/2010

Coverage is based on a sliding scale covers 200% to 300% FPL.
Note: May include a fee for service.

Narrative:
Maryland's state only MCHP Program provides coverage to eligible women with family incomes up to 250% of the poverty level. Children in families with incomes up to 200% of the poverty level are eligible for MCHP. The MCHP Premium Program provides coverage to uninsured children and adolescents children up to age 19, who have not dropped employer-sponsored health insurance within the previous six months, and who have paid the monthly premium payment per family. The family income standard for eligibility is at 200% through 300% of the FPL. Premiums vary by family size and income and range from $41 to $52 per month. For both, MCHP and MCHP Premium, assets are not considered in determining eligibility. In addition, MCHP and MCHP Premium beneficiaries receive health benefits through HealthChoice, Maryland's Medicaid Managed Care Program.

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	1	No
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:

The MCH Program now has access to timely population based and program data from several sources. Maryland has established and is working on improving routine access to six of the nine linked data sets and surveys identified in Title V Block Grant Health Systems Capacity Indicator #9(A): 1) the annual linked birth-death certificate database, 2) a linked birth and newborn screening file; 3) birth defects surveillance system, 4) the hospital discharge database, 5) the Pregnancy Risk Assessment Monitoring System (PRAMS), and 6) the Youth Risk Behavior Surveillance System (YRBS). Analyses and reports generated from these databases have been used to conduct surveillance, develop MCH reports and enhance MCH program and policy development. In addition, the MCH Program has been working with Medicaid to gain direct access to a Medicaid database, on an as-needed basis. This connection is being utilized to link Healthy Kids data with information from the Medicaid managed care enrollee database for a study on childhood obesity.

Maryland became a PRAMS state in 1999 and released its first PRAMS Report covering 2001 births in April 2004. PRAMS reports for the 2002-2005 birth cohorts have been completed. PRAMS data will be used to track and monitor several state and national performance measures including unintended pregnancy and breastfeeding; and to conduct in-depth analyses to guide planning for perinatal systems building.

Since the mid-1990's, Maryland's SSDI Project has focused on improving epidemiologic and data capacity at the State level; strengthening the State's ability to assess annual targets for Title V performance measures; and improving State and local capacity to assess and prioritize needs, develop annual plans, and monitor program performance.

/2009/ Maryland continues to negotiate with WIC and the Vital Statistics Administration to obtain electronic access to files relevant to MCH data analysis and needs assessment. //2009//

/2010/ The Title V progress has direct access linked infant birth and death certificates. //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

Notes - 2010

Narrative:
Maryland used funds received from the tobacco settlement to establish the legislatively mandated Tobacco Use Prevention and Cessation Program. The Program was required to collect baseline data on tobacco use habits among youth (middle and high school students) and adults at the state and local levels. These surveys were to be repeated at least every other year for use in monitoring achievement of program goals. Baseline data for the Maryland Youth Tobacco Survey was collected in the fall of 2000. A second survey was completed in the fall of 2002. The surveys show that tobacco use by youth attending public high schools declined from 23% in the fall of 2000 to 17.6% in the fall of 2002. State budget cuts delayed completion of the next round of surveys until 2006.

The Maryland Adolescent Survey (MAS) is jointly sponsored by the State Departments Education; and Health and Mental Hygiene. Every two years, a sample of sixth, eighth, tenths

and twelfth graders are surveyed to determine trends the use of alcohol, tobacco, and other drugs among adolescents. The most recent survey in 2004 was completed by 33,979 students and represented 12 to 14% of the State's public school enrollment. Reported findings included reductions in thirty day tobacco use rates for tenth and twelfth graders. Maryland become a YRBS state 2004. Students completed the first survey in April 2005 and the State completed its first report in 2006. A second YRBS survey was completed this past schoool year.

IV. Priorities, Performance and Program Activities

A. Background and Overview

This section describes Maryland's progress on required national and state performance measures and documents accomplishments, current activities and the State's plan for FY 2009. In many cases, the most current available data is for calendar (CY) or state fiscal year (FY) 2006. Therefore, for many performance measures, we were unable to report on progress for FY 2006. In several instances, the data for the year 2007 will not be available until the fall of 2007 or later. As this data becomes available, it will incorporated into subsequent applications.

In FY 2007. Maryland's Title V Program served approximately 213,159 pregnant women, infants, children, including those with special health care needs and adults. As this report will show, Maryland was able to meet or surpass many of its target objectives for the state's 33 performance and outcome measures. Conversely, measures such as the continued decline in the early prenatal care rates remain as a challenge.

Maryland's MCH Program seeks to improve and enhance the health of all Maryland women, infants, and children including those with special health care needs through funding of Title V and state supported activities and programs. The Program's vision includes a State in which: all pregnancies are planned, all babies are born healthy, all children including those with special needs reach an optimal level of health, and all women and children have access to quality health care services. Title V activities discussed in this document are designed to reflect this vision.

Activities and services are delivered at each level of the MCH pyramid and directed at each of the Title V population groups: pregnant women and infants, children and adolescents, and children with special health care needs. Reducing infant and child mortality and improving health outcomes are Program priorities as described in the next section. All activities and programs are linked to these outcome measures.

B. State Priorities

Below are Maryland's 8 priority needs identified, as required, as part of the state's 2005 Needs Assessment process. Please note that while the 2005 priorities are numbered, the assigned numbers do not reflect their importance. Consideration was given to multiple factors in selecting Maryland's 2005 MCH priority needs. These included findings from a review of data trends and analyses; focus group comments; local health department surveys and meetings; the CAST -- 5 capacity assessment and input from Title V Program staff and other MCH serving agency staff in DHMH.

1. To eliminate racial and ethnic disparities in maternal and child health.

Over the past two decades following the publication of national and state reports (e.g., the 1987 Maryland Governor's Commission on Black and Minority Health), awareness has been raised about racial and ethnic disparities in health. Both the Maryland Department of Health and Mental Hygiene and the Title V Program are committed to eliminating health disparities. DHMH was also recently mandated by the state Legislature to create an Office of Minority Health and Health Disparities. Racial and ethnic disparities were identified as a priority area during the last comprehensive needs assessment remain as a priority for the 2005 needs assessment.

Maryland data consistently reveal substantial racial and ethnic disparities on numerous key indicators of heath and access to health care including infant and child mortality. The research literature is increasingly recognizing that social factors including poverty, and discrimination contribute significantly to these disparities. Maryland has begun to look at the role of stress and racism as a stressor in poor birth outcomes for African American babies. The role of public health

in addressing social issues that normally have been viewed as issues that fall outside of our rubric will be considered over the next five years as Maryland attempts to address persistent, yet amenable disparities within its maternal and child health population. Technical assistance will be provided to local health departments and other MCH serving agencies within DHMH to address this priority.

The selected state performance is the percentage of jurisdictions with written plans to address racial/ethnic disparities in MCH. A related national outcome measure is the ratio of Black infant deaths to white infant deaths. A concerted effort will be undertaken to determine the causative factors of key disparities, including maternal and infant mortality, and asthma morbidity.

2. To promote healthy pregnancies and healthy pregnancy outcomes.

As part of its mission statement, Maryland's Title V Program envisions a future in which all pregnancies are planned, all women reach an optimal level of health and well-being prior to pregnancy, no woman dies or is harmed as a result of being pregnant, and all babies are born healthy. Results of the 2005 Needs Assessment indicate that much work remains to be done if this future is to be realized for all mothers and babies. The majority of babies in our state are born healthy to healthy mothers who experience healthy pregnancies. However, Maryland continues to have one of the nation's highest infant mortality and low birth weight rates. The health disparities identified in priority #1 partially contribute to this finding.

Two state performance measures have been selected to address this priority: (1) Percentage of pregnancies intended, and (2) Percentage of women using alcohol during pregnancy. This priority is directly linked to the infant mortality outcome measure as well as performance measures # 8, 15, 17 and 18.

3. To promote optimal family functioning.

Throughout the five year needs assessment, we heard about the need to support and strengthen families to assure that children remain healthy and thrive. This need for support is cross-cutting and required for all Maryland families, especially socio-economically disadvantaged families. However, the Title V Program also recognizes that families of children with special health care needs are especially vulnerable and in need of services that enhance their ability to care for their children and address their need for supportive services such as respite and child care.

Many Maryland families were anecdotally described as "in crisis or in peril." We heard that families are disconnected; parents are stressed and overwhelmed with the process of parenting as well as accomplishing the tasks of daily living; parents are placing demands on their children to be "successful;" children are being abused and neglected; and parental substance use is a growing problem. Family support can take many forms including parenting classes; affordable quality child care; mental health counseling programs; and substance abuse treatment programs. Over the next five years, the Title V Program will promote optimal family functioning by partnering with other MCH serving agencies, families, and communities to develop and implement policies and programs that promote optimal family functioning for all families.

4. To promote healthy children.

Similar to 2000 needs assessment findings, both qualitative and quantitative data continued to reveal unacceptable levels of morbidity and mortality among children in the early and middle childhood periods. Areas of continuing concern included asthma, overweight and obesity, dental caries, mental health related problems, and child abuse and neglect. This priority was selected to ensure continued focus on improving the health of children in the early and middle years. For example, asthma currently affects more than 100,000 Maryland children and it is the leading cause of hospitalization for children in the elementary and middle school years as well as leading reason for school absenteeism. Asthma is a controllable disease when properly managed. The

use of hospital emergency departments for routine asthma management can be an indicator of poor asthma management. The Maryland Asthma Control Program which is administratively housed in the Center for Maternal and Child Health is implementing a statewide plan to reduce mortality and morbidity from asthma by promoting educational and other to improve asthma management. The emergency department use rate due to asthma will be used as one the state performance measures for this priority.

This priority was also chosen because of the relationship between health, school readiness and school performance. The Center for Maternal and Child Health is the recipient of an MCHB funded Early Childhood Comprehensive Systems Grant. This funding is being used to develop a plan for promoting school readiness by improving the health of young children in Maryland through early childhood systems building and collaboration. The second state performance measure for this priority is the percentage of students entering school ready to learn.

5. To promote healthy adolescents and young adults.

Adolescence, however it's defined (ages 10 -- 19 or 12-19 or 13-24), is a time of tremendous change and growth. This transitional developmental period between childhood and adulthood offers many physical, mental and emotional challenges. Risk taking is the norm during this period. Many adolescents make the transition to adulthood with few problems, others do not fare as well. Focus groups with parents and service providers consistently identified the need to promote healthy, positive youth development by offering adolescents "a sense of future." The health care system was not viewed as "adolescent friendly" and seen as ill equipped to address growing mental health, psycho-social and emotional problems of teens. Hence, adolescent health promotion was chosen as a priority to highlight the unique needs and issues that affect this often overlooked segment of the MCH population within the public health system.

Data on the health and mental health of Maryland adolescents, beyond traditional vital statistics measures, is limited. The Title V Program has chosen the high school graduation rate as the state performance measure and the adolescent/young adult mortality rate as an outcome measure for this priority. Other national Title V measures linked to this priority include rates of teen births, suicide, juvenile arrests and high school drop-outs.

6. To promote healthy nutrition and physical activity across the lifespan.

Adult and childhood overweight/obesity is increasing at alarming rates in the U.S. and we suspect in Maryland. Data on the prevalence and incidence of childhood overweight is currently limited, but efforts are underway to improve obesity surveillance in Maryland. The latest BRFSS data for adults indicates that almost half were overweight or obese and that these rates have increased over the past decades. Rising rates of childhood overweight and obesity were repeatedly identified as a concern by focus group participants, service providers and local health department staff. Two major factors accounting for the rise obesity rates include unhealthy eating habits and physical inactivity. Parents in our focus groups expressed concerns about school vending machines that promote unhealthy eating habits, a decline in physical education programs and outdoor recess time in schools, and an increased reliance on sedentary activities such as television viewing and computers for entertainment. Because Maryland currently does not have an obesity/overweight surveillance system for the entire child population, a performance measure will be developed in the interim years as data capabilities in this area improve.

Breastfeeding is recognized as the optimum form of nutrition for infants throughout the first year of life. While breastfeeding initiation rates in Maryland have been improving and are approaching the Healthy People 2010 goal of 75%, few Maryland moms continue to breastfeed beyond the early months. Survey data for 2003 estimate that at six months, two in five mothers continued to breastfeed and less than one in five breastfed exclusively. Because breastfeeding has long term benefits and is viewed as essential to giving infants an optimal nutritional start in life, Maryland has chosen the percentage of infants breastfeed at six months as the state performance

measure.

7. To improve systems of care for Children with Special Health Care Needs

A problem highlighted in the needs assessment by both families and providers is the issue of "navigating the system" or finding out about available services within the community and gaining access to them. This is particularly troublesome for CSHCN and their families who require not only extensive health care services but also multiple family support services. The OGCSHCN has addressed this by funding information and referral mechanisms at the large specialty centers, at a Regional Resource Center on the Eastern Shore, and at Parents' Place of Maryland. However, the majority of these centers are located centrally within the state, and getting the word out has been slow. Not all local jurisdictions are equipped to assist families with locating needed services, and parents do not feel that that pediatrician's offices are a good source of information on accessing community resources. Pediatricians agree that they don't typically have this type of information. There is a need to improve the capacity of local jurisdictions and a child's medical home to quickly and efficiently disseminate information about community resources and to advertise the information and referral mechanisms that already exist. The selected state performance measure for this priority is the percentage of jurisdictions that partner with medical homes to develop and disseminate resource materials.

8. Improve the infrastructure for supporting systems of care for women, children and families

This broad priority focuses on infrastructure level issues, namely data, work force and manpower maldistribution issues that impact the state's ability to serve mothers and children. The CAST- 5 process noted that Maryland's Title V Program has recently made substantial process in collecting and analyzing data since the last needs assessment. CMCH now employs both a senior level MCH epidemiologist and a family planning program epidemiologist. The PRAMS and YRBS datasets are now available. However, it was noted that current capacity remains insufficient for undertaking in-depth studies that could provide greater direction for development of MCH policies and interventions. For example, in the mid-nineties, Maryland had one of the nation's highest early prenatal care rates, but over the past several years, early prenatal care rates have declined significantly. The Program lacks sufficient capacity to fully examine the reasons for this decline. In this instance, staff had the expertise, but lacked the time to perform this in-depth analysis.

The CAST-5 discussions also revealed that the CMCH process for data analysis is not systematic and that greater understanding of the needs affecting the most vulnerable MCH populations in our state is the goal, then the environment for data sharing will need to be improved, in addition to work force development. The Title V Program plans to address these issues by identifying at least one major issue requiring in-depth study and analysis each program year. This work will be accomplished in partnership with other MCH serving agencies, where appropriate. The initial state performance measure for this priority will be the number of policy briefs developed.

Public health workforce and health manpower shortage and development issues were identified as a subsetof this priority. A great deal of concern was expressed throughout the CAST-5 deliberations and in meetings with local health departments about the long term implications of the aging of the MCH workforce.

C. National Performance Measures

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

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	95	95	95	95	95
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	132	125	170	182	199
Denominator	132	125	170	182	199
Data Source					NBS databases (NSS, NEST, StarLIMS, Pediatrix
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	99	99	99	99	99

Notes - 2008
Newborn screening data is reported by calendar year, CY 2008, to be consistent with the reports to the National Newborn Screening and Genetics Resource Center (NNSGRC).

A new performance measure is formulated as control of newborn screening laboratory testing was returned to the State. HB 216 (2008) gave the State Public Health Laboratory the sole authority to perform first tier newborn screening tests for Maryland babies. The bill went into effect 01/01/2009- so 2008 data is still fragmented -being collected from 4 different databases in 2 different labs. However, data will be better in the coming year being gathered from only 2 databases.

While we would like to maintain our record of treating 100% of confirmed cases, we are aware that a single case lost to follow up would significantly decrease our performance. It seems unrealistic to believe that a case could never be lost to follow up- although we are very tenacious. The number of confirmed cases includes 103 sickling disorders but only 39 of them have "gold standard" confirmation. Only these 39 were reported to the NNSGRC. The remaining 64 have 2 abnormal NBS specimens but no electrophoresis done at over 3 months of age and no DNA.

Notes - 2007
Newborn screening data is reported by calendar year, CY 2007, to be consistent with the reports to the National Newborn Screening and Genetics Resource Center.

A new performance objective is not formulated for the coming year. Problems in obtaining data from the commercial laboratory , insufficient IT resources and the loss of veteran follow up staff have made it almost impossible to compile accurate unduplicated data. The commercial lab does not report all abnormals, only presumptive positives, and they do not report data on all babies, only those born in Maryland hospitals with whom they have a contract. For example, they do not always report abnormals, even presumptive positives on home births or babies born to Maryland residents in DC who have their initial screen in DC but their subsequent screen in Maryland, or babies born in Maryland but then transferred to the NICU at Children's National Medical Center in Washington, DC. (Maryland has a 2 specimen system.)

The number of presumptive positives has decreased. New automated pipetting systems for the

assays for T4 , TSH , galactosemia and biotinidase have reduced false positives. In addition, growing expertise with tandem mass spectrometry is reducing the false positives in the amino acid and acylcarnitine profiles. Our increasing expertise is due, in part , to courses taken by lab personnel at Duke and Mayo, to an ongiong relationship with Mayo and the "scorecard" project. Other factors include the constant refinement of cut offs, a lab subcommittee of our Advisory Council and the use of new ratios to evaluate abnormal patterns .

New legislation restoring a single newborn screening laboratory will take effect January 2009 and the newborn screening program will be reorganized. These changes make us confident that we can meet higher standards and have better data. Therefore a new objective is chosen for 2010 .

Notes - 2006
Newborn screening data is reported by calendar year, CY 2006, to be consistent with the reports to the National Newborn Screening and Genetics Resource Center.

A new performance objective is not formulated. We are not sure if we can sustain our historical strength in this area, in part because of the problems of obtaining data from the commercial laboratory and in part because of the loss of veteran follow up staff. Thecommercial lab does not report all abnormals, only presumptive positives, and they do not report data on all babies, only those born in Maryland hospitals with whom they have a contract. For example, they do not always report abnormals, even presumptive positives on home births or babies born to Maryland residents in DC who have their initial screen in DC but their subsequent screen in Maryland. (Maryland has a 2 specimen system.) However, we have made progress and now receive presumptive positives on military babies. The number of presumptive positives has not grown dramatically despite the addition of cystic fibrosis to the screening panel. New assays for T4 and TSH have reduced false positives. In addition, growing expertise with tandem mass spectrometry is reducing the false positives in the amino acid and acylcarnitine profiles.

a. Last Year's Accomplishments
Newborn screening (NBS) data is reported by calendar year, CY 2008, to be consistent with the reports to the National Newborn Screening and Genetics Resource Center.

Maryland screens for all the disorders recommended by the ACMG, the AAP and the March of Dimes including the secondary targets.

Throughout CY 2008, the program continued to struggle with the challenge of operating with 2 competing NBS labs and 4 different databases. HB 216 (2008) restored sole authority to perform first tier newborn screening tests for Maryland babies to the State Public Health Laboratory, but HB216 only went into effect 01/01/2009. On 09/13/2009, the new lab database, StarLIMS went live, although the follow up modules had not yet been designed. The NBS follow up program had to obtain lab results and demographics from both the old State lab system (NNS) and the new State lab StarLIMS system as well as the Pediatrix/Perkin --Elmer system. StarLIMS does not communicate with the existing follow up database(NEST) so all data after 10/13/2008 had to be hand entered in the NEST follow up system. Data from initial specimens and subsequent specimens (Maryland has a 2 specimen system) had to be reconciled. Problems in obtaining data, insufficient IT resources and the loss of veteran follow up staff made it almost impossible to compile accurate unduplicated data.
The planned reorganization of the newborn screening program took place. The short term follow up unit moved to the laboratory in January 2009. The newborn screening fee was increased from $40 to $70 to allow for the purchase of new lab equipment, lab and follow up database computer programming and to support the short term follow up system. A new follow up nurse and genetic counselor were hired and trained. The provider manual was updated. The MOU with University of Maryland, Division of Human Genetics, to hire a new clinical biochemical geneticist to be medical director of the NBS program and to allow UMD staff to take evening and weekend call in rotation with State NBS staff was approved. New regulations were written and promulgated.

The OGSHCN continued to work with the State genetics / tertiary care centers to provide diagnostic evaluations. The OGCSHCN also works with each child's primary care provider (PCP) and makes every effort to find a primary care provider who can provide care in a medical home for each child with a confirmed diagnosis. The OGCSHCN also continued to work with the metabolic genetics, endocrine, hematology and CF centers to assure ongoing care for confirmed cases. In FY 2008, the OGCSHCN provided long-term follow-up services including case management, nutritional management, counseling, health education, and family support to 354 families with confirmed metabolic disorders and 1,374 children with sickle cell disease and the genetics centers served over 7,805 individuals and provided 10,365 laboratory services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support newborn screening for all the disorders recommended by the March of Dimes, the AAP and the ACMG for all Maryland babies	X		X	
2. Support the newborn screening follow up staff through the transition to the Laboratories Administration			X	X
3. Work with the Laboratories Administration to construct a follow up module to the StarLims laboratory data management system			X	X
4. Continue to refine lab testing and follow up protocols	X	X	X	X
5. Provide short term follow up assuring that all abnormal or inadequate test results are followed to resolution	X	X	X	
6. Support the State's designated metabolic, endocrine, hematology and CF centers through small grants		X		X
7. Provide metabolic nutritionists from the OGCSHCN to provide case management and nutritional therapy	X	X		
8. Provide case management for sickle cell disease patients through the 6th birthday and continue to develop resources for transition and care for them as adults	X	X		X
9. Continue to work with the commercial laboratory to assure a smooth transition, provide 2nd tier tests and improve completeness of State data			X	X
10. Continue to educate providers and parents, update educational materials and enhance the website.	X	X	X	X

b. Current Activities

A group objecting to Maryland's long standing policy of informed consent for NBS, introduced HSB 160 to make screening for disorders with proven beneficial interventions absolutely mandatory (the Nebraska model) and to require Maryland to adopt the Massachusetts model of a split screening panel where some disorders are mandated and informed consent is required for others. The OGCSHCN had been required to prepare a report for the legislature on whether NBS should be made mandatory and concluded that it should not. Under existing law, authority to change policy belongs to the Advisory Council on Hereditary and Congenital Disorders (ACHCD) (consumer dominated with expert medical, DHMH and legislative representation.) The Council voted to move from the informed consent model to the informed dissent model used by the overwhelming majority of other states. Families seldom refuse NBS (only 3 in CY 2007, 2 in CY2008).The sponsors of SB 160 disagreed with the report/decision of the ACHCD. The provisions requiring Maryland to adopt a Massachusetts style split screening panel were a surprise. Such a change would have required major reorganization of the NBS system. The State lab had just constructed its new StarLIMS system based on the existing protocol. The bill was defeated but advocates complained to federal Secretary's Advisory Council alleging that the

DHMH lied to the legislature. This misunderstanding is not yet fully resolved and a new legislative proposal is expected in 2010.

c. Plan for the Coming Year

The NBS staff will continue to work with the IT staff from the Family Health Administration, the Laboratories Administration and the StarLims systems design personnel/ programmers to develop the new follow up module. Primary care providers and tertiary care centers will be trained to obtain results and to add follow up information to the follow up module.

The recently hired genetic counselor left and we are recruiting.

The program continues to refine its lab testing protocols and replace ageing equipment. Progress on reducing false positives continues. Our increasing expertise is due to experience, new and better equipment, a relationship with Mayo and "scorecard" project, the constant refinement of cut offs, a lab subcommittee of our Advisory Council and the use of new ratios to evaluate abnormal patterns.

The program will continue to work with Dr Ann Moser on the NBS test for X-linked Adrenal Leukodystrophy and with Dr Jennifer Puck on the screening protocol for Severe Combined Immune Deficiency. The validated ALD test method was just published, [Mol Genet Metab. 97(3):212-20 (2009)] The program will continue with the CDC/HRSA project to evaluate the usefulness of the routine second newborn screening specimen for endocrine disorders. The program will also continue to work with researchers to study false positives in order to minimize the negative effects of false positives, to devise an optimal method of informing families about carrier status, to evaluate a possible role for NBS in identifying both mothers and babies with disturbed B12 utilization at risk for hematological problems and to study long term outcomes in SCD patients.

The program will prepare for the introduction of new legislation, expected in the 2010 session, making NBS mandatory.

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	70	70	71	72	55
Annual Indicator	68.1	68.1	68.1	54.8	54.8
Numerator	142329	142329	142329		
Denominator	209000	209000	209000		
Data Source					SLAITS 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

	2009	2010	2011	2012	2013
Annual Performance Objective	55.5	56	56.5	57	57

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

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

Annual Performance Objectives have been revised based on the most recent data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. The SLAITS data continue to be the best estimate of this performance measure.

a. Last Year's Accomplishments
According to the 2005-06 National Survey of CSHCN (NS-CSHCN), just under 55% of Maryland families of CYSHCN report that they are partners in decision-making and are satisfied with the services they receive, compared with over 57% nationally. This is a significant change from the 2001 NS-CSHCN, when over 68% of families of CYSHCN reported success in this outcome. This is a disappointing finding, as family-professional partnership and satisfaction with care have traditionally been areas of relative strength for Maryland compared with other states. The reasons for this change are not clear.

The OGCSHCN continued its support of The Parents' Place of Maryland (PPMD), a non-profit, family-directed and staffed center serving parents of children with disabilities and special health care needs. PPMD also houses the Maryland Chapter of Family Voices. PPMD and OGCSHCN have an ongoing partnership in a number of activities, including the Family-to-Family Health Education and Information Center, which serves as a statewide resource about the health care system by providing information, support, advocacy, and referrals for families of CYSHCN. In FY08, PPMD parent staff provided individual assistance to 789 parents of CYSHCN through telephone, e-mail, and face-to-face meetings. PPMD has been very successful in its minority outreach efforts; 38% of those served were minority parents. PPMD has fostered relationships with a number of organizations connected with ethnic/racial minority populations and provides materials and training in Spanish and uses community contacts for translation in other languages. PPMD also sends out a monthly newsletter (ParenTalk) covering both health and education topics that reached at least 13,900 individuals.

PPMD continued the Family as Faculty program this year in partnership with UMD School of Medicine and Johns Hopkins School of Public Health, facilitating home visit matches followed by a debriefing for pediatric residents and students with diverse families of CSHCN on a monthly or bi-monthly basis, and presented on CSHCN from the family's perspective at the AAP annual leadership meeting in June. Evaluations of this program continue to be positive.

Last year, PPMD conducted a variety of workshops for both parents and professionals aimed at increasing partnership and advocacy skills and effectively accessing health care services for CYSHCN. In FY08, PPMD conducted 47 workshops across the state for 1322 participants including parents and providers. PPMD also held an intensive training entitled, "Maryland Health TIES" to support and assist parents to improve their capacity to partner with policymakers to help systems of care be more responsive to the needs of families of CYSHCN. A total of 20 parents participated in this training in Southern Maryland.

OGCSHCN support enables PPMD to identify and support emerging parent leaders to participate in leadership and policymaking activities through sponsored parent participation in the B'more and Health LEADers programs. LEADers graduates are then linked with various state and local committees, councils, and task forces to provide a family perspective.

OGCSHCN support enables PPMD staff to participate in a number of venues, providing parent input into health policy and program design activities. For instance, a PPMD parent representative spent one day per week in the State Medicaid office, and also sat on the Medicaid Advisory Committee. Parents provide representation on the State Rehabilitation Council, AAP Special Needs Committee, State Interagency Coordinating Council, Autism Waiver Steering Committee, and a number of local committees.

OGCSHCN itself employed two parents of CSHCN. One heads the Birth Defects Reporting and Information System and provides information and referrals to the parents of infants with birth defects. The second was our Regional Resource Development Coordinator, who was particularly active and effective in lending her expertise as a parent to the Maryland Developmental Disabilities Council, The Maryland Caregiver's Support Coordinating Council, and the Maryland State Department of Education's Inclusive Child Care Work Group.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support The Parents' Place of Maryland to provide families of CYSHCN with a central source of information, education, direct family support and referrals		X		X
2. Support The Parents' Place of Maryland to provide parent training, including Health TIES (Training, Information, Education, and Support) program		X		X
3. Support parent input into health policy and program design activities				X
4. Support employment of family members of CYSHCN		X		X
5. Collaborate with partners to collect data and information from families of CYSHCN via multiple sources				X
6. Support The Parents' Place of Maryland to maintain and expand a Families as Faculty Program				X
7. Work with The Parents' Place of Maryland and other stakeholders to further develop a Community of Care Consortium for CYSHCN in Maryland that promotes and supports family-professional partnerships				X
8. Disseminate materials and resources that promote Family-Centered Care				X
9.				
10.				

b. Current Activities

The OGCSHCN supports programs that gather data/information from families of CYSHCN to assess their needs and ensure that families, including families from diverse cultures, low-income, and urban/rural areas, have a voice in program/ policy decisions. PPMD provides data, collected from parents who call them, regarding parent concerns, and gaps in services. The OGCSHCN works with PPMD to enroll families of CYSHCN in a voluntary, confidential database for ongoing needs assessment. A statewide parent conference in Spanish, planned with Latino providers, was held on 06/13/2009.

PPMD, partnering with the OGCSHCN, received a State Implementation Grant for Integrated Community Systems for CYSHCN. Block grant funded OGCSHCN staff provided leadership/staff support to develop the Community of Care (COC) Maryland Consortium for CYSHCN. The inaugural summit, held in November 2008 was attended by over 100 physicians, other professionals, and families. Summit participants worked in small groups, including one on family-professional partnerships and satisfaction with care.

The COC has held quarterly meetings and identified priorities including building relationships between families and professionals through education and joint training. The COC is facilitating family-professional partnerships by having parents participate in provider workshops/trainings on early and continuous screening for special health care needs and medical home.

c. Plan for the Coming Year

The activities described will continue. The COC will collaboratively plan implementation, and evaluation strategies to achieve and sustain an integrated, community-based system of services for CYSHCN and their families. Support of family-professional partnerships and cultural competency will be integral to these activities. The COC and each of its workgroups is a racially, ethnically, culturally, linguistically, socioeconomically, and geographically diverse group, including the parents and other family members of CYSHCN. Their charge is identifying and implementing strategies to promote family-professional partnerships and cultural competency in all of their activities. Examples include incorporating principles of family-professional partnership and cultural competency into their mission, goals, and operating procedures; considering and addressing known disparities when prioritizing and implementing strategies; and gathering data from diverse groups. The Mini-Grant program (grants to be awarded for community implementation during the Project) of the COC requires family participation and strategies for cultural competency in all projects.

Family members are required participants in all activities. Family members serve as members of COC community teams for the CYSHCN Learning Collaboratives for developmental screening and follow-up. New family members will be paired with experienced parent professionals (PPMD regional parent coordinators) for mentorship and support. Mentors will assess the information and training needs of new family members and provide individual/ group training and include them in the leadership training activities of PPMD's Family-to-Family Health Education and Information Center. Families receive stipends for their participation and reimbursement for travel/childcare. The COC strives to accommodate special needs of its members including sign and foreign language interpretation. OGCSHCN and PPMD have Spanish-speaking staff to provide interpretation and translation of written materials.

The COC will disseminate/ promote the use of the Family Voices Family Centered Care Self-Assessment Tools (FCC Tools.) These assist health care practices and families to assess areas of strength, identify areas for growth, plan future efforts, and track progress toward family partnership in medical care and family satisfaction. The FCC Tools will be used in medical student/ practicing provider trainings at CNMC, the University of MD Dental Program, the MD Association of School Health Nurses, and the Family as Faculty program.

OGCSHCN will involve PPMD in preparing the MCHB Title V Block Grant for 2010 and the 5-year Needs Assessment.

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	60	60	61	62	46
Annual Indicator	56.3	56.3	56.3	45.6	45.6
Numerator	117667	117667	117667		
Denominator	209000	209000	209000		
Data Source					SLAITS 2005-2006
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	46.5	47	47.5	48	48

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

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

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. The SLAITS data continue to be the best estimate of this performance measure.

a. Last Year's Accomplishments
CYSHCN in particular need the type of care embodied by the medical home model. According to the 2005-06 NS-CSHCN, 45.6% of Maryland CYSHCN receive care that meets the criteria for a medical home compared with 47.1% nationally. Medical home was measured differently in the 2001 and 2005-06 surveys but Maryland dropped from 10th in the nation to 38th in this goal.

The OGCSHCN continues to assist children and families who are identified and receive services through its programs in finding a medical home, including children identified by the metabolic and hearing screening programs, the birth defects program and those served in the Children's Medical Services (CMS) specialty care payment program. OGCSHCN also continues to support the Complex Care Program (CCP) at Children's National Medical Center. The CCP supports medical homes by bridging/ filling the gap between primary care providers and tertiary services provided by the medical center. Both clinical and care coordination services are offered. The CCP continues to grow. In FY08 there were 356 visits for 310 patients, of which 115 were new to the program.

OGCSHCN's Medical Home Projects Coordinator provided support to the Medical Home Leadership Team (MHLT) and coordinated implementation of the medical home state plan for CYSHCN and related projects. The MHLT met regularly and completed a pilot educational program with a small group of pediatricians and key office personnel called "Extreme Medical Home Makeover." A series of four interactive learning and sharing sessions over a several month

period provided participants with concrete tools and strategies to enhance the provision of high quality primary care for CYSHCN. Participants heard from experts and engaged with peers in a small group format. Session topics included coding/ reimbursement for complex patients; care coordination/ chronic condition management; understanding and finding community resources; and quality improvement strategies. The goals and activities of the MHLT will continue in a modified format as the core members of the MHLT are integrated into the Medical Home Workgroup of the COC for CYSHCN. The COC is funded by a State Implementation Grant for Integrated Community Systems for CYSHCN from MCHB.

Improving the system of care coordination for CYSHCN through local health departments (LHDs) has continued to be an OGCSHCN priority. Unfortunately, due to budget cuts, the capacity of the LHDs to provide care coordination for CYSHCN is shrinking. With OGCSHCN support, 13 LHDs provided case management services for a total of 1076 CSHCN and their families. Also 15 LHDs provided respite care in FY08 to 683 CSHCN and their families. In February 2008, the OGCSHCN distributed a state report, and individual county reports, entitled "Access to Components of a Medical Home for CSHCN in Maryland", which summarized findings from surveys distributed in FY06 to parents/caregivers of children receiving respite care through LHDs in Maryland. In the survey, parents/caregivers were asked to answer specific questions about the different components of care delivered through their child's medical home, i.e. by the child's primary care doctor. While caregiver satisfaction around components of compassionate and culturally effective care was relatively high, the majority of caregivers indicated a lack of services around many aspects of medical home, such as communication and care coordination between providers, resource information provided by doctors, and shared decision-making. The report shows that there continue to be notable regional disparities in services for CSHCN, especially in access to primary and specialty care.

The Baltimore City Health Department (BCHD), with continued support from OGCSHN, maintained its "Medical Homes Project" aimed at improving the quality of medical homes for children in Baltimore City. This project works to improve the rates with which pediatric primary care providers in Baltimore City effectively screen young children for developmental delays and strengthens the linkages between pediatric primary care providers and BCHD resources that can support the health and development of young children at risk. In FY08 the project conducted "public health detailing" with five pediatric practices, and re-trained five practices from the previous year, in an effort to increase the familiarity of Baltimore City pediatric practices with the community-based resources available to CSHCN.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Work with families receiving services through the OGCSHCN to find medical homes		X		
2. Support the Complex Care Program at Children's National Medical Center		X		X
3. Provide leadership and support for Maryland's Medical Home Leadership Team and medical home state plan				X
4. Educate families and providers about medical home partnerships through dissemination of materials and conducting trainings and presentations		X	X	
5. Fund gap-filling care coordination for CYSHCN through local health departments, and make needed quality improvements to system		X		X
6. Support multiple efforts to improve developmental screening and appropriate referral for all children within the medical home		X	X	

through policy-level and practice-level change				
7. Work with The Parents' Place of Maryland and other stakeholders to develop a Community of Care Consortium for CYSHCN in Maryland that promotes and supports medical home improvement				X
8. Support Johns Hopkins University in the development of a medical home model for selected high prevalence, high impact and/or high cost conditions within the Harriet Lane Clinic				X
9. Collect data and report findings on medical home through parents/caregivers of CSHCN receiving respite care in Maryland				X
10.				

b. Current Activities

PPMD, partnering with the OGCSHCN, received a State Implementation Grant for Integrated Community Systems for CYSHCN. OGCSHCN staff provided leadership and staff support to develop the Community of Care (COC) Consortium for CYSHCN. The inaugural summit was attended by over 100 physicians, other professionals, and families. Participants worked in small groups. The Medical Home Workgroup focused on improving access to medical homes for CSHCN. They identified and prioritized strategies to improve access to medical homes statewide. Strategies included: Medical Home Indexing, physician /family training, parent involvement in physician/resident training, revisiting case management, realigning compensation with Medical Home goals, and maintaining an inventory of community resources. While all of these priorities cannot be immediately addressed, some will move forward. At the first quarterly COC meeting in January 2009, group members identified priorities and chose medical home as their first priority. At the second meeting in April 2009, Dr. Virginia Keane, President, MD AAP, presented an overview of the medical home in Maryland, Dr. Diana Fertsch of Dundalk Pediatrics, a state leader in instituting the medical home model, spoke on implementation strategies for private practice. COC members then brainstormed about what is already being done and what other steps can be taken to further Medical Home in their communities.

c. Plan for the Coming Year

The above activities will continue. A major COC goal is to improve access to family-centered, coordinated, comprehensive care for CYSHCN through medical homes that are part of an integrated, community-based system of services. A key strategy is the use of learning collaboratives, based on the NICHQ Medical Home Learning Collaboratives. A unique feature of the COC Project is a community-level focus to the design and implementation of these collaboratives. The COC's original plans for medical home development, including the Learning Collaboratives, have been delayed by loss of key OGCSHCN staff, including the Associate Medical Director and the Medical Homes Project Coordinator, and PPMD is now taking greater responsibility for other aspects of implementation. Despite the efforts of PPMD, progress on the medical home performance measure was negatively affected, and work is now focused on finding alternative methods for implementing the medical home model. The OGCSHCN has received approval to fill one vacant position and it is anticipated that one additional part-time staff member will also be hired to work on the State Implementation grant. The OGCSHCN and PPMD have agreed to contract with Dr. Tracy King, a pediatrician and Assistant Professor of Pediatrics at Johns Hopkins, to serve as an expert in the area of Medical Homes while recruitment is ongoing. Additionally, discussions with the Maryland Chapter of the American Academy of Pediatrics (MD AAP) have led to the redesign of the approach to implementing this goal.

In the coming year, the COC and the MD AAP will partner in a series of 4 regional forums to bring together physicians, allied health providers, local health departments, community service providers, families, and others to discuss medical home and the integration of medical home approaches into the pediatric practices in their regions. Practices interested in participating in a Learning Collaborative will be recruited.

A statewide medical home summit will be held to bring stakeholders and state policy staff together. The project will report on key findings from the regional forums and work with the group to develop a strategy for supporting primary care practices.

Another COC goal is to improve developmental screening and linkage with appropriate community-based services. The MD AAP implemented a train-the-trainer model to spread developmental screening training to medical homes statewide. The AAP and PPMD, conducted 8 grand rounds presentations on Developmental Screening in various parts of the state, including Baltimore City, Baltimore County, Easton, Frederick, Cecil County, and Montgomery County. As a result of these sessions, the developmental screening training curriculum was modified to provide for office-based staff trainings and more in-depth training with hands-on activities for large regional groups of 10 or more practices.

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	70	70	70	70.5	65.7
Annual Indicator	67.5	67.5	67.5	65.5	65.5
Numerator	141075	141075	141075		
Denominator	209000	209000	209000		
Data Source					SLAITS 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	65.9	66.1	66.3	66.5	66.5

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

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

Annual Performance Objectives have been revised based on the most recent data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. The SLAITS data continue to be our best estimate of this performace measure.

a. Last Year's Accomplishments

Indicator data from the National Survey of CSHCN, 2005-2006. The same questions were used to generate the NPM04 indicator andthe 2001 and the 2005-2006 CSHCN survey.

In the past year, the Office for Genetics and Children with Special Health Care Needs (OGCSHCN) continued to partner with The Parents' Place of Maryland (PPMD) and its Family-to-Family Health Information and Education Center. One of the goals of this center is to increase the knowledge and skills of parents/caregivers of CYSHCN so that they may more effectively access health care services for their children. PPMD has developed and has been continuously refining health-related workshops for families, several of which are related to insurance issues including, "Choosing a Health Care Plan," "Getting Needed Services from Your Health Plan," "Appealing Health Plan Decisions," and "Understanding Medical Assistance in Maryland." These workshops are scheduled on an ongoing basis throughout the state, both face-to-face and by teleconference. In FY08, PPMD staff conducted 31 workshops across the state with a total of 897 participants (412 parents, 485 providers). PPMD parent staff members are also available to provide individual assistance to parents of CYSHCN through telephone, e-mail, and face-to-face meetings. In FY08, individual contact was provided to 541 families. Tracking this contact data, the top three parent concerns were: the need for information about community resources, assistance in accessing appropriate providers, and obtaining funding to pay for needed services.

OGCSHCN also continued to support opportunities for PPMD staff to provide parent input into insurance-related policy and program design activities. For instance, a PPMD family representative spent one day per week in the central Medicaid office, and participated on the Medicaid Advisory Committee. PPMD and the OGCSHCN continued planning for the Community of Care Consortium of CYSHCN, a group of providers and parents working to address the six core outcomes of Healthy People 2010; "Health Care Financing" -- including specific details related to insurance coverage of services for CYSHCN -- is one of the core outcomes upon which the consortium is focused. The kick off for the consortium took place over 2 days in November 2008, and included representatives from Medicaid, Special Needs Coordinators from Maryland MCOs, as well as parents and professionals from other organizations. Staff from the OGCSHCN also provided an in-service training for PPMD staff about the Children's Medical Services (CMS) program as another payment source for CYSHCN to insure that direct service staff is up-to-date on services offered by the OGCSHCN.

The OGCSHCN provided payment for specialty care and related services through the Children's Medical Services Program (CMS) to Maryland CYSHCN who are uninsured or underinsured and have family incomes up to 200% FPL. Recent changes to the program's eligibility guidelines, which allow the Program's income eligibility to automatically update each year in accordance with the new federal poverty guidelines, as well as the establishment of two bilingual staff served to increase the number of eligible children for the program. In FY08, CMS paid for services for an increased number of consumers - approximately 250 CYSHCN. The vast majority of the children served by the program are Hispanic immigrants. The program's Spanish-speaking staff, the Bilingual Outreach Coordinator and the Care Coordinator for Montgomery county, worked directly with families and providers to facilitate access to timely and appropriate CMS program services. The capability of directly providing Spanish-language services to CMS families has been invaluable to the Program, and has promoted greater parent-program communication and has increased parent education/awareness of related program services.

The OGCSHCN continued to refer potentially eligible families to Medicaid programs as well as other public programs that might provide pathways to securing funding for health care and related services such as SSI and the Developmental Disabilities Administration. For those who are neither eligible for these programs nor CMS, the office makes every effort to connect the family with other charitable sources of care and resources, including: Maryland Health Insurance Plan (MHIP), Catholic Charities, and Shriners Hospital.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support The Parents' Place of Maryland to educate parents of CYSHCN about health insurance and how to access services for their children through a series of workshops		X		X
2. Support parent input into policy and program design activities related to health insurance for CYSHCN				X
3. Provide payment for specialty care and related services for CYSHCN who are uninsured or underinsured with family incomes up to 200% FPL through the Children's Medical Services Program	X	X		
4. Implement changes to Children's Medical Services program regulations that will allow the program to serve more CYSHCN				X
5. Provide outreach and case management to Hispanic families through bilingual staff in Children's Medical Services program		X		
6. Partner with Medicaid and private insurers to implement policy changes that support improvements in developmental screening, including coding and reimbursement				X
7. Work with The Parents' Place of Maryland and other stakeholders to develop a Community of Care Consortium for CYSHCN in Maryland that promotes and supports adequate insurance				X
8. Conduct a cost-benefit analysis of Maryland's two medical day care centers for infants and young children				X
9.				
10.				

b. Current Activities

The Community of Care (COC) Consortium for CYSHCN was established to address access to care for CYSHCN and had its kickoff Summit on Nov 6-7, 2008. COC members include parents, public/ private providers, pediatricians, health insurers, Local Health Departments, Centers of Excellence(COE), community clinics, and health-related foundations. A statewide strategic plan for all the core outcomes, including adequate insurance, was drafted. The "Health Care Financing" group discussed the strengths/needs of the current insurance system. Medicaid (MA) and related MCOs participate in the COC's quarterly meetings. Issues of financing/ insurance have been addressed in subsequent COC meetings. Meeting agendas have included: medical home improvement, developmental screening, and youth involvement/health care transition.

MA /EPSDT, and the American Academy of Pediatrics, MD Chapter continue to partner in the Assuring Better Child Health and Development (ABCD) Screening Academy. Due to loss of key OGCSHCN personnel, Dr. Virginia Keane, President of the MD-AAP has taken the lead and is pursuing better insurance coverage of developmental screening.

CMS program staff advocate for CSHCN in the program and work with hospital billing staff/ insurance providers to pay claims and sometimes to cover insurance premiums for CSHCN who qualify for MHIP. It is more cost effective to cover such premiums than to pay for individual services and the policy also provides primary care.

c. Plan for the Coming Year

The activities described above will continue in the coming year. In addition, PPMD, in partnership with the OGCSHCN, was awarded a State Implementation Grant for Integrated Community Systems for CYSHCN from MCHB. Through that grant, the COC Consortium was created and

continues to meet quarterly. Due to severe fiscal constraints and the departure of three key staff at the OGCSHCN, PPMD is now taking on greater responsibility for other aspects of implementation.

The OGCSHCN has received approval to fill 1 vacant position, and is in the early stages of recruitment. It is anticipated that one additional part-time staff member will also be hired to work on the State Implementation grant. The OGCSHCN and PPMD have agreed to contract Dr. Tracy King, General Pediatrician and Assistance Professor of Pediatrics, to serve as an expert in the area of Medical Homes while further recruitment is ongoing.

Additional plans include the development and use of a database for record and note-keeping for the CMS program. Program staff has met with IT and Database personnel within the Family Health Administration to begin preliminary plans for programming, ultimately to begin a paperless note-keeping method, to minimize paper use and to maximize the efficiency of note-taking and communication amongst staff members working on the same case. CMS continues to be one of a very limited number of payment sources still utilizing paper claims to process payments, and will eventually need to work toward an electronic payment system as some hospitals/facilities decline payment that requires paper claims be file, thus decreasing the number of service providers that can be accessed by families within the program.

The Maryland Institute of Policy Analysis and Research (MIPAR) at the University of Maryland, Baltimore County completed a cost-benefit analysis to evaluate the two medical daycare centers, PACT and FICCC, from a fiscal standpoint. The final report concluded that it was difficult to estimate actual benefits to families and to the state in general per dollars spent. The centers did receive supplemental funds from the state legislature for FY09 and FY10, however PACT was eliminated from the list of United Way recipients for the coming year. Fiscal concerns remain because of the cost of care, thus further collaboration and study will likely be necessary.

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	75	75	75	75.5	89.5
Annual Indicator	70.6	70.6	70.6	89.3	89.3
Numerator	147554	147554	147554		
Denominator	209000	209000	209000		
Data Source					SLAITS 2005-2006
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	89.7	89.9	90.1	90.3	90.3

Notes - 2008

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

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

Annual Performance Objectives have been revised based on the most recent data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. The SLAITS data continue to be our best estimate of this performance measure.

a. Last Year's Accomplishments
The Office for Genetics and Children with Special Needs (OGCSGCN) has long worked to improve the availability of and access to needed health and family support services for CYSHCN in Maryland. Over the past year, the OGCSGCN continued to support selected outreach specialty clinics throughout the state, including genetics, developmental pediatrics, and endocrinology clinics. However, it is has become increasingly difficult to maintain the infrastructure for these clinics. Both the continued availability of funding and sub-specialty manpower to staff the clinics are areas of concern. In FY08, there were 897 visits made to 21 outreach specialty clinics serving CYSHCN and supported by OGCSHCN.

The OGCSHCN has also continued its efforts to address the need for assistance with "navigating the system" i.e. finding and accessing available resources within the community. The OGCSHCN provides grant funding to four Centers of Excellence (COE) in Maryland and Washington, D.C. to support a Resource Liaison, or similar personnel at each center, whose function is to assist families of CYSHCN to locate needed resources both within the centers and within the community. In some centers, these individuals may work directly with particular clinics and play a greater role in coordinating the care of CYSHCN; for instance, the ASK Program (Access for Special Kids) at the University of Maryland places one nurse in the pediatric primary care clinic, and one nurse in the specialty clinics to assist families with finding resources and coordinating care. The Resource Liaisons work closely with CMS staff to coordinate care for children within the program, who often require the services of multiple specialists, and whose families benefit from the added supports. The Resource Liaison at Children's National Medical Center (CNMC) works as part of the Complex Care Program (CCP). Last year, the CCP saw 310 children and provided information about a variety of community resources to their families. In FY08, grants from the OGCSHCN funded gap-filling care coordination for CYSHCN in a number of jurisdictions; 1011 children were served by staff in fourteen Local Health Departments. Grant funds from the OGCSHCN also provided 581 children with respite care in fifteen counties throughout the state. The OGCSHCN also continued to provide funding to the Parents' Place of Maryland (PPMD) to expand its Family-to-Family Health Information and Education Center, which operates a toll-free information and referral line as well as a network of parent representatives throughout the state who are available to work one-on-one with families of CYSHCN. A similar "Children's Resource Line" is answered by staff at the OGCSHCN.

The availability of quality childcare and respite services for CYSHCN within their communities remains a significant problem in Maryland. OGCSHCN continued to support the operation of two medical day care centers that served 110 medically fragile infants and young children in FY08. These unique centers provide quality childcare, nursing, and developmental services to children whose medical needs are too great to be served in traditional day care settings, allowing their caregivers to return to work. Also continued were grants to local health departments for the

funding of a variety of respite services for 581 children and families in FY08.

Lastly, OGCSHCN worked with the Maryland Early Intervention Program to monitor and assure the quality of Early Intervention services for families in their communities. OGCSHCN distributes the federal match for the Medicaid eligible children receiving Early Intervention case management through the Infants and Toddlers program, 5,858 children in FY08.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support selected subspecialty outreach clinics throughout the state	X	X		X
2. Support a Resource Liaison or similar personnel at 4 Centers of Excellence, and The Parents' Place of Maryland for outreach, information, and referral to families and providers		X		X
3. Support the operation of 2 medical day care centers serving medically fragile infants and young children	X	X		X
4. Support the local health departments and parent organizations to provide a variety of respite services to families of CYSHCN		X		
5. Work with the Maryland Early Intervention Program to monitor and assure the quality of Early Intervention services for families in their communities				X
6. Fund gap-filling care coordination for CYSHCN through local health departments, and make needed quality improvements to system		X		X
7. Work with partners to develop web-based county-specific resource lists for each jurisdiction and disseminate		X		
8. Work with The Parents' Place of Maryland and other stakeholders to further develop a Community of Care Consortium for CYSHCN in Maryland that promotes and supports easy to use, community-based service systems				X
9. Partner with PPMD and other agencies to develop and deliver “Padre Tú Puedes” all Spanish parent conference to address cultural/linguistic competence to make systems more accessible and “easy to use.”		X		
10.				

b. Current Activities

Large budget cuts are decreasing the capacity of LHDs to provide care coordination. The OGCSHCN is working to maximize current resources. Parents in a rural county suggested that they would rather have more funding for care coordination and less for respite care. Funds were shifted to better serve the county, so some types of services in some counties will be reduced. Counties have seen growth in the number of children requesting services/served. County-specific resource maps on the OGCSHCN website are updated constantly.

The number of CSHCN served in Montgomery increased to 138 from 75 (FY 07). The cultural and linguistic competency of the new Spanish-speaking Care Coordinator increased the number of referrals and completed CMS applications. Clearer communication with parents about the need for pre-authorization resulted in fewer missed appointments.

A "Padre, Tú Puedes" Conference (06/13/2009) was developed by the OGCSHCN, PPMD, MD Developmental Disabilities Council, Prince George's County ITP Program, and MD Disability Law Center and conducted entirely in Spanish to maximize parent participation, education,

understanding and confidence. OGCSHCN Community Systems Development Coordinator was instrumental in the planning and made two presentations. Topics included: How to Advocate for Your Child, Special Education: Your Rights and the Law and the Children's Medical Services Program. (80 persons attended: 52 parents/caregivers and 28 presenters/resource providers)

c. Plan for the Coming Year

The above mentioned activities, including supporting Local Health Departments for respite and care coordination close to home, support and recruitment of culturally and linguistically competent staff, and collaboration with the COC and PPMD will continue into the coming year to facilitate easy to use services for families of CYSHCN.

The OGCSHCN has approved a grant for the Kent County Health Department to conduct a needs assessment of CYSHCN in the county during FY2010. Kent County, on the northern portion of the Eastern Shore, is a rural, isolated community with very limited public transportation, and limited resources for the care of CSHCN. Based upon results of this needs assessment, Kent will likely become another county to whom OGCSHCN provides support for care coordination, respite or other needed services in coming years.

Regional meetings conducted by OGCSHCN staff with LHD staff in March 2009 focused on community resources and the development of collaborative relationships among Local Health Departments in a given region. Meeting attendees in Western Maryland were particularly interested in developing more shared services among them. Such relationships and collaborations have become vital given the current economic climate. OGCSHCN will continue to promote such relationships in the coming year to maximize services for CSHCN, especially in rural, underserved communities, where resources are limited in order to make resources more widely available and easier for families to use.

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	11	12	38
Annual Indicator	5.8	5.8	5.8	37.5	37.5
Numerator					
Denominator					
Data Source					SLAITS 2005-2006
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	38.5	39	39.5	40	40

Notes - 2008

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

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

Annual Performance Objectives have been revised based on the most recent data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. The SLAITS data continue to be our best estimate of this performace measure.

a. Last Year's Accomplishments
The 2005-06 National Survey of CSHCN estimates that 37.4% of Maryland CYSHCN ages 12-17 receive the services necessary to transition to the adult world compared with 41.2% nationwide. There were significant differences between the 2 surveys but Maryland still ranks only 42nd among the states, only slightly better than ranking 44th in 2001.

The OGCSHCN continued to promote successful health care transition for youth with sickle cell disease (SCD) and diabetes (DM) through support of transition clinics at the Johns Hopkins Hospital. Youth with SCD 18 to 24 years of age are cared for jointly by the pediatric and adult hematologists, in the transition clinic in the Department of Internal Medicine, prior to transfer of care to the adult hematology clinic. In FY08, the SCD transition clinic provided 192 visits to 42 patients between the ages of 18 and 25 years. The transition clinic for youth with DM targets patients in their last year of high school. In this model, parents and youth are introduced to the adult endocrinologist at the transition clinic. The adult endocrinologist meets with the patients and their parents both with and without the pediatric endocrinologist. In FY08, the clinic saw 52 patients in 23 transition clinic sessions. The diabetes transition clinic staff is collaborating with a research psychologist at NIH on an evaluation component. A total of 84 patients have been enrolled under the IRB-approved research protocol Transition from Pediatric to Adult Diabetes and 26 patients from the study have transitioned from pediatric to adult endocrinology. Data has been collected on all patients.
The study has 3 parts: 1) a "pre-transition" interview looking at patient (15-17 year olds) and parent expectations for post-pediatric care; 2) a "post-transition" interview of 18-22 year old patients who graduated to adult care, and 3) a longitudinal study evaluating the transition program by looking at the same patients both before and after the transition. 26 patients from the research protocol have transitioned from pediatric to adult endocrinology care.

OGCSHCN staffs the Statewide Steering Committee on Services for Adults with Sickle Cell Disease established in 2007 under Maryland HB 793. OGCSHCN hopes to use its involvement to raise general awareness of health care transition issues as well as to ensure that there are appropriate systems of primary and specialty care for CYSHCN with sickle cell disease to transition into as adults.

The OGCSHCN funded Kennedy Krieger's (KKI) Transition Lecture Series, now completing its 6th successful year. A total of 135 youth, families and providers attended seven lectures. Topics included: "College and University Support Services," "Respite, Camp, & Vacation Opportunities

for Individuals with Disabilities," and "SSI & SSDI." Lectures are videotaped. Copies are loaned to families and are available at the Regional Resource Center for Children with Special Needs on the Eastern Shore.

OGCSHCN worked with KKI to develop a survey to assess pediatricians' current practices and needs related to supporting the health care transition process for YSHCN in their care.

The OGCSHCN distributed a state report, and individual county reports, entitled "Access to Components of a Medical Home for CSHCN in Maryland", which summarized findings from a non-randomized survey distributed in FY06 to parents/caregivers of children receiving respite care through LHDs. Parents/caregivers with CYSHCN aged 13 or older were asked whether their child's primary care doctor had addressed issues of healthcare transition with the family and 43.2% of YSHCN aged 13 or older have primary care doctors who have discussed the changing needs of the child as they grow older; 27.1% of YSHCN aged 13 or older have a transition plan developed with the child's primary care doctor; and 16.6% of YSHCN aged 13 or older have primary care doctors who have discussed having the child eventually see a doctor who treats adults.

OGCSHCN works with the MD State Department of Education to disseminate the "10 Steps to Health Care Transition" tip sheet to high school students with IEPs.

The CMS Program pays for specialty care for YSHCN enrolled in the program until the age of 22 years. Care may be covered until age 25 years in some circumstances. The CMS Program staff work with YSHCN/families to assist them with transitioning into programs for adults well in advance of the time when they will lose their eligibility for the CMS Program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support transition clinic activities including clinics for youth with sickle cell disease and youth with diabetes		X		X
2. Support monthly Transition Lecture Series for youth, families, and providers hosted by Kennedy Krieger		X		
3. Partner with Maryland State Department of Education to disseminate "10 Steps to Health Care Transition" education sheet to high school students with IEPs			X	
4. Provide payment for specialty care and related services for uninsured YSHCN until age 22 years through Children's Medical Services program	X			
5. Support the work of the legislatively mandated Statewide Steering Committee on Services for Adults with Sickle Cell Disease				X
6. Educate youth, families, and providers about health care transition through presentations at multiple venues		X		X
7. Partner with The Parents' Place of Maryland to develop a Youth Advisory Council to the OGCSHN				X
8. Partner with the Interagency Transition Council to assess programs serving transition-age youth for incorporation of health care transition elements				X
9. Support Johns Hopkins university and University of Maryland in efforts to assess and improve health care transition services				X
10.				

b. Current Activities

PPMD, partnering with the OGCSHCN, received a State Implementation Grant for Integrated Community Systems for CYSHCN. OGCSHCN staff provided leadership and staff support to develop the Community of Care (COC) Consortium for CYSHCN. The inaugural summit was attended by over 100 physicians, other professionals, and families. Participants worked in small groups, including a group focused on CYSHCN having the necessary services to make transitions to all aspects of adult life, including adult healthcare, work, and independence. As a result of the Summit, the Maryland State Department of Education (MSDE) is including information about health transition in the manual they are developing for transitioning youth and their families and will incorporate information on health transition in their statewide transition training for youth, families, and staff. In addition project staff were asked to provide presentations to a number of groups in the state including a plenary at the annual statewide transition conference.

The OGCSHCN continues its involvement with the Statewide Steering Committee on Services for Adults with Sickle Cell Disease as a mechanism for raising awareness of health care transition issues. The Steering Committee's responsibilities include establishing institutional and community partnerships; educating the public and health care providers; and developing a comprehensive education and treatment program for adults with sickle cell disease.

c. Plan for the Coming Year

The above activities will continue. The COC will work collaboratively to strengthen existing transition services for YSHCN. The COC Transition Workgroup found current transition services to be characterized by fractured activities with no common end. Maryland lacks a clearly defined, comprehensive, coordinated, community based, culturally competent, collaborative, youth/family centered system of care to facilitate success in transition from pediatric- to adult-based health care. This issue is compounded by the problems of this age group in obtaining their own health insurance.

The COC's plans for health care transition systems have been modified. Originally, PPMD/ OGCSHCN planned to increase the participation of youth in advisory roles through the development of an OGCSHCN Youth Advisory Council (YAC). PPMD is taking greater responsibility for development of the YAC in light of severe staff shortages at OGCSHCN. The YAC will be formed by partnering with the Maryland Center for Developmental Disabilities (MCDD) and the University Centers for Excellence in Developmental Disabilities Education, Research, and Service (UCEDD) at KKI. The MCDD approached PPMD to partner in the development and implementation of a transition advocacy training and mentoring project for YSHCN. To avoid duplication of efforts and to maximize project impact and long-term sustainability, the COC decided to partner with MCDD in the development of the curriculum/ training and to develop the YAC jointly. Initial trainings for mentors (older youth who have transitioned and/or family members) and trainings for youth will begin in FY10. The training sessions for youth will use modules adapted from the Working Together for Successful Transition: Washington State Adolescent Transition Resource Notebook and other adolescent health transition training resources, and will include a focus on serving in advisory roles. Youth will be supported in advisory roles to the MCDD, PPMD and to the OGCSHCN/ Title V program. Funding for the activities of the youth training and council will be shared by the partners. Training youth in navigating their own health care and serving in advisory roles will prepare them for leadership in and participation on advisory committees.

PPMD and the OGCSHCN will also work with the Maryland Interagency Transition Council to identify and implement strategies to facilitate health care transition. The partners will assess member agencies/organizations to identify the health care transition elements incorporated into their programs and identify promising practices and areas of needed improvement. The findings will be shared with the Council members. The project plans to provide technical assistance to

address areas of needed improvement in the future.

The Johns Hopkins Department of Pediatrics has revamped its OGCSHCN funded Center of Excellence grant to focus on health care transition in the Harriet Lane primary care clinic.

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	80	85.1	81	83	86.5
Annual Indicator	80.0	80.0	79.9	92.4	92.4
Numerator	180072	180072	176242	206988	206988
Denominator	225089	225089	220579	224013	224013
Data Source					Vital Statistics 2007 and Oral Health Survey 05-06
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	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	93	93	93	93	93

Notes - 2008
Estimated percentage is based on data from the National Immunization Survey, Q1-Q42007- 92.4% immunized according to 4:3:1:3:3 series. This percentage was applied to the estimated number of children between the ages of 1-3 in 2007 based on Maryland Vital Statistics reports. Data for 2008 is currently unavailable.

Notes - 2007
Estimated percentage is based on data from the National Immunization Survey, Q1-Q42007- 92.4% immunized according to 4:3:1:3:3 series. This percentage was applied to the estimated number of children between the ages of 1-3 in 2007(Source: Maryland Vital Statistics population estimates).

Notes - 2006
Estimated percentage is based on data from the National Immunization Survey, Q1-Q42006 - 79.9% immunized according to 4:3:1:3:3 series. This percentage was applied to the estimated number of children between the ages of 1-3 in 2006 (Source: Maryland Vital Statistics population estimates).

a. Last Year's Accomplishments
According to the Centers for Disease Control and Prevention (CDC)'s sponsored National Immunization Survey (NIS), in 2006, 79.9% of Maryland children ages 19-35 months were fully immunized as defined by the 4:3:1:3:3 series. This percentage slightly below the national average

of 80.4% for this time period and meets Maryland's target goal of 80% for this measure. Immunization rates for children in Baltimore City at 76% in 2006 were lower than both the State average and State average outside of Baltimore City (80.5%) according to the NIS. NIS data for the Q32006/Q2007 period, estimate that immunization levels statewide improved to reach 86%.

Immunization issues were included in Maryland's Title V funded early childhood grant development activities. A priority of the Early Childhood Health Plan completed by CMCH in 2007 is to increase access to medical homes for young children. Immunizations are an important component of well child care to be promoted within the medical home. Education about the importance of immunizations as well as new Maryland vaccination guidelines are part of early childhood health outreach efforts.

The Community Health Administration, Center for Immunization is largely responsible for statewide immunization activities in Maryland. Ongoing activities to promote early childhood immunization in FY 2006 included the distribution of immunization educational materials to the parents of every child born in the State, administration of the State's immunization registry, ImmuNet, and operation of the Maryland Vaccines for Children (VFC) Program. VFC allows enrolled physicians to provide all routinely recommended vaccines, free of cost, to children 18 years old and younger who are Medicaid enrolled; uninsured; underinsured or Native American/Alaskan Native. There are currently approximately 750 enrolled providers practicing at 1,000 public and private practice vaccine delivery sites throughout the State. Immunization Excellence Awards are given to VFC providers, who demonstrate excellence in all critical areas reviewed by the VFC Program, including immunization coverage rates of two year olds; and pediatric practice standards.

ImmuNet, the State's immunization registry, began implementation in June 2004. As of May 2008, ImmuNet included 4,500,000 immunization records and was being used in 225 practitioner offices. The registry provides a consolidated vaccination record for children enrolled, provides reminder and recall notices, and prints forms for schools, camps, and day care.

Title V also continued to support local health department efforts to inform consumers, communities and providers about the importance of immunizations. Although the majority of children are immunized in private physician offices, several local health departments continued to offer immunization clinics serving children in underserved areas of the State in 2007. MCH nursing staff in local health departments educated families about the importance of immunizations during home visiting and early childhood programs as part of a comprehensive approach to well child care. Educational materials to promote awareness of the need for immunization continued to be a part of all MCH outreach activities. WIC Program staff determined the immunization status of their clients at every encounter.

One local health officer initiated an aggressive immunization program. The action plan includes working with the WIC program to identify children with delayed immunizations. MCH staff are also using simplified an immunization schedule cards during nurse home visits and Infants and Toddlers visits. This enables MCH staff to identify children with delayed immunizations and provide education to parents regarding the immunization schedule. Immunization tracking is completed through mailings or visits to physician offices.

DHMH adopted new school immunization requirements for the 2006-2007 school year. Pneumococcal vaccine is now required for children enrolled in preschool programs. As of January 2007, varicella and hepatitis B vaccination became a requirement for all students in preschool through ninth grade. Both CMCH and the Center for Immunization are continued to work with local health departments, health providers and MCIP to educate parents about the new guidelines.

The Maryland Childhood Immunization Partnership (MCIP) functions as an advisory committee to

ImmuNet. MCIP is a partnership between DHMH and MD Chapter of the AAP and offers training to professionals.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distribute educational materials to parents of every newborn in the state that includes information on immunizations (Center for Immunizations).			X	
2. Fund local health department immunization clinic and outreach/education activities	X		X	
3. Continue to expand the state's immunization registries. Immunet (statewide) and the Baltimore City registry. Title V support the Baltimore City registry.		X		
4. Provide insurance coverage for immunizations through Medicaid and MCHP.		X		
5. Administer the Vaccines for Children Program (Center for Immunizations).				X
6. Promote immunizations through home visiting and early childhood programs. Promote access to medical homes for all children through Early Childhood Health Grant.			X	
7. Screen for immunization status in WIC and other MCH programs.			X	
8. Participate in the Maryland Immunization Partnership.				X
9. Provide outreach and education to the general public and health care provider to improve immunization levels.			X	X
10.				

b. Current Activities

During this year, the Center for Immunization expanded ImmuNet and conducted outreach and education activities directed at both providers and families to improve immunization levels. Strategies were implemented to increase the immunization coverage rate as measured by the 4:3:1:3:3 series on the National Immunization Survey to 85% by 2020 from a baseline of 73% in 2001. Elimination of the six percentage point disparity in the vaccination rates among racial/ethnic groups was addressed. The MCH Program continued to collaborate with the Center for Immunization on these objectives.

The Title V Program continued to support immunization outreach and education efforts provided by local health departments. Title V funds continued to directly support Baltimore City's Immunization Registry, developed independently of ImmuNet. The City's Registry maintains a database of immunization and demographic information on Baltimore City children collected from pediatric providers. MCH staff identify children who are not up to date with their immunizations and refer them to a medical home.

c. Plan for the Coming Year

During the coming year, there is a plan to distribute educational materials to parents of every newborn in the State that includes information on immunizations (Center for Immunizations). Funding to local health department immunization clinics and outreach/education activities will continue to support immunization administration. The State's immunization registries, Immunet (statewide) and the Baltimore City registry will be expanded. Title V will continue to support the Baltimore City registry.

Insurance will continue to provide coverage for immunizations through Medicaid and MCHP and the Center for Immunizations will continue to administer the Vaccines for Children Program. Immunizations will continue to be promoted through home visiting and early childhood programs and access to medical homes for all children through the Early Childhood Health Grant.

WIC and other MCH programs will continue to screen for immunization status. The Maryland Immunization Partnership will continue to function as an advisory committee to ImmuNet. CMCH will continue to participate on Maryland Childhood Immunization Partnership, the state's childhood immunization coalition. Outreach and education will continue to the general public and health care providers to improve immunization levels and maintain Maryland's status as one of the state's with the nation's highest immunization rates.

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	24.6	17.9	17.4	16.4	16.4
Annual Indicator	17.9	16.8	17.5	18.3	18.2
Numerator	2106	2047	2118	2200	2200
Denominator	117602	121697	121211	120146	120894
Data Source					MD Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	17.5	17.5	17.5	17.5	17.5

Notes - 2008
2008 data is not yet available - used 2007 data estimate

Notes - 2007
Source: 2006 Maryland Vital Statistics Report; Data estimated for 2007 and based on 2006 findings.

a. Last Year's Accomplishments
Maryland's birth rate for teens aged 15-17 rose 4% between 2006 (17.5/1000) and 2007 (18.2/1000). The birth rate declined among White non-Hispanic teens between 2006 (8.6/1000) and 2007 (8.5/1000). The birth rate increased from 28.0/1000 to 29.4/1000 among Black teens and from 50.8/1000 to 54.4/1000 among Hispanics, over this time period. Teen Pregnancy prevention efforts are largely addressed and coordinated through two programs: the Maryland Family Planning Program and the Maryland Abstinence Education and Coordination Program.

In FY 2008, the Family Planning Program served a total of 19,806 (this is down from 2007) teens ages 15-19 and 1,336 teens under the age of 15. Additionally, there was a total of 2,037 youth between the ages of 15 to 19 served in the State's three Healthy Teens and Young Adults (HTYA) sites. These clinics are located in Baltimore City, Prince George's County and Anne Arundel County. HTYA clinical services are offered through model clinics which embrace a comprehensive, holistic approach to health care. The program extends special services to teens and young adults who face social, cultural, institutional, and financial barriers to care. The physical and psychosocial needs of the client are equally considered. Part of this holistic approach includes information and counseling about abstinence and delaying sexual activity in addition to assuring assess to contraceptives. The clinics are supported with outreach services based on a philosophy of "Reaching Out/Reaching In." Outreach staff actively reach out to young people where they live, go to school, work, and play. They reach in to young people to develop self-esteem, personal responsibility, and goals for the future.

In 2008, the Maryland Abstinence Education and Coordination Program (MAECP) continued to fund 18 local health departments to provide abstinence education programming. The majority of these jurisdictions supported programs using an after-school program intervention model targeting middle and high school students. MAECP grantees served approximately 2000 youth between the ages of 10--19 years old. Student were taught from a required abstinence curriculum that was supplemented by programming from other curricula promoting positive youth development and decision making. Local activities included development of an abstinence education message that was presented as a movie trailer in local theaters and viewed by 8,000 patrons and student development of promotional abstinence education videos and other media.

In light of uncertainty over continued federal funding for Title V abstinence programs, MAECP strengthened efforts to improve coordination and collaboration with community based abstinence education providers. Meetings were held to explore potential partnerships within various state agencies including the Department of Human Resources- Foster Care, and the Department of Juvenile Justice. MAECP partnered with Hope Worldwide (a CBAE grantee) and the YMCA to sponsor an abstinence focused youth rally at Dunbar Middle School in Baltimore City. Over 533 youth attended the rally. From this rally, a Youth Ambassador Club was formed and 39 students were trained as abstinence peer educators.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide comprehensive family planning and reproductive health services to approximately 25,000 teens annually.	X			
2. Fund three Healthy Teen and Young Adult Programs promoting a holistic approach to teen pregnancy prevention.	X	X		
3. Administer the federal abstinence education grant. Fund abstinence education programming through grant to local health departments and other community based groups.		X		
4. Conduct training and education events, including conference provider, adolescents and parents/caregivers to promote abstinence and reduce teen pregnancy.				X
5. Collaborate with other agencies to promote positive youth development				X
6. Monitor data and trends.				X
7.				
8.				
9.				
10.				

b. Current Activities
At the request of the Governor's State Stat Team, this year, CMCH developed a matrix for prioritizing jurisdictions of greatest need for teen pregnancy prevention resources in the State. Should additional State or federal funding become available, the plan is to potentially use this methodology to target resources. The matrix includes seven factors including teen birth rates, infant mortality rates and high school graduation rates.

For Teen Pregnancy Prevention Month in May 2008, MAECP grantees were asked to implement abstinence focused outreach campaigns, to initiate youth councils or hold focus groups with youth to get their thoughts on ways to promote abstinence and to hold workshops to promote parent/child communication. One example is a youth media project developed by a youth media company, Wide Angle, for Baltimore City's abstinence program that includes posters promoting abstinence among Baltimore youth. The messages were developed by teens.

CMCH also worked with the Western Maryland region which has high teen births rates in some communities to hold an Abstinence Youth Summit in June 2008.

The uncertainty over Title V funding has made it much more difficult to manage MAECP. In spite of this, the abstinence education coordinator has been working with various vendors to develop outreach and educational materials, develop an abstinence website with sections for youth, parents and professionals, and promote parent-child communication.

c. Plan for the Coming Year
MCH plans for the coming year include:
*Continuing to provide family planning services and reproductive health programs directed at adolescent pregnancy prevention including Healthy Teen and Youth Adult sites;

*Working to address the increases in teen pregnancy particularly within the Latino population; and

*Reviewing the state infrastructure for teen pregnancy prevention activities in Maryland and research best and promising practices nationwide as part of the 2010 Title V needs assessment

* Monitoring and analyzing data and trends to update the state's teen preganacy prevention plan.

Although the Maryland Abstinence Program will be ending the teen pregnancy prevention program will focus on strengthening State collaborations, promoting greater parent/child communication, expanding programming to teens and continue to focus on the positive youth development philosophy.

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	30	30	30	30	42.5
Annual Indicator	23.7	23.7	23.7	42.2	51.6
Numerator	17703	17703	17703	25466	34145

Denominator	74696	74696	74696	60400	66173
Data Source					MSDE Public and Non-Public School Enrollment
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	52	52	52	52	52

Notes - 2007
Source: University of Maryland Dental School. Survey of the Oral Health Status of Maryland School Children, 2005-2006 School Year. This is a periodic survey conducted by the University, last conducted in 2001-2002.. Based on weighted prevalence of dental sealants among MD 3rd graders during the 2005-2006 school year.

a. Last Year's Accomplishments
Access to oral health care is a critical problem for underserved and minority populations in Maryland. The 2005 - 2006 Survey of Oral Health Status of Maryland School Children, conducted by the University of Maryland Dental School, found that 31% of children in kindergarten and third grade had untreated tooth decay. Children residing on the Eastern Shore and in Southern Maryland had the highest rates of untreated tooth decay. Low-income, African-American and Hispanic children suffer even higher rates of tooth decay than white and upper-income children.

The 2000 Survey of Oral Health Status of Maryland's Head Start Children conducted by the University of Maryland at Baltimore Dental School, Department of Pediatric Dentistry examined three- and four-year-old children from 37 Head Start programs across Maryland. Head Start is a federally- funded program whose participants must be under 185 percent of the federal poverty level. All children enrolled in Head Start are to receive comprehensive health services, including medical, dental, nutrition and mental health services. In addition, since most of these children are from low-income groups, they are eligible to receive Medicaid services including EPSDT.

The study found that 54.6 percent of the children had decayed or filled tooth surfaces (dfs), with a mean dfs of 3.64. Such high caries prevalence in three and four-year-old children is similar to other reports from Head Start children in the U.S. Children in rural areas experienced a 16 percent greater caries experience and a 27 percent greater numbers of decayed surfaces. This may be due to the fact that children living in rural areas are less likely to drink water from fluoridated community water systems when compared to children from metropolitan areas.

The Maryland Legislature continued its mandated review of utilization rates of dental health services by children enrolled in Medicaid. Inadequate access to oral health care, particularly for uninsured and Medicaid clients, continued as a concern for all areas of the State. In CY 2007, 32.9% of enrolled Medicaid children received at least one dental service. In addition, less than one quarter of enrolled Medicaid children received one restorative service. This is occurring despite high rates of dental disease among children in Maryland.

While Medicaid has been successful in recruiting additional participating dentists in recent years, only 671 or 16.6% of 4,033 Maryland dentists are actively serving and billing Medicaid recipients. Further, less than 9 percent of all Maryland licensed dentists bill more than $10,000 per year in services to Medicaid.

In 2007, Secretary Colmers convened a Dental Action Committee (DAC) in response to increasing evidence of inadequate access to dental care. The DAC was charged to develop recommendations for improving access to dental services for all low income children. The Committee made 7 major recommendations (60 recommendations total) with a goal of establishing Maryland as a national model for children's oral health care. One of their recommendations was to hire a full-time state Dental Director who joined the Department of Health and Mental Hygiene in January 2008. With the strong assistance and support from federal and state legislative partners, Maryland is moving forward with the recommendations and dental reforms.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Partner with the Office of Oral Health, Medicaid and other stakeholders to develop and sustain a statewide Oral Health Coalition focused on improving access to oral health care services and assisting with implementing recommendations				X
2. Survey preschool and school aged children to ascertain and monitor oral health status needs.				X
3. Fund and support a range of oral health service for children in local health departments including diagnostic, preventive and restorative services. Title V supports services in Baltimore City. The office of Oral Health support services statewide.	X	X		
4. Plan and promote strategies to improve early childhood oral health.				X
5. Provide insurance coverage for dental health services for children and pregnant women through Medicaid and MCHP.				X
6. Administer a loan repayment program fro dentist who serve low income populations (Office of Oral Health).				X
7. Fund school based dental sealant programs.				X
8. Promote the P.A.N.D.A Project, a child abuse and prevention program that trains dentist to recognize dentists to recognize abuse.				X
9. Disseminate a Resource Guide that identifies discounted and low cost dental health services available to eligible Marylanders.		X		
10. Conduct a statewide pilot school sealant demonstration project in partnership with the University of Maryland Dental School to determine the most efficacious and cost-effective means to deliver dental sealants in a school environment	X	X		

b. Current Activities

Recommendations of the DAC - the 2008 Maryland General Assembly took the following actions:

. Recommended $14 million in FY 2009 budget for the first installment of a three-year effort to bring Maryland Medicaid dental rates up to the 50th percentile of the American Dental Association's South Atlantic region charges.

. Recommended $2.1 million in FY 2009 budget to enhance the dental public health infrastructure and increase access to dental public health services for low-income children - to establish new dental public health clinics and to support school-based dental programs including support for a dental wellmobile. Currently six (6) new county dental clinic programs have been established in regions of the state where there had been no dental public health program or

facility.
. Passed Legislation to create a new "public health dental hygienist" category to enhance the ability of dental hygienists working in public health facilities to provide needed dental screening and preventive services for low-income populations.
In addition, beginning in July 2009, the Maryland Medicaid program will carve out the dental program from the Medicaid program and contract with a single dental vendor to administrate and oversee Medicaid dental services. Through a partnership with the University of Maryland Dental School and the MD State Dental Association, DHMH helped develop a training program for physicians and general denists in the risk assessment and treatment of very young children.
An attachment is included in this section.

c. Plan for the Coming Year
This coming year, the MCH Program will continue:
. Working with the Office of Oral Health to implement a plan to improve the oral health of children in Maryland. Activities will include (1) working with the Maryland State Department of Education to develop a phased-in multi-year approach to integrate dental screenings into the current vision and hearing screening programs tied to school enrollment and (2) developing a multi-cultural oral health message that reinforces the importance of oral health to the public.
. Participating in various statewide alliances and coalitions that address oral health;
. Implementing early childhood health plan strategies that address oral health including completion of a second oral health assessment of Head Start enrollees;
. Assisting the Maryland Office of Oral Health in its plans, beginning July 2009, to enable EPSDT medical providers inlcluding pediatricians, family medicine physicians and nurse practitioners to be reimbursed by the Medicaid Program for assessing and applying a preventative fluoride varnish agent to very young children not currently being seen by dentists;
. Collaborating with the Office of Oral Health in its planned efforts to institute a dental sealant demonstration project to assess and evaluate the most efficient and cost-effective means to develop statewide dental sealant initiatives;
. Supporting local health efforts to improve access to oral health services for low-income children; and
. Reviewing oral health data for the Title V needs assessment including examining the results of an evaluation of the State's dental health infrastructure to determine additional avenues for Title V to collaborate with the Office of Oral Health to improve access to dental services for children and pregnant women.

An attachment is included in this section.

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	3.5	2.6	3	3	3.5
Annual Indicator	3.4	2.4	2.5	3.1	2.9
Numerator	39	28	28	34	34
Denominator	1153514	1153348	1112945	1107687	1160562
Data Source					MD Vital Statistics Data (2007)
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	2.9	2.9	2.9	2.9	2.9

Notes - 2008
Data for 2008 not available. Estimate based on Vital Statistics Administration data from 2007.

a. Last Year's Accomplishments
Injuries, including motor vehicle accidents remained the leading cause of death for children. In 2007, (the most recent year for which data is available from the Vital Statistics Administration), 34 Maryland children under the age of 15 died in motor vehicle crashes. In FY 2008 the MCH Program continued to provide support and technical assistance to state and local Child Fatality Review (CFR) teams legislatively mandated to review child deaths in Maryland, including those caused by motor vehicle accidents. Several jurisdictions identified motor vehicle accidents as a priority concern. The 2007 Child Death Report prepared by the MCH Epidemiogist for the state CFR team identified trends in deaths due to motor vehicle accidents.

State activities directed at preventing deaths due to motor vehicle accidents largely fall outside of the purview of the MCH Program. Maryland has enacted several strict safety belt laws. As a result of aggressive enforcement of these laws, Maryland has an 93% seat belt usage rate, one of the highest on the east coast. Children and young people up to 16 years of age must be secured in seat belts or child safety seats, regardless of their seating positions and may not ride in an unenclosed cargo bed of a pick-up truck. Maryland law also strictly forbids driving while impaired by alcohol or other drugs and the minimum lawful drinking age is 21 years.

Maryland law requires that "A person transporting a child under the age of 8 years in a motor vehicle shall secure a child in a safety seat in accordance with the child safety seat and vehicle manufacturers' instructions unless the child is 4 feet, 9 inches tall or taller; or weighs more that 65 pounds". Since the 1980's, the Maryland Kids in Safety Seats (KISS) Program has been the State's lead agency for promoting child passenger safety. KISS is housed in the Family Health Administration's Office of Health Promotion and funded by the Maryland Department of Transportation. Its mission is to reduce the number of childhood injuries and deaths by educating the public (e.g., 1-800 helpline, media campaigns, website) about child passenger safety including the correct use of safety seats.

During National Child Passenger Safety Month in September 2008, jurisdictions throughout the state participated in child safety seat checks and community outreach and education activities. Child safety seat inspections conducted in Maryland reflect that while an estimated 80% of the target population uses child safety seats; the majority (75% in FY 2007 -- most recent data) of these restraints are improperly installed. KISS continued to administer a loaner program that provided child safety restraints to over 1022 low-income families in FY 2008. In addition, KISS offered 17 child passenger safety certification trainings to Marylanders including law enforcement, health care/nursing, health department staff and auto dealerships.

The Center for Preventive Health Services (CPHS) funds local injury prevention programs, several of which address motor vehicle safety. CPHS also administers a project that links state crash and medical outcome data to identify the medical and financial consequences of motor vehicle crashes. CPHS uses this information to support preventive efforts.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct state and local child fatality review processes that include a review of deaths due to motor vehicle crashes.				X
2. Enforce strict Maryland child safety seat, safety belt and DUI laws.				X
3. Enforce laws requiring children of certain weights and at certain ages to use child passenger safety seats.)				X
4. Educate the public about child safety seat laws and the correct use of child passenger safety seats. Administer the Kids in Safety Seats Program that includes a free loaner program. (Office of Health Promotion		X		
5. Fund local injury prevention programs promoting motor vehicle safety (Family Health Administration).			X	
6. Monitor data and trends. Publish an annual child fatality review report that includes data on deaths due to motor vehicle crashes.				X
7. Collaborate with other agencies and coalitions (e.g., the Partnership for a Safer Mary and) to reduce injuries.				
8.				
9.				
10.				

b. Current Activities

Ongoing activities from last year are continuing in 2009. These activities include the MCH Program continues to provide support and technical assistance to state and local Child Fatality Review (CFR) teams legislatively mandated to review child deaths in Maryland, including those caused by motor vehicle accidents. Several jurisdictions identified motor vehicle accidents as a priority concern. The 2007 Child Death Report prepared by the MCH Epidemiogist for the state CFR team identified trends in deaths due to motor vehicle accidents.
the The MCH Epidemiologist is currently completing the 2008 Annual Child Death Report. Once again, the report identifies injuries, including those due to motor vehicle accidents, as a leading cause of child deaths.

In addition, this year legislation will enable the CFR data to be transferred to a national data base for better information regarding trends and program implementation.

c. Plan for the Coming Year

In FY 2010, the State Child Fatality Review Team and the MCH Program will continue to partner with other DHMH and state agencies to reduce child deaths due to motor vehicle accidents.

MCH will continue to be represented on the Partnership for a Safer Maryland, a coalition convened by the Center for Preventive Health Services (CPHS) to advocate for injury and violence prevention. The 80 member Coalition will assist in developing and implementing a Maryland Plan for Injury Prevention. CPHS received a five year CDC grant to support building of additional state infrastructure for injury prevention. Reducing childhood deaths and injuries due to motor vehicle accidents is part of the Coalition's focus.

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			42	44	41
Annual Indicator		40.8	40.2	43.0	43.0
Numerator		29085	31127	33565	33565
Denominator		71286	77430	78057	78057
Data Source					MD PRAMS Report 2007 births
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	44	44	44	44	44

Notes - 2008
Maryland PRAMS report 2007 births data applied to number of births indicated by MD Vital Statistics Annual Report 2007

Notes - 2007
Source: National Immunization Survey. Breastfeeding rates for Maryland children born in 2004. Indicates that an estimated 40.2% of Maryland women were breastfeeding at 6 months. This percentage was applied to the number of births in Maryland in 2006. Data for 2007 is currently unavailable.

Notes - 2006
Source: National Immunization Survey Breastfeeding rates for Maryland children born in 2004. Indicates that an estimated 40.2% of Maryland women were breastfeeding at 6 months. This percentage was applied to the number of births in Maryland in 2006.

a. Last Year's Accomplishments
According to the CDC National Immunization Survey, for births in 2004, 70.7% of Maryland mothers initiated breastfeeding, and 43.1% continued to breastfeed at six months, with 12.2% breastfeeding exclusively at six months. These percentages were very close to the national averages. Maryland ranked 26th among the 50 states and the District of Columbia for the percent of mothers who breastfeed their infants at 6 months.

The CDC report showed a continued significant racial disparity in breastfeeding nationwide, with 55.7% of non-Hispanic Black mothers ever breastfeeding, compared with 73.5% of non-Hispanic white mothers and 80.3% of Hispanic mothers. Maryland PRAMS data for the same birth cohort showed less racial disparity in the State, with 70.2% of non-Hispanic Black mothers ever breastfeeding, compared with 74.2% of non-Hispanic white mothers and 91.6% of Hispanic mothers (Maryland PRAMS Report, 2004 Births).

Title V continued to support the agenda of the Maryland Breastfeeding Coalition, providing leadership and staffing support in FY 2008. The Maryland Breastfeeding Coalition continued its mission "to improve the health of Maryland citizens through collaborative efforts that protect,

promote and support breastfeeding." The Coalition identified the following areas for ongoing efforts:
1) community outreach and education, 2) professional education, 3) advocacy, and 4) support for breastfeeding mothers with infants in neonatal intensive care. The Coalition's professional speakers' bureau continued to provide breastfeeding education to healthcare professionals in Maryland. Bureau members received funding from the American Academy of Pediatrics to bring a breastfeeding expert to Maryland for events planned for early 2009.

The Title V Program maintained a breastfeeding support website (www.marylandbreastfeeding.org) with resources for breastfeeding women, health professionals, and employers. The Title V Program also launched a statewide Breastfeeding-Friendly Workplace Initiative in February 2008. An employer's toolkit was distributed to Maryland employers to encourage their support of breastfeeding employees. Employers providing such workplace supports were able to apply for a "Breastfeeding-friendly Workplace Award", sponsored by the Title V Program and the Maryland Department of Health and Mental Hygiene. Two Title V Program staff members completed the HRSA "Business Case for Breastfeeding" course designed to train individuals to recruit businesses to become breastfeeding-friendly.

Last year, both the Title V and WIC Programs continued to pro-actively promote and support breastfeeding efforts across the State. Breastfeeding was promoted in Title V funded Improved Pregnancy Outcome Programs found in every jurisdiction in the state. The Medicaid Healthy Start Home Visiting and Case Management Program promoted breastfeeding to enrolled pregnant and postpartum women. Requirements for lactation support in all of Maryland's birthing hospitals remained a part of the Maryland Perinatal System Standards. The WIC Program continued to promote breastfeeding as the preferred method of infant feeding for all clients. WIC has a Breastfeeding Coordinator and all WIC staff have received training in advanced lactation support. WIC continued its Peer Counseling Breastfeeding Support Program in several Maryland counties.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Disseminate a breastfeeding toolkit for employers to promote breastfeeding in the workplace. Designate work sites as "breastfeeding friendly".				X
2. Update and maintain the "Breast Feeding in Maryland" website.				X
3. Educate the public about the passage of "Right to Breastfeed" legislation in Maryland			X	
4. Fund and support breastfeeding promotion activities in local health departments				X
5. Educate health providers about the benefits of breastfeeding and encourage health providers to promote breast feeding.			X	
6. Maintain standards fro lactation support in all of Maryland's birthing hospitals.				X
7.				
8.				
9.				
10.				

b. Current Activities
The CDC National Immunization Survey for births in 2005 shows 73.0% of Maryland mothers initiating breastfeeding, 43.0% breastfeeding at 6 months (11.6% exclusively) and 20.7% at 12

months (data essentially unchanged from last year, and closely matching national averages). Maryland now ranks 24th among the 50 states and DC for percent of mothers breastfeeding at 6 months (Maryland ranked 41st for births in 2000). Maryland PRAMS data for 2005 births show less racial disparity in breastfeeding in Maryland than nationwide with 68.8% non-Hispanic Black, 74.4% non-Hispanic white, and 96.8% Hispanic mothers ever breastfeeding (CDC reports 58.7% non-Hispanic Black, 74.5% non-Hispanic white, 80.6% Hispanic nationally). The Title V Program supported the Maryland Breastfeeding Coalition through much of FY 2009. In April 2009, the Coalition became an independent group, with Title V no longer providing leadership and staffing support. Title V continues to maintain a breastfeeding support website at www.marylandbreastfeeding.org with resources for women, health professionals, and employers. The Breastfeeding-Friendly Workplace Initiative, launched in February 2008, has continued to expand. A first round of "Breastfeeding-friendly Workplace Awards", sponsored by Title V and the Maryland Dept. of Health and Mental Hygiene, will be awarded in August during International Breastfeeding Week. Breastfeeding is promoted in Title V funded Improved Pregnancy Outcome Programs in every jurisdiction.

c. Plan for the Coming Year

During the coming year, the Title V Program plans to continue its ongoing activities that support breastfeeding as the norm for infant feeding in Maryland. Plans for FY 2010 include:

- Expand the Breastfeeding-Friendly Workplace Initiative by recruiting businesses in the State to become breastfeeding-friendly workplaces.
- Showcase successful breastfeeding-friendly workplaces by recognizing them with the Maryland Breastfeeding-Friendly Workplace Award and through media events and online recognition.
- Maintain and expand the Maryland Breastfeeding website.
- Expand awareness in the state of the Maryland law protecting the right to breastfeed.
- Provide outreach and technical assistance to local health departments and other state agencies to implement breastfeeding promotion activities appropriate to their area of responsibility.
- Continue to educate health providers about the benefits of breastfeeding and encourage their promotion of breastfeeding.
- Expand community outreach activities to increase the number of Maryland mothers, of all racial and ethnic groups, who not only initiate breastfeeding but continue breastfeeding for at least 6 months. Examples include activities at health fairs, community events, ethnic street fairs, faith-based organizations, etc.
- Continue to identify other funding sources to address breastfeeding promotion activities.

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	90	90	90	90	90
Annual Indicator	91.2	88.5	89.4	92.5	98.8
Numerator	64793	62870	64657	68622	74276
Denominator	71083	71013	72345	74196	75210
Data Source					State IH System
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the					

last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	98	98	99	99	99

Notes - 2008
Number of occurrent births is from MD Vital Statistics and is only provisional at this time. The screening data is primarily from the old state IH system because the new OZ eSP system was not in place for the full year.

While we would like to maintain our progress in screening an increasing percentage of babies before hospital discharge, our historical struggles with databases and providers, make us wary of setting 100% as the measure for satisfactory performance. It may not be realistic.

Notes - 2006
Newborn hearing screening data is reported by fiscal year, FY 2006.

a. Last Year's Accomplishments
Last Year's Accomplishments

The long term goal of this project is to ensure that all Maryland babies born deaf or hard of hearing receive timely and appropriate follow- up in order to achieve their communication potential. Review of the Infant Hearing Program's previous years' statistics revealed significant issues with data collection and analysis. An inadequate data base severely hampered abilities to analyze trends and identify weaknesses and deficiencies in the newborn hearing screening program; therefore, the decision was made to implement a new online data management system. As a result of the state RFP process, an online system and vendor was selected with the anticipation of full implementation into the Maryland birth hospitals by October 2008. The implementation and utilization of this new system was the focus of the previous year with the following goals in mind:
1. Increase result reporting
2. Decrease reporting errors
3. Improve timeliness of test result availability
4. Facilitate continuity of care and tracking of follow up care
5. Identify factors influencing loss to follow up
6. Decrease the number of initial screening failures who do not return for rescreens by one month of age
7. Decrease the number of second level screening failures that do not receive timely diagnostic audiologic evaluation
8. Increase the number of children diagnosed as deaf or hard of hearing with early intervention outcomes
9. Utilization of the online system for diagnostic result reporting by all the State's pediatric audiologists

In 2008 the new online data management system was fully implemented into all of the Maryland birth hospitals. By August 2008, 100% of the hospitals were reporting hearing screening results into the online data system. Screening results are available now in real time, as opposed to 3-5 days after screening, to all providers identified as being involved in the baby's hearing healthcare as well as to the Infant Hearing Program at the Department of Health and Mental Hygiene. The rate of babies receiving follow up screening by one month of age increased 5%, but the rate for diagnostic evaluations by 6 months decreased approximately 10%. However, it should be noted that data from the new system is only available for 8 months therefore many of those infants

needing diagnostic evaluations are still in process. A more accurate assessment of the loss to follow up will be available once the system has been operational for at least a year.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support hearing screening for all Maryland newborns.	X		X	
2. Provide tracking and follow-up on all screening referrals and not tested infants to confimation of hearing status.	X	X	X	
3. Educational materials regarding hearing screening for parents, familes, and providers developed and available		X	X	X
4. Educational materials developed and available for parents regarding hearing evaluation and developmental milestones in multiple lanugages for provider use.		X	X	X
5. Enhance the program's website to include educational brochures and reporting forms in downloadable format for providers and families		X	X	X
6. Continue training in an ongoing manner for birthing facilities and audiologists/other providers in entering the patient data in the web based eSP sysyem	X	X	X	X
7. Birthing facilities provided with site evaluations	X	X	X	X
8. Contiue the enhancement of the eSP database to add additional features	X	X	X	X
9.				
10.				

b. Current Activities

The current year's goals:

Goal 1: Improve data management through installation of the eSP online data management system:
All Maryland birth hospitals are now currently utilizing eSP. An online training was developed for the audiologist users and training is on-going. Full utilization is expected by 2010.
Goal 2: Increase result reporting, decrease reporting errors, and improve timeliness of test results availability.
The eSP system allows for direct data importing from the hospital's admissions data base directly into eSP to reduce data error. Full implementation is expected by 9/2009.
Goal 3: Identify factors influencing loss to follow up of infants that do not pass or miss newborn hearing screening.
Monthly compliance reports are compiled and shared with each birthing hospital.
These findings will be reported and a plan for improvement will be developed during the annual Stakeholders meeting.
Goal 4: Decrease the number of rescreen failures who do not receive timely diagnostic audiologic assessments.
Communication processes have been initiated through newsletters and professional presentations to reach the audiologist and pediatric provider communities and encourage their involvement in the EHDI process.
Goal 7: Increase the number of children diagnosed as deaf or hard of hearing into appropriate early intervention by 6 months of age.
An MOU is being developed between the DHMH and the MSDE to enable data sharing regarding hearing results and early intervention.

c. Plan for the Coming Year
MD EHDI has elected to focus intense efforts on the technical aspects of hearing screening tracking and surveillance. The addition of the online data management system, while an expensive, time consuming project, has already proven to have numerous benefits. However, there are limitations to the data base and the Infant Hearing Program is seeking funding for data enhancements through the Centers for Disease Control. Funding is being requested to configure an early intervention module of eSP in order to track and monitor referral and enrollment status of children with hearing loss in the state of Maryland. An aggregate reporting feature to the EI module will be programmed to allow users to see how many referrals and enrollments are present and/or needed. The second report to be added is an aging report to provide analysis of the age at which referrals and enrollments were provided to children in Maryland. Programming enhancements will be made to improve the tracking of at risk infants, reducing duplications, and logic changes that will improve statistical analysis.

Unmet need continues to be the availability of diagnostic pediatric facilities. Parts of the state have no audiology referral sites and parents are forced to bring their babies to the larger urban centers such as Baltimore and Washington D.C.. Remote auditory brainstem response testing appears to be the best solution, whereas an ABR unit would be rotated to the various areas of the state that are not served and testing would be completed by an audiologist in a distant urban center via telehealth networks. However, the practical aspects of funding and initiating this type of technical, as well as service, program are significant. Infant Hearing Program administrators are committed to this goal, and efforts will be made to make this type of program a reality.

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	10	9.5	9.6	9.6	12.1
Annual Indicator	9.6	9.6	12.0	12.0	10.0
Numerator	133902	133902	163264	163264	150000
Denominator	1394808	1394808	1360531	1360531	1500000
Data Source					MHCC (2007)
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	10	10	10	10	10

Notes - 2008
Health Insurance coverage in Maryland through 2007 (January 2009)

Notes - 2007
Source: Maryland Health Care Commission, Maryland Health Insurance Coverage in 2005-2006, issued November 2007. Estimates that 12% of children under the age of 19 in Maryland are were

uninsured. Based on findings frm the March 2007 Bureau of the Census revised Current Population Survey estimates. Estimate based on 2005-2006 findings since data for 2007 is currently unavailable.

Notes - 2006
Source: Maryland Health Care Commission, Maryland Health Insurance Coverage in 2005-2006, issued November 2007. Estimates that 12% of children under the age of 18 in Maryland are were uninsured. Based on findings frm the March 2007 Bureau of the Census revised Current Population Survey estimates. Population estimate from 2006 Vital Statistics report for ages 0-17.

a. Last Year's Accomplishments
An estimated 760,000 (15.4%) Marylanders under the age of 65 lacked health insurance coverage in 2006-2007 according to a Maryland Health Care Commission report based on data from the Census Bureau's Current Population Survey. Approximately 20% of the State's uninsured were children under of the age of 19 .Medicaid and MCHP are partially credited with a Maryland trend towards decreasing numbers of uninsured children. Among racial/ethnic groups, the uninsured rate is highest in Hispanics.

Medical Assistance and the Maryland Children's Health Insurance Program (MCHP) continued to provide health insurance coverage for low income children. MCHP, which is administered by the Medicaid Program, provided access to health insurance coverage for significant numbers of uninsured Maryland children in families with incomes up to 400% of the poverty level. MCHP Premium serves children in families with incomes between 200% and 300% of the federal poverty level. Enrolled families pay a monthly contribution. During federal fiscal year 2005, enrollment in MCHP exceeded 130,000 while Medicaid provided coverage to 404,146 children.

The Children's Medical Services Program within the OGCSHCN provides coverage for specialty care for uninsured and underinsured CSHCN in family incomes below 200% of the federal poverty level. Since Medical Assistance also covers this same income group, most of the children served are undocumented.

The MCH Hotline (1-800-456-8900) refers families to local health departments to receive assistance in determining their eligibility for Medicaid and MCHP programs. During Child Health Month and other special observances, the CMCH Outreach Coordinator works closely with local health agencies to distribute pamphlets and other materials that promote Medicaid and MCHP. Resource guides, brochures and fact sheets are periodically distributed by CMCH at health fairs and community events.

Maryland's immigrant population has increased tremendously over the past decade. The 2006 Maryland Legislature appropriated funding for a new Immigrant Health Initiative to be administered by CMCH. As of June 30, 2007, funding for the Immigrant Health Initiative ended. This occurred because Medicaid cuts were restored by the Legislature when the courts ruled that the cuts had violated Maryland's Constitution. CMCH submitted a final report for the Legislature on this Initiative.

The 2008 legislative session passed the Kids First Act to improve outreach to uninsured children. This legislation requires the comptroller to provide notice of a child's potential eligibility for Medicaid or the Maryland Children's Health Program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Refer families to Medicaid and medical services through the MCH hotline.		X		

2. Provide health insurance coverage for eligible low income children in families with incomes to 300% of the federal poverty level through Medicaid and MCHP.		X		
3. Provide coverage fro eligible CSHCN through the Office for Genetics and Children with Special Health Care Needs.		X		
4. Provide outreach to enroll eligible children into Medicaid and MCHP. Disseminate resource information, including sources of financial assistance fro health care at health/community fairs and other outreach events (MCH staff in local health department		X		
5. Assess health needs and issues confronting uninsured children and families including geographic and racial/ethnic disparities.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In FY 2009, State and local MCH programs will continue to support the Medicaid Program in enrolling eligible children and adolescents. Outreach strategies will include distributing MCHP/Medicaid eligibility information to schools, licensed day care centers, Head Start programs, and at community events and health fairs. As funding allows, periodic media campaigns will be used to promote the MCH Information and Referral Hotline. The MCH Hotline will continue to refer pregnant women and families to local health departments and other program sites that determine eligibility for Medical Assistance Programs.

c. Plan for the Coming Year
Reforming the health care system to reduce the numbers of uninsured in Maryland continues to be a priority of the new Health Secretary. In preparation for the 2010 MCH needs assessment, a planning group will begin reviewing data on the uninsured children and families in Maryland and assessing the State's capacity to reduce the numbers of uninsured children and women of childbearing age.

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			32.5	32.5	32.5
Annual Indicator		33.0	33.0	33.0	33.0
Numerator		10944	10944	11881	13308
Denominator		33164	33164	36002	40326
Data Source					WIC Program Data for 2008
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	32	32	32	32	32

Notes - 2008
Maryland WIC Program data.Maryland WIC estimates for 2008 based on enrollment and BMI analysis for the period, July-December 2008.

Notes - 2007
Source: Maryland WIC Program data.Maryland WIC estimates for 2007 based on enrollment and BMI analysis for the period, July-December 2007.

a. Last Year's Accomplishments
Childhood overweight/obesity is identified as a priority issue. Maryland has done much work to address the issue of childhood obesity. Among the most significant accomplishments has been our ability to engage policymakers and other key stakeholders in recognizing obesity as a significant issue in childhood, and to get buy-in into the recent weight status terminology change to include use of the term "obese" when referring to children.

Surveillance data on overweight and obesity among Maryland children and adolescents is limited, but improving. In 2008, activities continued to focus on improving access to data sources for measuring the nutrition and physical activity patterns of Maryland children. Data sources continue to include the 2007 YRBS survey which provides nutrition and physical activity data on teens in grades 9 to 12; Medicaid data from chart reviews, and BMI data collected by the WIC Program. At this time, WIC program data continues to be the primary source for overweight and obesity data for children <5 years of age. WIC Program data for 2008 show that 16.8% of two to five years old WIC enrollees were overweight and an additional15.7% were identified as obese. The prevalence of overweight and obesity among 2-5 year old WIC recipients is roughly comparable to the National prevalence (prior year). The prevalence of obesity in Hispanic children 2-5 years (23.9%) was higher than that of whites (13.9%) and African Americans (12.2%).

The 2003 National Survey of Chidren's Health provides statewide estimates of the percentage of children, ages 10-17, overweight or obese. An estimated 13.3% were overweight (obese according to current terminology) and another 16.6% were at risk for being overweight (overweight according to current terminology). Black (42%) and Hispanic (32%) children were more likely than White (24%) children to be overweight/obese.

The Office of Chronic Disease Prevention (OCDP) addresses chronic disease prevention and has lead responsibility for addressing overweight/obesity in Maryland. In 2008, CMCH continued to collaborate with OCDP to address childhood obesity through strategic planning, surveillance, provider education, research translation, and public awareness. Dr. Cheryl De Pinto leads childhood obesity prevention activities for CMCH and serves as the liaison to OCDP in implementing the Maryland has a Nutrition and Physical Activity Plan. Plan objectives include:
. To increase breastfeeding rates (e.g., initiation among African American women; exclusive breastfeeding at six months and beyond);
. To increase student engagement in moderate physical activity for at least 30 minutes for five days per week and reduce television viewing;
. To increase fruit and vegetable consumption among students; and
. To develop, maintain and/or enhance surveillance systems.

In 2008, the Governor's Council on Heart Disease and Stroke designated a Committee on Childhood Obesity. The Committee operates under the direction of the OCDP. This Committee is charged to report on (1) the insurance reimbursements paid to health care providers to diagnose

and treat childhood obesity; (2) a system for collecting, analyzing and maintaining statewide data; (3) best and promising practices; (4) methods to enhance public awareness of the chronic diseases related to childhood obesity; and (5) methods to increase the rate of obesity screenings for children. Lead administrative responsibility for this Committee rests with the Office of Chronic Disease Prevention within the Family Health Administration. Dr. DePinto is an Expert Advisor to the Committee.

One significant accomplishment was the completion of data analysis project, "Childhood Overweight and Obesity Surveillance Among Medicaid EPSDT Enrollees" by Dr. De Pinto and Lee Hurt, MCH epidemiologist, in collaboration with the Medicaid EPSDT Program. This project has resulted in a strengthened collaborative relationship with Medicaid, and has set the foundation for surveillance activities among Medicaid enrollees regarding childhood obesity. The study showed:

1. A significant proportion of overweight and obese participants are not diagnosed;
2. Many obese participants are not appropriately screened for complications, but of those screened, a significant proportion have an obesity related complication.

These findings will be used to develop a quality improvement approach addressing obestiy prevention and treatment.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with th Office of Chronic Disease Prevention, WIC, and others to plan and implement strategies to reduce childhood overweight and obesity.				X
2. Implement child and adolescent health components of the state's most recent Nutrition and Physical activity Plan				X
3. Work with the Academy of Pediatrics, Medicaid and other to improve surveillance.				X
4. Promote awareness of childhood overweight and obesity among health provider, families and the general public through presentation at conference, funding of pilot programs and conduct education sessions.			X	
5. Support implementation of referral networks and other services for children who are overweight or obese.				X
6. Collaborate with he OCDP to develop policy recommendations for reimbursement fro obesity risk assessment, prevention, and treatment.				X
7.				
8.				
9.				
10.				

b. Current Activities

Current activities related to childhood obesity prevention primely reflect a continuation of last year's accomplishments. In addition, the Maryland Health Quality and Cost Council, which is chaired by the Lt. Governor and co-chaired by the Secretary of Health, has a Wellness and Prevention work group which has prioritized childhood obesity. As part of the Governor's health reform initiatives, the Health Quality and Cost Council is charged with identifying actionable strategies to create a culture of wellness in Maryland communities. Strategies under consideration include promoting work site wellness to enhance the health of parents who are role models for their children's behavior, a campaign to promote the availability of data-driven, evidence-based childhood obesity programs through non-profit hospitals' community benefits, and enhancing access to childhood obesity treatment through third-party reimbursement or

convergence grants. The Council will also champion recommendations of other State agencies and Councils that are working to increase access to healthy food and opportunities for physical activity in communities and schools.

The Office of Chronic Disease Prevention is funding two demonstration projects to implement proven, multi-level interventions (Shape Up Somerville and We Can) in 2 Maryland counties. OCDP provides technical assistance for childhood obesity interventions in Baltimore City and with the State's implementation of the WIC food package change.

c. Plan for the Coming Year

Planned activities for 2009 include continuing to work with the Healthy Eating and Active Lifestyle Coalition to promote healthy eating and active lifestyles for all Marylanders. In addition, the Title V agency will continue to work with the Committee on Childhood Obesity as it prepares its report to the Legislature which is due by December 1, 2009.

Data on obesity among children and adolescents remains sparse. In 2002, CMCH facilitated a statewide meeting of experts and stakeholders to develop recommendations for reducing childhood obesity. Childhood surveillance data was identified as a major unmet need. The Title V Agency will continue to work with the Maryland State Department of Education, Medicaid and the American Academy of Pediatrics, Maryland Chapter to explore ways to improve childhood overweight/obesity surveillance.

Planning for the 2010 MCH needs assessment will continue in 2009. Data from various sources including the WIC Program, the YRBS, the Maryland Youth Tobacco Survey, the Maryland Adult Tobacco Survey, Medicaid and the BRFSS will be compiled to present a profile of the status obesity and overweight among children, adolescents and women of childbearing age in Maryland.

The current surveillance activities as implemented through the Medicaid surveillance project will work to evaluate environmental factors that contribute to obesity. The dataset for the project will expand to include more recent data. Further analysis on comorbid conditions such as asthma will be conducted.

CMCH and the OCDP will continue to collaborate with the Maryland State Department of Education on implementation and evaluation of wellness policies, and school-based surveillance recommendations.

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			10.9	10.7	7.6
Annual Indicator		11.1	7.8	9.3	9.3
Numerator		8270	6040	6160	6160
Denominator		74500	77430	66425	66425
Data Source					2007 MD 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?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	9	9	9	9	9

Notes - 2008
Numerator, denominator, and percentage based on MD PRAMS estimates for 2007.

Notes - 2007
Numerator, denominator, and percentage estimates based on MD PRAMS

a. Last Year's Accomplishments
Data from the Maryland Behavioral Risk Factor Surveillance System (BRFSS) Database indicate that 8 percent of pregnant women smoked in 2007. Prenatal smoking rates varied by jurisdiction and tended to be higher in jurisdictions where higher percentages of low income women lived. 2008 BRFSS data is not currently available.

Data from the 2007 Maryland Pregnancy Risk Assessment Monitoring System (PRAMS) survey indicates that over 9% of women surveyed reported smoking during the last 3 months of pregnancy. Smoking was most prevalent among White non-Hispanic and younger mothers. Among mothers over the age of 19, those with more than a 12th grade education were four times less likely to smoke than those with less education (4% vs. 17%).

Data from the Maryland Prenatal Risk Assessment Dataset indicate that low-income pregnant women were more likely than pregnant women in the general population to smoke prenatally. This database reported that 21.1% of the 18,140 pregnant women referred to local health departments through the Prenatal Risk Assessment process were tobacco users in FY 2008. (The Prenatal Risk Assessment Form is completed by health providers serving predominantly Medical Assistance and low income women in the State. The database included approximately 23% of the State's pregnant women in 2007).

The Maryland Center for of Health Promotion, Education, and Tobacco Use Prevention is the lead agency responsible for smoking cessation activities in DHMH. This Center administers the Smoking Cessation in Pregnancy (SCIP) Program as well as Cigarette Restitution Funds (CRF). SCIP is a multi-component program that trains local health department and Medicaid managed care staff to facilitate smoking cessation among pregnant women and women considering pregnancy. Women smokers meet with public health nurses who counsel them to quit or reduce tobacco use. Along with one-on-one counseling, participants receive self-help materials in the form of a manual and a "Quit Kit." In FY 2007, approximately 1,200 Quit kits and 800 brochures were distributed, as well as over 700 other promotional items for the public. The Center updated its SCIP Booklet in Early 2008 to reflect more current data and information.

Cigarette Restitution funds are awarded to every jurisdiction in the State to fund awareness, prevention and cessation programs. The CRF Program also manages a statewide "Quit Line" and website, conducts surveillance, supports community coalition and funds regional groups to provide outreach and technical assistance to minority groups.

During FY 2007, local health departments continued to promote smoking cessation during pregnancy as a part of preconception health counseling during family planning clinic visits. Some clinics supplied nicotine patches and/or Zyban to clients. Educational materials promoting smoking cessation were also offered during home visits and at health fairs and other educational events. Local health departments continued to partner with groups such as the March of Dimes to

educate pregnant women about the health risks linked to smoking during pregnancy.

In 2008, the Cigarette Restitution Fund Program will conduct a statewide tobacco use survey to track smoking patterns among adults and adolescents to evaluate program accomplishments. This data will be reviewed by the MCH Program and reported on in the 2010 Title V needs assessment.

On February 1, 2008 the Maryland Clean Indoor Air Act took effect. This Act bans smoking in bars and restaurants statewide and is designed to protect workers and patrons, many of whom are pregnant women, from the dangers of secondhand smoke.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor trends in smoking rates during pregnancy using sever data source include PRAMS and birth record.				X
2. Promote smoking cessation during preconception health counseling in family planning clinics, during local health department prenatal care clinic visits and during prenatal and postpartum home visits.		X		
3. Refer women of childbearing age who smoke to smoking cessation programs including the Smoking Cessation in Pregnancy Program (SCIP) administered by the Office of Health Promotion.		X		
4. Promote smoking cessation in schools.			X	
5. Enforce Maryland laws enacted to eliminate smoking in schools.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In 2009, CMCH continues to collaborate with multiple groups include the Center for Health Promotion, the American Lung Association, private providers, community-based organizations and the American College of Obstetricians and Gynecologists to promote strategies to reduce smoking during pregnancy. ICMCH used the PRAMS dataset to complete additional analyses on smoking during pregnancy. The analysis showed smoking prevalence was significantly higher among mothers with a delivery paid by Medicaid compared to those with private insurance (14% vs. 7%). Smoking prevalence was highest among White non-Hispanics with a Medicaid delivery (33%). Delayed initiation of prenatal care and inadequate consumption of preconception vitamin supplements are also associated with smoking. Smokers are significantly more likely to report an unintended pregnancy than nonsmokers. Smokers (especially Black non-Hispanic, heavier smokers) are also significantly more likely to report experiencing such stressful life events as homelessness and physical fights with a partner than nonsmokers. Lastly, this additional analysis showed that heavier postpartum smokers were significantly more likely to report symptoms of postpartum depression than nonsmokers (28% vs. 13%). These women reported often or always feeling down, depressed, hopeless, or having little interest or pleasure in doing things. Black non-Hispanic heavier smokers reported the highest prevalence of postpartum depression symptoms at 36%.

c. Plan for the Coming Year
In 2010, CMCH plans to use the PRAMS dataset to continue assessing prenatal use of tobacco. In addition, pilot programs will be implemented in three family planning clinics to enhance smoking cessation referrals.

The Center for Health Promotion, Education and Tobacco Use Prevention, has developed the Body Sense Program with the goals of educating female teen smokers about smoking related health risks, motivating them to quit, and providing support for them to quit successfully and maintain a smoke-free lifestyle. Counseling is offered to teenage girls receiving family planning services from one of Maryland's local health departments.

Training is offered to local health departments and health centers that wish to educate and counsel teens about smoking. The program uses a self-help tool in the form of an upbeat, colorful newsletter which explores the relationship between tobacco use and health issues of concern to teen girls, such as weight loss and skin care. Nurses distribute the newsletter during counseling sessions. Participants are encouraged to read the newsletter complete the enclosed evaluation card and return the card to clinic staff for a small incentive. The cards are returned to the Center for Health Promotion for evaluation. The Title V Program plans to work with the Center in the coming year to promote this Program to teens in high risk areas of the State. Other ongoing activities will continue in 2009.

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	5.2	5.9	4.7	4.6	4.1
Annual Indicator	4.8	6.2	4.2	6.6	6.6
Numerator	19	25	17	27	27
Denominator	396044	405382	406425	408340	408340
Data Source					MD Vital Statistics Annual Report 2007
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	6.6	6.6	6.6	6.6	6.6

Notes - 2008
2008 data is not available so 2007 data has been used

Notes - 2007
Estimate based on 2006 data. Data for 2007 is currently unavailable.

a. Last Year's Accomplishments
Homicide and suicide are leading causes of deaths among adolescents in Maryland. Twenty-seven adolescents between the ages of 15 and 19, committed suicide in Maryland in 2008, a rate of 6.6 deaths per 100,000 youth. The rate has increased from 2007 when the rate was 4.2 per 100,000.

The Maryland Mental Hygiene Administration (MHA) has lead responsibility for administering programs to prevent adolescent suicide among youth and young adults ages 15-24. Maryland is nationally recognized as a leader in reducing adolescent suicide rates among this age group. For the past 13 years, October has been proclaimed as Youth Suicide Prevention Month in Maryland. During October, MHA sponsors an annual conference on suicide prevention and oversees a Youth Crisis Hotline. Funds are also awarded to local school districts to sponsor educational events. A full time Youth Suicide Prevention Coordinator supports these activities.

Maryland was the first State in the nation to offer a toll free decentralized hotline service to address the needs of troubled youth. The 24-hour toll free Youth Crisis Hotline (1-800-422-0008) is staffed by trained counselors and uses a decentralized system which enables the counselor to access or refer the youth to local agencies for assistance. Throughout its 16 year history, the hotline has been very successful in intervening with youth considering suicide.

The Coordinator Child Fatality Review took over as the DHMH/CMCH Title V representative on the Inter-Agency Workgroup on Youth Suicide Prevention in 2008. This workgroup assists the Mental Hygiene Administration with youth suicide prevention activities. This year's involvement included serving on the annual suicide prevention conference planning committee and participating in the review process for the awards distributed from the Garrett Lee Smith Youth Suicide Prevention Grant.

The Youth Risk Behavior Survey (YRBS) 2007 data, helped to paint a better picture of the magnitude of depression and suicide among adolescents in Maryland. These data indicated that:
•23% of high school students reported feeling sad or hopeless, a proxy measure for depression. Rates were higher for females (31%) than males (16%).
• 13% reported seriously considering suicide, while 10% indicated making a suicide plan.
•8% reported attempting suicide with females (8%) more likely than males, (7%), to report an attempt.
•2% reported requiring medical attention following a suicide attempt.

In July 2008, the MCH Program sponsored a half day session on the prevention of suicide in the school setting, as part of the State's annual four day School Health Interdisciplinary Program (SHIP) conference. This session provided participants with a greater understanding of the hidden emotional challenges faced by school aged children that too often lead to suicidal thinking. Strategies that schools can adopt to meet the growing academic and mental health demands of children were discussed. There are plans for a similar session at the 2009 SHIP conference.

The State's Child Fatality Review Coordinator represented MCH on the Maryland Committee on Youth Suicide Prevention which worked to update the State's Youth Suicide Prevention Plan ,"For a Better Tomorrow: A Plan for Youth Suicide Prevention in Maryland." This plan originated from a Gubernatorial Task Force, "Child, Teenage and Young Adult Suicide and Other Associate Mental Health Problems" (Governor's Task Force on Youth Suicide Prevention -- July, 1987). The new Plan was completed in May 2008. In October 2008 Maryland was awarded 1.5 million dollars from the Garrett Lee Smith Youth Suicide Prevention Grant.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct state and local child fatality review processes that include suicide prevention.				X
2. Co-sponsor and participate in planning for the annual statewide youth suicide prevention conference.				X
3. Work with the Mental Hygiene Administration's Youth Suicide Prevention Program to implement the new statewide plan and promote school based activities.				X
4. Administer a statewide Youth Crisis Hotline (Mental Hygiene Administration).		X		
5. Collaborate with other stakeholders to promote positive youth develop through initiatives such as Ready by 21.				X
6. Assess and monitor data on youth suicide and related factors.				X
7. Participate in the grant review and awards process from the Garrett Lee Smith Youth Suicide Prevention Grant				X
8.				
9.				
10.				

b. Current Activities

In 2008 Maryland was awarded funding from the Garrett Lee Smith Suicide Prevention Grant. This substantial funding focused on reaching young people through schools and community based projects in many areas, especially in high risk areas.

In 2009, he Garrett Lee Smith Suicide Prevention Grant funds were awarded to jurisdictions within Maryland. Level One funding for School Programs was awarded to 17 school districts. Level Two finding for High Risk Counties was awarded to 3 counties, while Level Three funding for Community Based Projects was awarded to 2 counties.

Planning is proceeding on this year's Annual Suicide Prevention Conference, the theme of which is, "Inner Strength During Challenging Times". The conference seeks to address some of the special challenges of the past year.

c. Plan for the Coming Year

The Mental Hygiene Administration, in collaboration with the Governor's Interagency Workgroup on Youth Suicide Prevention and CMCH, will continue to plan and implement the annual statewide adolescent suicide prevention conference, periodic media campaigns, and school based youth suicide prevention programs.

The 21st Annual Suicide Prevention Conference is scheduled for October 7, 2009. Title V funds will continue to be used to help in underwriting conference costs.

Finally, the MCH Program will review vital statistics data, YRBS results and data from other sources to gain a better picture of the magnitude of youth suicide and related factors (e.g., depression) in Maryland as part of the 2010 MCH needs assessment.

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	90	87.5	89.5	89.6	89.7
Annual Indicator	89.3	88.7	87.8	89.3	89.3
Numerator	1180	1070	1138	1138	1138
Denominator	1322	1206	1296	1275	1275
Data Source					MD DHMH, Vital Statistics Administration
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	89.8	90	90	90	90

Notes - 2008
Data for 2008 not available. Estimate based on Vital Statistics Administration data from 2007.

Notes - 2007
Data provided by Vital Statistics Administration.

Notes - 2006
Source: Maryland Vital Statistics Administration. Defined as vlbw admissions to Level III hospitals in MD and excludes 42 cases for whom status was unknown.

a. Last Year's Accomplishments
The Center for Maternal and Child Health (CMCH) continued to work to improve hospital-specific birth outcomes and to lower neonatal mortality rates by promoting the standard that all very low birth weight (VLBW) infants should be born at level III perinatal centers. Level I and Level II hospitals should make every effort to keep the number of VLBW births at those hospitals as close to zero as possible. Among 2006 births, according to the MD Vital Statistics Administration (VSA), 90% of VLBW infants born in Maryland were delivered at Level III facilities, 7.6% were born at Level II facilities and 2.3% were delivered at Level l hospitals.

In FY 2008, CMCH and MD VSA again provided hospital-specific data on VLBW births and deaths to all birthing hospitals in the State. Data are presented by encoded hospital of birth, and hospitals are grouped into 3 levels of perinatal care, as outlined in the Maryland Perinatal System Standards. The goal is to improve compliance with the Standards, to reduce the number of VLBW births outside of Level III facilities, and to improve the quality of obstetric and neonatal care in Maryland hospitals.

In April 2008, the Department of Health and Mental Hygiene (DHMH) reconvened its Perinatal Clinical Advisory Committee (PCAC) to review and update the Standards. The Standards were developed in 1995 as voluntary standards for Maryland hospitals providing obstetric and neonatal services. The Standards have been incorporated into the regulations for perinatal referral centers (Level III) by the Maryland Institute of Emergency Medical Services Systems (MIEMSS), and into the Maryland Health Care Commission's State Plan regulations for obstetric units and neonatal intensive care units.

Also in FY 2008, CMCH as part of the MIEMSS site visit review team, completed 5 year reviews of all Level III perinatal centers in the State. These reviews are required as part of the designation process of these hospitals as Perinatal and Neonatal Specialty Referral Centers. The site review team includes the Medical Director of CMCH and the Director of the Family Health Administration.

Title V funding continued to support the Maryland Advanced Perinatal Support Services (MAPSS), a statewide program of telemedicine and on-site high-risk consultation services provided by the State's two academic medical centers to obstetric provider. This service provides outreach education as well as clinical consultations that allow rural patients to remain in their communities rather than traveling to metropolitan areas of the State for specialty consultations. Title V also continued to support a Perinatal Collaborative with the Maryland Patient Safety Center. The Collaborative includes 25 member hospitals, with the goal of improving patient safety in labor and delivery units. Focus areas include improving communication, team building, standardizing electronic fetal monitoring, reducing nosocomial infections, and reducing elective deliveries prior to 39 weeks gestation. With the National Perinatal Information Center, the Collaborative is collecting pre and post-intervention data.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide hospital-specific data on VLBW births and deaths to Maryland hospitals.				X
2. Collect and analyze perinatal data.				X
3. Review, update and disseminate the Maryland Perinatal System Standards.				X
4. Provide technical assistance to improve compliance with Standards.				X
5. Support and expand statewide program of telemedicine and on-site high-risk consultation services.				X
6. Work with the Maryland Patient Safety Center to improve quality of care in hospital settings.				X
7.				
8.				
9.				
10.				

b. Current Activities

Among 2007 births, 89.3% of very low birth weight infants born in Maryland were delivered at Level III facilities, 8.5% were born at Level II hospitals, and 2.3% were delivered at Level I hospitals.

In FY 2009, CMCH with VSA provided hospital-specific data on VLBW births and deaths to all birthing hospitals in MD. The Department of Health and Mental Hygiene's (DHMH) Perinatal Clinical Advisory Committee (PCAC) completed a full review and update of the Maryland Perinatal System Standards to ensure consistency with AAP and ACOG standards. The updated Standards, on the CMCH website at http://fha.maryland.gov/mch/perinatal_standards.cfm, were released in Oct. 2008 and specify that VLBW infants should be born at Level III perinatal centers.

CMCH also completed regulations to codify the State's Fetal and Infant Mortality Review (FIMR) Program, and establish a statewide Morbidity, Mortality, and Quality Review Committee (see c. below). CMCH has begun work with the Governor's Delivery Unit to reduce infant mortality in Maryland (see c. below). CMCH continues to support and participate in the Maryland Patient

Safety Center's Perinatal Collaborative. CMCH is also an active participant in a new Neonatal Collaborative, initiated in FY 2009 by the Maryland Patient Safety Center. CMCH continues to support the Maryland Advanced Perinatal Support Services (MAPSS) program of telemedicine and on-site high-risk obstetric consultation services provided by the State's 2 academic medical centers.

c. Plan for the Coming Year

CMCH, with VSA, will continue to provide Maryland hospitals with hospital-specific data on VLBW births and deaths, and to monitor perinatal outcomes in the State. These activities will be enhanced by the establishment of a statewide Morbidity, Mortality, and Quality Review (MMQR) Committee. In FY 2009, CMCH completed regulations for House Bill 535, passed by the Maryland Legislature in 2008. The regulations will codify the State's Fetal and Infant Mortality Review (FIMR) Program, and establish the MMQR Committee, under DHMH leadership, to review statewide outcomes related to pregnancy, childbirth, infancy and early childhood. This Committee will convene in early FY2010.

CMCH will continue to work to improve compliance with the updated Maryland Perinatal System Standards. CMCH has begun work with the Governor's Delivery Unit (GDU) on the Governor's Strategic Goal to reduce infant mortality in Maryland by 10% by 2012. This project has 3 specific focus areas: 1. healthier women before conception, 2. earlier entry into prenatal care, and 3. improved perinatal and neonatal care. As part of the GDU project, CMCH will conduct site visits at all Maryland Level I and II hospitals to promote compliance with the Standards. In 2010, CMCH will also begin planning with the Maryland Institute of Emergency Medical Services Systems (MIEMSS) for the next round of reviews and site visits of Level III centers.

Also as part of the GDU project, CMCH will support expansion of the MAPSS program of telemedicine and on-site high-risk obstetric consultation services. CMCH will remain an active participant in the Maryland Patient Safety Center's Perinatal Collaborative, now designated as a Perinatal Learning Network. CMCH will also continue to participate in the Neonatal Collaborative, initiated in FY 2009. The Neonatal Collaborative has over 30 member hospitals in Maryland, the District of Columbia and northern Virginia. The goal of this Collaborative is to improve patient safety in neonatal intensive care units. Focus areas include improving communication, team building, reducing central line-associated bloodstream infections, and standardizing initial resuscitation and stabilization of VLBW infants.

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	90	83.9	82.3	82.4	81
Annual Indicator	82.3	81.3	81.7	79.5	79.5
Numerator	60235	59896	62261	62068	62068
Denominator	73230	73678	76248	78057	78057
Data Source					MD Vital Statistics Annual Report 2007
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	80	80	80	80	80

Notes - 2008
Data for 2008 not available.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
The State's early prenatal care rate continued to decline to 79.5% in 2007; 9.4% percentage points lower than the 1997 rate of 88.9%. Early prenatal care percentages declined for women enrolled in both Medicaid and non-Medicaid programs. According to Maryland Vital Statistics, in 2007 early prenatal care rates were lowest for Hispanics (63%) followed by African Americans (73.5%).

The Healthy People 2010 goal is for 90% of women to initiate prenatal care within the first trimester. In 2007, three counties (Calvert, Carroll, and Howard) met or surpassed the 2010 goal. In three jurisdictions, early prenatal care percentages fell below the 2010 goal by 15% or more -- Allegany County (68.9%), Baltimore City (74.2%) and Prince George's County (66.6%).

PRAMS data for 2003-2007 have demonstrated consistent trends in why women delay receiving prenatal care. Commonly cited reasons include: couldn't get an earlier appointment, didn't have insurance or enough money, doctor or health care plan would not start care earlier, did not have a Medicaid card, or not aware of the pregnancy/keeping the pregnancy a secret. Additionally, FIMR findings have suggested that many women are unable to find a provider to schedule an appointment. Some women are undocumented immigrants and have been placed on waiting lists for existing no-cost prenatal clinics which are unable to accommodate these women. In 2006, Maryland initiated a second effort to improve birth outcomes, named Babies Born Healthy. The Babies Born Healthy Initiative received support as a result of the State's rising infant mortality rate. Because of the complexity of lifetime events that may contribute to a poor pregnancy outcome, Babies Born Healthy provides interventions in each of the four phases: (1) preconception/ interconception; (2) prenatal; (3) perinatal; and (4) postneonatal. In 2008, the Babies Born Healthy Initiative worked to improve perinatal health through a comprehensive approach. Babies Born Healthy Initiative activities include expansion of the University of Maryland's Maryland Advanced Perinatal System Support, a pilot program using telemedicine to provide high-risk obstetric care to women in rural areas of the State. Baltimore City's Healthy Start, Inc. (BCHSI) Program has used community health workers to provide enabling services to pregnant and post-partum women in at-risk communities since 1991.

Additional strategies include building local and State partnerships to improve birth outcomes by promoting access to prenatal care, providing enabling services (e.g., prenatal education, family support services) to high risk African American and low-income women, expanding access to preconception and prenatal health services and strengthening FIMR. One example of this is the MCH -- WIC (Women, Infant, and Children) initiative designed to ensure preconception health of women by linking MCH and WIC services.

In late 2007, Babies Born Healthy partnered with Maryland Medicaid to enhance its Healthy Start program. The Medicaid's Healthy Start program provides care coordination for pregnant and postpartum women. A software package was purchased to enhance the surveillance capabilities through tracking enabling services received and perinatal health outcomes. The data tracking system will allow for better case management, as well as realization of best and promising practices within Maryland. The MCH Hotline continued to refer pregnant women to prenatal care

providers in FY 2008.

Additionally, in collaboration with the Annie E. Casey Foundation, the Governor's Office for Children and others, another important needs assessment and action development occurred through Baby LAP (Leadership in Action Program). Baby LAP was a coalition of providers and advocates, who assessed the needs and promising practices for improved birth outcomes in Baltimore City. Baby LAP developed an action plan to reduce infant mortality that is focused on five impact areas. These impact areas include: reducing unintended pregnancies; providing support to women who have had a previous pregnancy loss or poor birth outcome; decreasing the number of women who enter pregnancy with poor health; decreasing barriers to early prenatal care; and decreasing infant sleep related deaths.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Refer women to prenatal care services through the MCH Hotline		X		
2. Promote the importance of early prenatal care in home visiting and care coordination programs		X		
3. Offer preconception health counseling in family planning programs that support early prenatal car and health habits before pregnancy.		X		
4. Fund local health departments based prenatal care services for low income uninsured and/or immigrant pregnant women	X			
5. Continue the Babies Born Healthy Initiative which promotes healthy birth outcomes by promoting strategies such as the improved access to early prenatal care.	X	X	X	X
6. Support fetal and infant mortality review processes in every jurisdiction to promote perinatal systems improvements.				X
7. Assess and monitor trends in the use of prenatal care.				X
8. Support perinatal eduction events and conferences to educate providers, families and the general public about best practices improving birth e outcomes.			X	
9. Continue Medicaid an MCHP coverage of prenatal care serves for pregnant women with incomes up to 250% of the federal poverty level.		X		
10.				

b. Current Activities

In 2008, DHMH reconvened its Perinatal Clinical Advisory Committee, a multidisciplinary committee representing 19 Maryland professional organizations, to review and update the Standards. The revisions to the Standards are made in order to be consistent with the latest edition of the Guidelines for Perinatal Care, which is issued jointly by the American Academy of Pediatrics (AAP) Committee on Fetus and Newborn and the American College of Obstetricians and Gynecologists (ACOG) Committee on Obstetric Practice as well as the AAP 2004 Policy Statement on Levels of Neonatal Care. The Perinatal Clinical Advisory Committee is reconvened and revisions to the Maryland Standards are completed every 5 years.

Babies Born Healthy (BBH) continues to provide a comprehensive approach to reduce risks to improve perinatal health which include expanding the University of Maryland's Maryland Advanced Perinatal System Support program to include a preconception and family planning component, continuing the MCH-WIC Collaborative and improving access to reproductive health

services.

The BBH Leadership Forum was to enhance awareness regarding primary prevention, quality initiatives and access to care as it relates to improved pregnancy outcomes. The Forum sought to provide a venue for Maryland's health officers, legislators, health policy makers, professional organizations, business leaders, the faith community and advocates to develop strategies and offer solutions to improve birth outcomes in MD.

c. Plan for the Coming Year

The Babies Born Healthy Initiative will continue to provide a comprehensive approach to reducing risks that improve perinatal health. These activities include continuing to partner with several agencies and organizations that promote early prenatal care including the March of Dimes, local health departments and State Medical Professional associations. The Baltimore City Health Department will be implementing 'The Strategic Plan to Improve Birth Outcomes in Baltimore City'. CMCH will work closely with Baltimore City Health Department as they develop programs and initiatives to support the identified impact areas. In addition, The Prince George's County Health Department will be utilizing Babies Born Healthy funding to increase access to primary prevention services through a referral to Greater Baden Medical Services. Greater Baden Medical Services provides outreach and serves women at risk of poor pregnancy outcomes with women's health and family planning services.

The CMCH will continue to support the University of Maryland's Maryland Advanced Perinatal System Support telemedicine to provide high-risk obstetric care to women in rural areas of the State. In addition, the CMCH will begin to establish a process to conduct site visits to Level I and Level II hospitals to ensure compliance with the Maryland Perinatal System Standards.

D. State Performance Measures

State Performance Measure 1: *Percent of pregnancies 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			58.9	60	60
Annual Indicator	58.8	57.0	59.7	56.7	56.7
Numerator	43806	42682	46226	44258	44258
Denominator	74500	74880	77430	78057	78057
Data Source					MD PRAMS Report 2007
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60	60.5	60.5	60.5	60.5

Notes - 2008

2008 data is not available so 2007 data has been used

Notes - 2007

Source: Estimate based on findings from the 2006 PRAMS report. Data for 2007 is unavailable.

Notes - 2006

Source: 2006 Maryland PRAMS Report, page 7.

a. Last Year's Accomplishments
intendedness. In 2007, there was a decrease in intended pregnancies from 59.7% in 2006 to 56.5% in 2007. The U.S. Healthy People 2010 goal is for no less than 70% of pregnancies to be intended.

An article based on 2001-2006 Maryland PRAMS data titled, "Association of Pregnancy Intention with Maternal Perinatal Behaviors and Birth Outcomes" by Diana Cheng, M.D., Eleanor B. Schwarz, M.D., M.S., Erika Douglas, M.S., and Isabelle Horon, Dr.PH. was published in the March 2009 issue of Contraception. Compared with the 59% of women with intended pregnancies, the 10% of mothers who reported unwanted pregnancies were more likely to delay initiation of prenatal care until after the first trimester, consume inadequate folic acid, smoke during pregnancy and postpartum, and report postpartum depression. Women with unwanted pregnancies were less likely to breastfeed for eight or more weeks. The 31% of mothers with mistimed pregnancies were also more likely to delay initiation of prenatal care, consume inadequate folic acid and report postpartum depression than mothers with intended births.

The Title X Maryland Family Planning provides subsidized family planning, preconception health, teen pregnancy prevention and colposcopy services to women and families in every jurisdiction in the State. The Program serves approximately 70,000 clients annually at 80 sites. Adolescents represent one third of persons served.

Preconception health activities included the WELL Program, a pilot project that expands family planning services to include preventive health services for women of childbearing age. The Babies Born Healthy, MCH/WIC Collaborative provided multivitamins (which includes folic acid) to clients referred from WIC to Family Planning Clinics in three Maryland counties. Local programs were introduced to and instructed in implementing the DHHS BodyWorks program, designed to help parents of adolescents improve family eating patterns and activity habits by providing hands-on tools to implement small specific behavior changes to avoid obesity and maintain healthy weight levels.

The Medicaid Program provides coverage for family planning services to enrollees. In addition, a federal waiver allows the Program to continue coverage for women who are no longer eligible for Medicaid following pregnancy. Eligible women may receive comprehensive family planning and reproductive health services including contraceptives. However, less than one in three eligible women are receiving services according to Medicaid claims files. Family planning program staff in several jurisdictions, including Baltimore City indicate that many women are still not aware of their eligibility for Medicaid waiver services. This continues to serve as a barrier to care.

Pregnancy intendedness was addressed in two new initiatives, Babies Born Healthy and the Early Childhood Health Plan. Both initiatives promoted strategies to improve access to family planning and preconception health services. Babies Born Healthy is a response to a worsening in the State's perinatal health indicators. This Initiative expanded access to preconception care, prenatal care and postpartum family services for uninsured and uninsurable pregnant women in local health departments and other safety net provider sites.
PRAMS data shows a decrease in unintended pregnancy in teens from 75.8% in 2006 to 69.6% in 2007. Teen pregnancy prevention efforts are discussed under national performance measure #8.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Fund family planning and reproductive health clinical services	X			

to promote access to care in every jurisdiction in the state				
2. Distribute family planning brochures to all residents requesting a marriage license. Develop a preconception health brochure that promotes the use of folic acid and promotes other healthy habits to persons planning to marry.				X
3. Analyze and disseminate PRAMS data on pregnancy intendedness in Maryland				X
4. Refer Marylanders to family planning services through the MCH hotline		X		
5. Continually update and disseminate family planning program administrative guidelines.				X
6. Identify and implement strategies to reduce teen and unintended pregnancies. Administer federal abstinence education federal funding.				X
7.				
8.				
9.				
10.				

b. Current Activities

CMCH was awarded a three-year (July 1, 2008 -- June 30, 2011) Title X Family Planning Supplemental Expansion grant to expand family planning clinical service delivery. The purpose of this grant is to provide additional clinical services to populations in need in an underserved area of the state - particularly low-income individuals, teens and Hispanics - through strategies that include adding new service providers, linking with other community-based entities, and employing clinic efficiency strategies to enhance the ability to serve additional clients. Reproductive health expansion services are targeted to low income clients, with a focus on teen and Hispanic clients, in the Prince George's County/Greenbelt area, and will provide Title X services to an additional 2,500-3,000 clients in need of subsidized reproductive health care after the first project year. Clients are now receiving services as of May 2009. Service delivery partners include a federally qualified health center and the Maryland WIC Program.

c. Plan for the Coming Year

Ongoing activities will continue in FY 2010. The Family Planning Program will continue to operate, and focus on a critical assessment of family planning activities and needs both at state and local program levels, as part of a strategic planning process that will take the Program into the future.. The MCH Program has prepared a budget initiative seeking additional funding for family planning services. According to the Guttmacher Institute, the Program is currently only able to serve less than half of the 200,000 Maryland women estimated to be in need of subsidized family planning services.

State Performance Measure 2: *Percent of women reporting alcohol use 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			9.8	9.7	7
Annual Indicator	7.2	6.5	7.3	7.4	7.4
Numerator	5364	4867	4842	4914	4914

Denominator	74500	74880	66619	66622	66622
Data Source					MD PRAMS 2007
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	7	7	7	7	7

Notes - 2008
Data for 2008 is not yet available, based on MD PRAMS 2007 data

Notes - 2007
MD PRAMS 2007

Notes - 2006
MD PRAMS 2006

a. Last Year's Accomplishments
Prenatal alcohol exposure is the leading known cause of mental retardation. Alcohol exposure at any point during fetal development may cause permanent, lifelong disabilities. Fetal Alcohol Spectrum Disorder (FASD), the term given to disorders caused by prenatal alcohol exposure, was identified as an emerging priority during the 2005 Title V needs assessment. It is estimated that between 700 to 750 new cases of FASD occur in Maryland each year.

PRAMS data for 2007 indicate that too many Maryland women are continuing to drink during the last three months of pregnancy (7.4%). A smaller percentage (< 1%) reported a binge drinking episode during the last three months of pregnancy. Alcohol use rates were highest for White women, women over the age of 35, and women with a more than a high school education. Local health department staff (particularly those in rural areas) surveyed for the Title V needs assessment indicated that they were seeing increasing evidence of alcohol addiction among pregnant women and women of childbearing age.

In 2006, a statewide FASD Coalition was formed. The Coalition includes representatives from State agencies (e.g., Education, Juvenile Services, Disabilities), DHMH agencies (e.g., Mental Health, Medicaid), universities and community groups. CMCH provides leadership and staffing for the Coalition and appointed a State FASD Coordinator in 2006. One major Coalition goal is to develop a long range plan for increasing awareness of FASD among all sectors -- health care, substance abuse treatment, social services, education, juvenile services, the faith community, business and industry as well as families and individuals. The Coalition has developed Work Groups to accomplish its tasks. Educational materials (e.g., posters, brochures) and a website have been developed for a public information campaign as mandated by Legislation passed in 2006. the Coalition continued quarterly meetings in 2008.

The FASD Coordinator continued to collaborate with the Early Childhood Health Team to develop and implement a CME unit to increase provider awareness of the need to screen patients to prevent and/or address FASD. The target group for training is psychiatrists, psychologists, OB/GYNs, and pediatricians.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide administrative and staff support for a statewide coalition to address Fetal Alcohol Spectrum Disorders (FASD).				X
2. Continue a state mandated outreach and education program			X	

to raise awareness about FASD. Develop and disseminate outreach materials.				
3. Maintain a FASD website				X
4. Hold a statewide FASD conference to educate providers and other stakeholders about FASD.				X
5. Analyze data and publish issue briefs and reports on the problem of FASD in Maryland.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activities this year have focused on continuing to promote awareness of FASD to professionals, women, teens and the general public. The FASD Coalition and its sub-committees developed a web based FASD toolkit as a resource for women of childbearing age. The Toolkit was provided to physician offices, local health departments, MCO's and on college/university campuses. Additionally, the State Coordinator along with other committee members has been working with the Girls Scouts of Central Maryland to develop a Service Project to promote awareness of FASD among adolescent girls. Finally, a FASD poster contest targeted to middle and high school students is being planned. Winning entries will be included in a 2009 FASD calendar.

Further activities of the Coalition included ongoing community outreach and work with faith based organizations. FASD exhibits were displayed at various health fairs around the State. A panel of experts presented at the School Health Interdisciplinary Program (SHIP) conference. Additional prsentations included working with the MD State Dept of Education and Alcohol and Drug Abuse Administration.

c. Plan for the Coming Year

In the coming year, CMCH along with the FASD Coalition is sponsoring an educational meeting for professionals and service providers, entitled "An Evening with Kathy Mitchell." Ms. Mitchell is the Director of the National Organization for Fetal Alcohol Syndrome. She will discuss the effects of FASD on children and families and will offer guidance on working with women to prevent this disorder.

The Coalition will focus on the following:

* Finalizing and widely disseminating a comprehensive five year action plan for prevention of FASD and improving the system of care families and individuals affected by FASD.
* Continuing a five year public information campaign based on recommendations in the FASD plan.
* Continuing to conduct continuing education seminars on FASD for physicians, health educators, school health personnel, foster care workers and juvenile justice staff.
*Collaboration with Juvenile Services with educating FASD to front line case managers.
* Organizing and hosting a 2nd statewide FASD conference.
* Analyzing available data on alcohol use during pregnancy.
* Identifying funding to sustain activities.
*Obtaining and distributing the NOFAS video in local health departments and doctors offices in Maryland.

State Performance Measure 3: *Percent of Maryland kindergartners entering school ready to learn*

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			61	67	68
Annual Indicator	58.0	60.0	67.0	67.0	73.3
Numerator	26086	31889	37609	37609	42366
Denominator	44975	53148	56133	56133	57775
Data Source					MSDE School Readiness Report 2008
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	69	70	71	72	72

Notes - 2007
The Maryland Model for School Readiness (MMSR) defines early learning standards and indicators of what children should know and are able to do before they start formal education. The MMSR includes as its assessment component the Work Sampling System™ (WSS), a portfolio-based assessment system that helps teachers to document and evaluate children's skills, knowledge, behavior, and academic accomplishments across a variety of curricular areas. This is done by ongoing observation, recording, and evaluation of daily classroom experiences and activities that help teachers to gain a better understanding of what students know, are able to do, and areas requiring more work. The seven WSS™ learning domains are:
1. Social and Personal Development;
2. Language and Literacy;
3. Mathematical Thinking;
4. Scientific Thinking;
5. Social Studies;
6. The Arts;
7. Physical Development and Health.

Notes - 2006
Source: MD School Readiness Report.

a. Last Year's Accomplishments
At the beginning of each school year, Maryland kindergarten teachers assess the school readiness skills of incoming students. These data are used to track progress in school readiness and to help teachers revise their curriculum to meet the needs of all kindergarten children. In the 2008-2009 school year, 73% of Maryland kindergartners entered school fully ready to learn, a 24% jump from 49 percent in the 2001-2002 school year. However, significant gaps in school readiness remain between the children most in need (e.g., poor children, children with limited English proficiency and those lacking high-quality learning environments) as compared to their counterparts.
During 2008, Maryland completed its third year of implementation of the ECCS State Plan-Growing Healthy Children. The Early Childhood Health Administrator, along with an Advisory Group of stakeholders, oversaw implementation of several strategies including:
. MD Social Emotional Foundations of Early Learning (MD-SEFEL): Train the Trainer model. Build upon the existing MD-SEFEL model in Maryland, in partnership with the Mental Hygiene Administration, and Maryland State Department of Education. This train the trainer's model was implemented in an additional statewide training of 4 days and provided early childhood mental health training and measurement tools to further strengthen workforce development in Maryland.
. Child care health consultant training to work with child care centers. This second training series involved training local health department and private nurses to provide support and training on a

myriad of early childhood health issues to licensed child care providers using the NTI training model developed at UNC.
. Improve developmental screening in pediatric practices in Maryland. In partnership with the Maryland Chapter of AAP, and the Office for Genetics and Children with Special Health Care Needs, this continuing project supported physician training by promoting developmental screening and measurement tools, conducting grand rounds and providing a developmental forum for pediatric providers.
. Raise provider awareness of the importance of preconception health. A CME has been developed as well as materials that promote preconception health (based on newly released CDC guidelines). A priority focus is on increasing provider awareness of screening to prevent and/or address FASD. The CME link will be accessed on State and provider websites. The target groups for the educational sessions include psychiatrists, psychologists and pediatricians and will be available in September 09.
. Head Start oral health needs assessment. The University of Maryland Dental School conducted an oral assessment of Head Start children in Maryland. The previous study, in 1999, formed the basis for providing oral health services in Baltimore City Head Start Programs. The results will be used to further enhance both ECCS and the Oral Health State Plans.

Partnership building and collaboration continued through CMCH representation on several interagency committees and work groups addressing early childhood health and school readiness issues. These include the Early Childhood Mental Health Steering Committee and the State's Early Care Advisory Council. The Early Childhood Mental Health Steering Committee is charged to develop a plan for integrating mental health services into existing early childhood programs.

Prevention of childhood lead poisoning continued as an important early childhood health activity within CMCH. Maryland has developed an inter-departmental plan with the goal of eliminating new cases of childhood lead poisoning by 2010. CMCH administers the Childhood Lead Screening Program and works in partnership with the Maryland Department of the Environment (the lead State agency for lead) to reduce childhood lead poisoning. Title V funds supported lead activities in Baltimore City and outreach and education activities of the Coalition to End Childhood Lead Poisoning.

CMCH continued to oversee development and implementation of a legislativie mandated targeting plan for identifying areas at risk for lead problems. Children in these areas are required to be screened for lead with a blood test at ages 12 and 24 months.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Implement the State's Early Childhood Health Plan				X
2. Hold a statewide Early Childhood Health Conference				X
3. Train regional child health consultants to work with child care programs.				X
4. Promote preconception health guidelines issued by the CDC.				X
5. Develop and distribute materials to increase provider awareness of FASD and maternal depression. Partner with the Mental Health Association to promote awareness of perinatal depression				X
6. Assess the oral health needs of low income children enrolled in the Head Start Program.				X
7. Represent DHMH on the interagency groups focused on improving school readiness.				X
8.				
9.				

10.				

b. Current Activities
This year, Maryland also saw an opportunity to improve the wellness of young children by applying for funding (for the second time) through a federal SAMSHA initiative, Project LAUNCH. CMCH has partnered with the Baltimore City to seek these funds to enhance the State's early childhood health infrastructure. If funded, the grant will allow the State to create a seamless system of care for young children and their parents/caregivers through the development of a local infrastructure in targeted communities of Baltimore City that incorporate quality and accessible health, mental health, behavioral health and socio-emotional services.

The Early Childhood Administrator continues to represent CMCH on numerous inter-agency groups addressing early childhood issues and works closely with the Maryland Department of Education (including Head Start, Infants and Toddlers, the Office of Child Care), the Governor's Office for Children, and the Mental Hygiene Administration.

CMCH was also a key partner in the planning of the first Healthy Homes Festival to coincide with the National Healthy Homes conference that was held in Baltimore September 2008. The Festival promoted the importance of the healthy homes approach to prevent lead poisoning, asthma, injuries and other environmentally health concerns

c. Plan for the Coming Year
Maryland will enter its third year of implementation of the ECCS State Plan: Growing Healthy Children in 2010. During the next 3 years of implementation, the Maryland ECCS program will continue the work built upon during the March 2008 Federal Partners Meeting, as well as continue to integrate the on-going early childhood state plan. These initiatives include a special a focus on resource integration in partnership with the Maryland Hygiene Administration (MHA). This special focus includes revision of the strategic plan of the early childhood mental health steering committee as well as the integration of that strategic plan into the Early Care Advisory Council goals as well as integration of the Head Start family support and home visit models. ECCS updated their needs assessment which clearly demonstrated a need for further work in parent education and disparities of African Americans related to health and school readiness. In the 2009-2010 grant award period ECCS will fund 2 major activities with our partners to address:
Critical Component: Parent Education
ECCS will ensure home visiting services reflect best practices by collaborating to conduct a cultural and linguistic competence training. This 2 day training, developed by Georgetown University, will be offered statewide to Maryland home visitors serving the largest percentages of English Language Learners. The training will be for 50 home visitors and includes the cost of the curriculum, supplies, and venue. Maryland home visitors will be trained to serve the largest percentages of English Language Learners. The training addresses disparities and working with minority populations.
Critical Component: Early Care and Education/Child Care
Working with our state and private partners, ECCS will help identify disparities and address leading factors to increase school achievement to further address disparities and achievement gaps of African American males. The Maryland Model for School Readiness identified African American males entering kindergarten as having the largest gap in achievement among all other Maryland children. A symposium and one year of quarterly follow up training will bring together all state stakeholders to determine what issues are in Maryland, create a plan of action and begin addressing the leading factors prohibiting African American males from successful school achievement.

The 2 major activities [listed above] are attainable and specific to Maryland's needs. In the next year, in addition to these 2 funded activities, ECCS will meet the goals in the time line by

partnering with our state and local agencies. In addition, if funded, CMCH will be the lead on Project LAUNCH activities in Maryland.

State Performance Measure 4: *Rate of emergency department visits for asthma per 10,000 children, ages 0-4*

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			170	200	220
Annual Indicator	186.1	203.1	221.9	186.5	186.5
Numerator	6783	7749	8171	7026	7026
Denominator	364507	381487	368199	376745	376745
Data Source					State Asthma Surveillance
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	220	218	218	218	218

Notes - 2007
Source: HSCRC Hospital Discharge data and ambulatory data. NCHS Vintage 2007 Population File

Notes - 2006
Source: MD Health Care Commission Reports for 2006.

a. Last Year's Accomplishments
Statewide, about 13.4% of Maryland adults and 13.1% of children have a history of asthma. About 8.9% of adults and 9.1% of children currently have asthma. Emergency department (ED) visits, hospitalizations and mortality suggest a failure to manage asthma properly. Children under the age of five have the highest ED visit of any age group in Maryland. While the Healthy People 2010 goal is for 80 visits per 10,000 population, Maryland's youngest children had 222 visits per 10,000 in 2006.

The Maryland Asthma Control Program or MACP addresses both pediatric and adult asthma and is administratively housed in CMCH. The Maryland Legislature mandated establishment of the MACP in 2002 and charged the Program to develop a statewide asthma surveillance system and an asthma control program. Maryland has received a CDC asthma grant since 2001 that supports staff salaries (i.e., an asthma epidemiologist and an administrator) and funds sub-grantees. Title V partially supports the costs of administrative staff, program printing and the purchase of educational materials.

MACP continued to implement select interventions to reduce asthma morbidity and mortality in 2008. The fourth edition of the Asthma Surveillance Report was completed. Chapters address asthma among Medicaid enrollees, emergency room and hospitalization usage and racial/ethnic disparities in asthma morbidity and mortality. The Program maintains a Website that includes a Maryland Asthma Resource Guide that was published in 2005 and is currently being updated. Asthma in Maryland 2007, the most recent asthma surveillance report, is available at www.marylandasthmacontrol.org.

An Asthma Action Plan has been developed for use by families and providers to ensure that appropriate actions are taken to control asthma. Health care providers from across the State

participated in educational programs focused on adherence to the NHLBI Guidelines and the importance of the Asthma Action Plan.

Asthma continues to disproportionately affect African American children in Maryland, particularly those living in Baltimore City. Title V funding to the Baltimore City Health Department supported the Childhood Asthma Program. This Program provides outreach, education and home based case management to families of young children (ages < 6) affected by asthma. Parents/caregivers are educated about the importance of eliminating environmental triggers and proper asthma medical
management.

In 2008, Dr,. Cheryl DePinto, Medical Director or Child and Adolescent Health, was appointed as the Principa Investigator for the CDC Asthma Grant. She co-chairs (with the American Lung Association) the MD Asthma Coalition and chairs the Executive Committee, an advisory arm to MACP and the Coalition.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Administer the Maryland Asthma Control Program.				X
2. Continue asthma surveillance activities including annual publication of surveillance reports and briefs.				X
3. Revise the State's Asthma Control Plan. Refine and implement a statewide plan to address disparities in asthma				X
4. Fund local health department based asthma interventions including support to local and regional asthma coalitions.				X
5. Co-chair and provide staff support for the Maryland Asthma Coalition.				X
6. Provide staff support for the Children's Environmental Health Advisory Council. Disseminate the Children's Environmental Health Indicators Report prepared by the Council and which includes asthma data.				X
7. Collaborate with State and local healthy homes initiatives.				X
8.				
9.				
10.				

b. Current Activities

In 2009, MACP submitted a proposal to the CDC for continued asthma grant funding. The notice of funding award will not be received until Fall 2009. MACP has also focused its efforts on revising the Maryland Asthma Plan. In April 2009, the Maryland Asthma Plan: An Action Agenda for Reducing the Burden of Asthma in Maryland was released. The Plan includes updated information and feedback from the community regarding proper asthma management and education.

MACP piloted the Asthma Friendly Schools Initiative (AFSI) in 2009. The AFSI was established in 15 schools in Maryland located in Baltimore County, Baltimore City and Garrett County. An asthma-friendly school supports the health academic success of students through maximizing asthma management and reducing environmental asthma triggers in the school environment. Awards to schools who have met the set criteria will be given.

Health promotion activities continue to build awareness and educate families about proper asthma management. A toolkit entitled "Asthma in the Older Adult: Tools to Better Health" was created to educate care givers and providers regarding asthma in adults over 65 years old.

Grants to selected local health departments in MD will support coalition building. A Montgomery County project is woking with low-income Latino parents. The Coalition to End Childhood Lead Pioisoning is now focusing on broader healthy home issues including asthma awareness.

c. Plan for the Coming Year

Proposed asthma activities for 2010 will include:

-Maintaining and expanding the asthma surveillance system. MACP anticipates participating in the BRFSS Asthma Call Back Survey. This Survey will provide data on the frequency and severity of asthma episodes, treatment and management practices, environmental controls and exposure, cost, etc. MACP has published four annual comprehensive surveillance reports (2002-2007), along with numerous one-page data fact sheets and mini-surveillance reports.

-Educating parents/caregivers, patients and the public about asthma prevalence, treatment and best practices management. The University of Maryland Breath mobile will continue to receive support to conduct education and case management for asthmatic children in Baltimore City. Activities and outreach will take place to educate providers and health officials concerning the updated NAEPP Guidelines.

-Educating providers, nurses and pharmacists in underserved locations (Eastern Shore, Western Maryland, Baltimore City) regarding proper asthma diagnosis and adherence to the BAEPP Guidelines.

-Continuing to support and maintain the Maryland Asthma Coalition as well as local coalitions. An Executive Committee to the Coalition has been re-engaged

-Promoting healthy environments to lessen the impact of asthma. MACP will continue its partnership with a national coalition to educate child care providers concerning the effects of the indoor environment on asthmatic children. This Healthy Homes approach includes provider trainings, two disparities workshops and numerous educational events throughout Baltimore City and Prince George's county.

State Performance Measure 5: *Percent of Maryland 12th graders who graduate from high school*

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			84.9	86	86.1
Annual Indicator	84.3	84.8	85.4	85.4	96.5
Numerator			51800	51800	59626
Denominator			60656	60656	61767
Data Source					Summary of Attendance Maryland Public Schools 2007
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	86.2	86.3	86.4	86.4	90

Notes - 2008

Data from Summary of Attendance Maryland Public Schools 2007-2008

Notes - 2007

Source: Estimate based on Maryland State Department of Education, Maryland Report Card for the 2006/2007 School year.

Notes - 2006
Source: Maryland State Department of Education, Maryland Report Card for the 2006/2007 School year.

a. Last Year's Accomplishments
Adolescence, however it's defined (ages 10 - 19 or 12-19 or 13-21), is a time of tremendous change and growth. This transitional developmental period between childhood and adulthood offers many physical, mental and emotional challenges. Risk taking is the norm during this period. While many adolescents make the transition to adulthood with few problems; others do not fare as well. During the 2005 Title V needs assessment, focus groups with parents and service providers consistently identified the need to promote healthy, positive youth development by offering adolescents "a sense of the future." The health care delivery system was viewed as "unfriendly" to adolescents and ill equipped to address growing mental health, psycho-social and emotional problems of teens. Adolescent health promotion was chosen as an MCH priority to highlight the unique needs and issues that affect this often overlooked segment of the MCH population within the public health system.

Evidence is mounting that school success largely depends on whether students are safe, healthy, and resilient. Positive health status has been linked to many aspects of academic achievement including improved test scores, retention, and decreased absenteeism. In Maryland, approximately 96.5% of high school seniors graduated in the 2007-2008 school year (MSDE Summary of Attendance report).
CMCH employs a Medical Director for Child and Adolescent Health as well as a State Adolescent Health Coordinator to oversee planning, policy development and program implementation for school and adolescent health. In addition, support for adolescent health is provided by a community health educator who oversees teen pregnancy prevention efforts and consults with Family planning program staff who work with teens.

DHMH and the State Department of Education are jointly responsible for developing standards and guidelines for school health programs and offering assistance to county boards of education and local health departments in implementing these standards and guidelines. CMCH is responsible for promoting the health of school aged children and ensuring that schools comply with mandated school health standards. The Medical Director for School and Adolescent Health continued to provide medical consultation on school and adolescent issues in 2008.

MCH provided several training opportunities in 2008 to promote healthy and positive youth development The School Health Interdisciplinary Program (SHIP) meeting held in August 2008, provided intensive professional development opportunities to school health and youth serving agency professionals. Training sessions focused on skill building to reduce risky behaviors among adolescents and to promote positive youth development.

During 2008, CMCH continued to collaborate with the Johns Hopkins Bloomberg School of Public Health (JHSPH) on a special project to improve adolescent health. The intent of the "Adolescent Colloquium" is to develop a set of core principles to guide adolescent health promotion and health service activities. Dr. Robert Blum of the JHSPH presented an overview of the research that supports the concept of youth development and the outcomes that youth development programs can have on the health and well-being of youth. The discussion that followed resulted in a concept paper to help promote youth development within all State and community serving organizations. Participants began developing an action agenda for moving the project forward.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Co-sponsor the annual School Health Interdisciplinary Program (SHIP), a four day institute design end to educate school personnel about a broad range of health and social issues that impact school retention and performance				X
2. Implement strategies to prevent teen pregnancy and improve life chances for students.				X
3. Monitor and publish data on adolescent health including assets and risk factors that impact school retention and performance.				X
4. Represent DHMH and the Ready by 21 Initiative and other partnerships sponsored by the Governor's Office for Children to promote healthy your development.				X
5. Conduct child fatality review processes to identify prevention strategies to protect teens.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Christine Evans, the new Adolescent Health Coordinator, serves as the staff point person and coordinator of the Adolescent Health Colloquium.

The Medical Director for School and Adolescent Health continues to represent the MCH Program on the statewide planning initiative, Ready by 21 sponsored by the Governor's Office for Children. The goal is prepare Maryland children and adolescents to be productive, healthy citizens and prepared for the workforce by the age of 21. Improving high school graduation rates is one of the objectives.

c. Plan for the Coming Year

Ongoing activities will continue in FY 2010.

CMCH is also currently taking steps to convene an adolescent health data collaborative to assist in promoting healthy adolescent development in Maryland. This involves pulling together representatives of State agencies involved with adolescent data issues to identify adolescent "hot spots" across the State to support policy and program development. These data would be used to (1) develop and refine adolescent health performance measures for the MCH performance monitoring system and (2) to identify communities most in need of positive youth development activities -- "hot spots," and (3) support the 2010 Title V needs assessment.

A Statewide Dropout Prevention Summit was held on June 22, 2009 in Baltimore County, MD at Randallstown High school. The Summit was hosted by the The Maryland State Department of Education in conjunction with the America's Promise Alliance. The State Adolescent Health Coordinator served as a member of the planning and will also participate in subsequent follow up action planning meetings with stakeholders and assist in the development of a statewide dropout prevention plan.

The Adolescent Health Colloquium has evolved into an Advisory Board on adolescent health and has developed a Healthy Adolescent Guide to provide guidance to a broad audience including providers, parents, and community based organizations serving youth. JHSPH's writer has

compiled the information provided by the Colloquium members. The Healthy Adolescent Guide is set to be made available for distribution in August 2009. There will be a workshop discussing ways to effectively use the guide as a resource at the 2009 School Health Interdisciplinary Program Conference (SHIP). In addition the Johns Hopkins Adolescent Health Center will be developing a press kit and a media launch for the guide. The guide contains concepts on various issues that can be lifted out as a resource for specific groups. The guide will serve as a resource which provides guidance to a broad audience on issues related to optimal adolescent health and well-being.

The School Health Interagency Program is scheduled for August 3 -6, 2009, at Turf Valley Resort and Conference Center. The title for 2009 is "Smoothing the Waters to Promote our Children's Success!" and includes topics covering the eight components or comprehensive school health. Speaker's topics include the adolescent brain, fetal alcohol spectrum disorder, the role of school health in eliminating health disparities, mental health issues in school health, gangs, school connectedness, youth suicide prevention, early childhood topics, family violence, trauma history and it's effects on school performance, HIV, pharmacology, internet safety, and others.

State Performance Measure 6: *Percentage of local jurisdictions addressing the issue of respite for families of CSHCN*

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	75	75	75	62.5
Annual Indicator	66.7	70.8	66.7	62.5	62.5
Numerator	16	17	16	15	15
Denominator	24	24	24	24	24
Data Source					OGCSHCN Grantee Reports
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	62.5	62.5	66	66	70

Notes - 2008
Source: Data from OGCSHCN. Number of jurisdictions awarded grants from OGCSHCN to fund respite services.

Notes - 2007
Source: Data from OGCSHCN. Number of jurisdictions awarded grants from OGCSHCN to fund respite services.

Annual Performance Objectives have been revised based on the most recent data.

Notes - 2006
Source: Data from OGCSHCN. Number of jurisdictions awarded grants from OGCSHCN to fund respite services.

a. Last Year's Accomplishments
In FY08, the Office for Genetics and Children with Special Health Care Needs (OGCSHCN) awarded respite funds to 15 of Maryland's 24 local jurisdictions. With continued level funding of the Block Grant and persistent State budget problems, local jurisdictions have been forced to tap into respite monies to cover the cost of living adjustments for their staff providing other services to CYSHCN such as care coordination. In fact, the overall funding for respite has steadily decreased

since FY05, with a corresponding decrease in numbers of children and families served (over 30%).

Despite this, local jurisdictions, in collaboration with families and community agencies, continued to have success in developing creative and cost effective respite initiatives. Their efforts provided funding to a total of 581 CYSHCN; these respite opportunities included a combination of "respite hours" and funds for camps. Funding was not limited to any particular special health care need or disability. Diagnoses varied from diabetes, asthma and heart disease to epilepsy, Down Syndrome, and cerebral palsy.

The OGCSHCN also provided funding in FY08 to disease-specific advocacy organizations to support operation of summer camps for CYSHCN. The Maryland Alliance of PKU Families received support for PKU Camp, a family camp which served 115 individuals in FY08. Monies were also awarded to support the operation of Camp New Friends, a camp for children with neurofibromatosis. In FY08, 86 individuals with neurofibromatosis participated in this camp as either campers, counselors or volunteers.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide grants to local jurisdictions to support a variety of respite care activities.		X		X
2. Provide grants to disease-specific advocacy organizations to support operation of summer camps for CYSHCN		X		X
3. Refer families to other potential sources of funding for respite care.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In FY09, Kennedy Krieger institute became the administrator for respite funds for CYSHCN in Baltimore City. The program, "My Own Time" has been a success as the specialty care hospital is a great referral source for children and youth who would most benefit from respite care.

The OGCSHCN Community Systems Development Coordinator is currently working with staff at the Wicomico County Health Department to better negotiate the agreement the county has with the local hospital, which provides subspecialty care to CYSHCN in the county with funds from OGCSHCN. Because of recent contractual changes, respite care was nearly eliminated for FY09; OGCSHCN are scheduled to meet with LHD staff to determine options to allow the health department to retain funds not utilized by the hospital they have contracted with for specialty outreach clinics.

OGCSHCN staff continues to work with LHD staff to access other types of programs and funding to provide for more respite care for CYSHCN throughout the state.

c. Plan for the Coming Year

To date, 14 of Maryland's local jurisdictions have been awarded respite funding for FY10. With continued level funding of the Block Grant and the State's persistent budget problems, the OGCSHCN does not anticipate being able to make significant strides in increasing the number of jurisdictions with funding for respite care. The OGCSHCN will continue to work with local health departments to explore mechanisms of partnering and collaborating with other community agencies to expand respite capacity as possible. In addition, the OGCSHCN will continue to refer families of CYSHCN to other sources of respite funding for which they may be eligible including funding through the Developmental Disabilities Administration, the Department of Human Resources, and disease specific foundations.

In FY2010, OGCSHCN again awarded funds for the PKU and Neurofibromatosis camps, and was able to re-initiate a Sickle Cell Day Camp after several years. The Sickle Cell Camp, called "Fun in the Sun," is a summer day camp funded by a community organization called "Destined to Live." This camp is specific to the needs of children ages 4-13 year, who have Sickle Cell Disease (SCD), who are siblings of children with SCD, or who are children of adults with SCD. Specific accommodations include a well-heated pool, wrapping methods for children who choose to swim, and others. The newly re-initiated camp will take place from June 22-July 31, 2009.

It is really difficult to improve performance in this performance measure in light of cuts in funding and staff and so we are not proposing an increased objective.

State Performance Measure 7: *Percent of mothers breastfeeding at six 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			42	44	46
Annual Indicator		40.8	40.8	40.8	
Numerator		29085	29085	29085	
Denominator		71286	71286	71286	
Data Source					
Is the Data Provisional or Final?				Provisional	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	48	50	50	50	50

Notes - 2008
This is no longer a state performance measure because it is a national performance measure.

Notes - 2007
This is no longer a state performance measure because it is a national performance measure.

a. Last Year's Accomplishments
This is no longer a valid state performance measure.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. This measure has been retired as a state measure since it became a national performance measure in 2006.				
2.				
3.				
4.				

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
This is no longer a valid state performance measure.

c. Plan for the Coming Year
This is no longer a valid state performance measure.

State Performance Measure 8: *Percent of local jurisdictions with written plans to address racial and ethnic disparities in maternal and child health*

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			2	10	15
Annual Indicator		8.3	8.3	8.3	12.5
Numerator		2	2	2	3
Denominator		24	24	24	24
Data Source					Survey of LHD MCH Programs
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	15	20	20	20	20

Notes - 2007
Source: Survey of local health department MCH programs.

a. Last Year's Accomplishments
The 2005 needs assessment identified (1) increasing racial/ethnic diversity within Maryland's population, (2) the existence of persistent and widespread racial and ethnic disparities in maternal and child health, and (3) the urgent need to systematically address these disparities if the health of women, children and families in Maryland is to improve. With few exceptions (e.g., suicide and substance use), African American mothers, babies, children and adolescents fare far worse than other racial/ethnic groups on most measures of mortality, morbidity, health and social status, and access to health care. Twenty of the State's 24 jurisdictions have racial and ethnic minority populations greater than 10%. In 2008, local health departments in at least three jurisdictions had developed written plans or program initiatives for addressing racial and ethnic disparities.

The Maryland General Assembly created the Maryland Office of Minority Health and Health Disparities in 2004. In 2005, MHHD received a five year $0.8 million Federal Office of Minority Health grant to address racial and ethnic health disparities in Maryland. Several MCH staff members attended the fourth annual statewide health disparities meeting sponsored by the Office of Minority Health and Health Disparities (MHHD). This Office released the State's first plan to eliminate minority health disparities in December 2006 and sponsors an annual conference.

Perinatal disparities continued to be addressed under the Babies Born Healthy Initiative initiated with new State funding in 2008. This Program was designed to address recent increases in the

State's infant mortality rate as well as known disparities in perinatal outcomes. Strategies included working with Baltimore City Healthy Start, Inc. to assess the need for expanding services to additional high risk areas in Baltimore City. A Maryland Babies Born Healthy Summit held in the fall of 2008 spotlighted the problem of infant death in Maryland including perinatal disparities. The audience for this invitation only conference included legislators, health providers, local health departments, community based groups, consumers, State and local agency staff and other stakeholders.

In 2007, CMCH was represented on an internal Family Health Administration (FHA) Workgroup charged to develop recommendations for an administration wide approach to addressing health disparities. This Workgroup developed a toolkit for addressing racial and ethnic disparities within FHA. This toolkit was updated in 2008 to include the addition of newly available materials.

Dr. Marsha Smith, the Medical Director for Perinatal Health participated in a workgroup to develop a cultural and linguistic competence self-assessment tool for use by Fetal and Infant Mortality Review (FIMR) teams. The development of this self-assessment tool is a new effort supported by collaboration between the National Center for Cultural Competence and the National Fetal and Infant Mortality Review Program. Dr. Smith also has also prepared and given a presentation on "Racial and Ethnic Disparities in Pregnancy Outcomes" before several groups in 2008 as part of the Babies Born Healthy Initiative.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Survey local health departments to determine activities				X
2. Participate on committees convened by the Office of Minority Health and Health disparities to address state health disparities				X
3. Work with the Family Heath Administration to develop a strategy to address racial and ethnic disparities in family health programs.				X
4. Develop and disseminate issue and policy briefs on MCH disparities.				X
5. Develop and implement a plan to address MCH disparities.				X
6. Educate local MCH program directors and staff about MCH disparities.				X
7.				
8.				
9.				
10.				

b. Current Activities

During 2009, the Title V Program provided funding to local agencies in Baltimore City and Prince George's County to address disparities in perinatal health. CMCH also continued to participate on a Coalition within Anne Arundel County whose goal is to reduce racial disparities in infant mortality and morbidity. CMCH provided technical assistance as needed to each of these projects.

The Center for Maternal and Child Health administers the State's Asthma Control Program (MACP). This year, MACP along with its partners , revised the State's Asthma Plan and included goals and objectives for reducing disparities in asthma.

c. Plan for the Coming Year
CMCH will continue to address MCH disparities as a priority focus in 2010. A health disparities webpage will be developed for the CMCH Website and an issue brief on MCH disparities will be completed. These activities were planned for last year as well, but limited staffing precluded their completion. CMCH plans to hire a new senior MCH epidemiologist with funding through the SSDI grant to complete work on disparities.

As part of 2010 needs assessment activities, the MCH Program is planning to review MCH disparities by jurisdiction and to use the results to structure technical assistance to local programs. The MCH Program plans to identify and work with at least two local health departments to strengthen data collection, data analysis and program planning to address MCH disparities. Technical assistance will be sought from the DHMH Office of Health Disparities to develop a model for working with local health department MCH staff to address disparities.

State Performance Measure 9: *Percent of jurisdictions that partner with medical homes to develop and to disseminate resource materials.*

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			41.6	50	58.3
Annual Indicator		33.3	41.7	41.7	41.7
Numerator		8	10	10	10
Denominator		24	24	24	24
Data Source					OGCSHCN Grantee Reports and survey of LHDs
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	45	50	54	58	62

Notes - 2008
Source: OGCSHCN survey of local jurisdictions. Currently reflects number of jurisdictions developing resource guides/materials and distributing these to pediatric health care providers to share with families.

Notes - 2007
OGCSHCN survey of local jurisdictions. Currently reflects number of jurisdictions developing resource guides/materials and distributing these to pediatric health care providers to share with families.

Notes - 2006
OGCSHCN survey of local jurisdictions. Currently reflects number of jurisdictions developing resource guides/materials and distributing these to pediatric health care providers to share with families.

a. Last Year's Accomplishments
Throughout the 2005 needs assessment, we heard that families of CYSHCN often lack information about available community resources and how to effectively access them. This was true for both health-related resources and family support services. Follow-up data from Maryland families indicated that while doctor's offices are the place where parents most often receive information about their CYSHCN, these offices are not seen as the most effective source of information, and parents would like more information related to both medical and non-medical

issues than they are currently receiving. Additional data from Maryland pediatricians confirmed that their offices lack information about important state and local resources, and that pediatricians don't feel like they have the time or personnel to put this together for their practice.

Based on data from the local health departments, at least 10 jurisdictions reported sharing their resource materials directly with medical home providers in order to make the information available to families.

Last year, the Baltimore City Health Department (BCHD), with grant support from OGCSHCN, continued "The Medical Homes Project." This project uses lessons learned from the pharmaceutical industry, which has proven itself extremely effective in "getting in the door" at medical sites and sharing its messages and products. The strategy of this project is to successfully engage pediatric primary care practice staff over provided lunches, with the staff of BCHD programs (Baltimore City Infants and Toddlers, Baltimore City Healthy Start, Healthy Families, Maternal and Infant Nursing, Baltimore HealthCare Access, the Childhood Asthma Program, and Child Find) to share information/resources, to make personal contacts, and to identify ways the systems of care can coordinate efforts on behalf of the children that they serve, particularly at-risk children and infants/young children with SHCN. Like the pharmaceutical companies, this effort included distribution of branded "leave-behind" items, such as mouse pads, pens, and post-it notepads, all imprinted with contact information for the above programs in order to foster better communication and more referrals. In FY08 the project conducted "public health detailing" with five pediatric practices and re-trained five practices from the previous year, which were targeted at increasing Baltimore City pediatric practices' familiarity with community-based resources available to CSHCN. These presentations were revised based on collected feedback from FY07 presentations, and posters and newsletters were also revised to reflect changes in the presentations. Materials were distributed at all initial and follow-up sessions. CDs that contained program referral forms, brochures, and samples of correspondence for each program were developed and distributed. These CDs enable practices to have comprehensive information about each program in one place.

The OGCSHCN and its partners also continued to develop and share resource information with medical home providers and their office staff in the context of the ABCD Screening Academy and through the "Extreme Medical Home Makeover" pilot educational program. Both the Screening Academy and Medical Home Makeover were supported by Leadership Teams. The goals and activities of the Medical Home Leadership Team will continue in a modified format as the core members of the MHLT are integrated into the Medical Home Workgroup of the Community of Care (COC) Maryland Consortium for CYSHCN. The Consortium is funded by a State Implementation Grant for Integrated Community Systems for CYSHCN from MCHB. The core members of the Screening Academy Leadership Team will be integrated into the Early and Continuous Screening Workgroup of the COC.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support Medical Homes Project to link Baltimore City pediatric primary care practices with the Baltimore City Health Department.		X		X
2. Develop and share resource information with medical home providers throughout the state through multiple mechanisms.		X		X
3. Appropriately staff and publicize the Children's Resource Line for its intended purpose.		X		X
4. Actively involve community partners in quality improvement efforts with medical homes through implementation of Community of Care for CYSHCN Learning Collaboratives				X

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
PPMD, in partnership with OGCSHCN, was awarded State Implementation Grant from MCHB. Block grant funded staff from OGCSHCN provided critical leadership staff support to develop the Community of Care (COC) Maryland Consortium CYSHCN. An inaugural summit was held in November 2008. Participants identified and prioritized strategies to improve access statewide to medical home, one of which is to create an ongoing inventory of community resources.

OGCSHCN completed the development of brief (1-3) page resource lists for each jurisdiction that are posted to the web, linked to a map of state counties. These lists continue to be readily accessible by pediatric health care providers in order to share with families. These lists are not exhaustive but meant to be a starting point for families in finding health-related and family support services for their child. The availability of these lists is publicized to providers and families through multiple mechanisms including the Maryland Chapter of the AAP, The Parents' Place of Maryland (PPMD), and local health department staff.

The OGCSHCN has had a "Children's Resource Line" for a number of years that has not been well staffed, publicized or utilized for its intended purpose. This year, the OGCSHCN began staffing this line with its Community Systems Development Coordinator. When she is unavailable, the Eligibility Coordinator for Children's Medical Services covers the Line. OGCSHCN handles an average of 10 to 20 calls per month.

c. Plan for the Coming Year
The ongoing activities described above will continue in the coming year. One of the COC's major goals is to improve access to family-centered, coordinated, comprehensive care for CYSHCN through medical homes that are part of an integrated, community-based system of services. Project plans for this year included a Community of Care (COC) for CYSHCN Learning Collaborative that identifies and engages key community partners in all aspects of the quality improvement process to be designed and implemented. One of the critical lessons learned from our recent experiences with the BCHD Medical Homes Project and The ABCD Screening Academy is the importance of actively involving community partners in quality improvement efforts with medical homes in order to share information/resources, to make personal contacts, and to identify needed areas of quality improvement in the ways the systems of care can communicate and coordinate efforts on behalf of the children that they serve.

In the coming year, the COC will partner with the MD AAP in a series of regional forums (4) to bring together stakeholders (physicians, allied health providers, local health departments, community service providers, families, and others) to discuss medical home and the integration of medical home approaches in pediatric practices in their regions.

A statewide medical home summit will be held that will bring stakeholders as well as state policy staff together. The project will report on key findings from the regional forums and work with the group to develop a statewide strategy for supporting primary care practices.

The COC will disseminate and promote the use throughout Maryland of the Family Voices Family Centered Care Self-Assessment Tools (FCC Tools.) These tools provide an opportunity for health care practices and families to assess current areas of strength and identify areas for growth, plan future efforts, and track progress toward family- centered care, with a focus on family partnership in medical care for CSHCN as well as family satisfaction with services received. This is an

important component of medical home. COC members plan on using the FCC Tools to add a family-centered care component to medical student and practicing provider trainings at Children's Hospital, the University of Maryland Dental Program, the Maryland Association of School Health Nurses, and the Family as Faculty program.

State Performance Measure 10: *Number of policy or issue briefs developed by the Title V 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			3	1	1
Annual Indicator			3	3	4
Numerator			3	3	4
Denominator	1	1	1	1	1
Data Source					CMCHdatabase
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	1	1	1	1	1

Notes - 2008
Source: Center for Maternal and Child Health Database

a. Last Year's Accomplishments
In FY2008, the Center for Maternal and Child Health (CMCH) published several annual briefs. These included the Asthma Surveillance Report (2006 data), State Child Fatality Review Annual Report (2006 data), State Child Death Report (2005 data), Maternal Mortality Review (2007 data), and the Child Abuse and Neglect Expert Panel 2007 Annual Report. These reports are available on the Family Health Administration website at http://fha.maryland.gov .

The Maryland PRAMS Program published results from surveys conducted in 2006. Additionally, PRAMS published three issue briefs, one on quality of prenatal care, a second on neonatal circumcision, and a third on HIV counseling and testing during pregnancy. These publications are available on the CMCH PRAMS Web Site, www.marylandprams.org and have been distributed at MCH stakeholders meetings and at specific perinatal health meetings.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Develop and disseminate MCH policy or issue briefs based on surveillance data, qualitative analyzes, analysis of secondary data sources and/or literature review of evidence based interventions.				X
2. Develop and disseminate a Title V Performance Measure Databook.				X
3. Develop and disseminate a Title X Performance Measure Databook.				X
4. Expand analysis of the PRAMS and Asthma surveillance systems				X
5. Develop and disseminate reports of state and local FIMR				X

findings				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In 2009, CMCH published several annual briefs:
Asthma Surveillance http://fha.maryland.gov/pdf/mch/AsthmaReport2007.pdf
Child Fatality Review http://fha.maryland.gov/pdf/mch/CFR_Annual_Report_2007.pdf
Child Death Report http://fha.maryland.gov/pdf/mch/Child_Death_Report2006.pdf
Maternal Mortality Review http://fha.maryland.gov/pdf/mch/2008_MMR_Report.pdf
Child Abuse & Neglect Expert Panel Report http://dhmh.maryland.gov/reports/pdf/dec08/SB0782-FHA_Child%20AbuseNeglect_Signed_12-18-08.pdf
PRAMS published 2007 survey results and 3 focus briefs (births to Hispanic mothers, smoking during pregnancy, and breastfeeding).
www.marylandprams.org
A new 'Women's Health Databook' reported on women's health in MD, including rates of preventive screenings, chronic disease, and causes of death.

CMCH completed the MD Asthma Control Plan: An Action Agenda for Reducing the Burden of Asthma in Maryland, 2010-2015.
http://fha.maryland.gov/pdf/mch/Asthma_Action_Agenda.pdf
CMCH produced a legislative report on the status of infant mortality programs in the State.
http://dhmh.maryland.gov/reports/pdf/jan09/FHA/105_FHA+MHHD_infant_mortality.pdf
Perinatal System Standards for obstetric and neonatal care in Maryland hospitals were updated and disseminated.
http://fha.maryland.gov/pdf/mch/perinatal_standards.pdf
CMCH updated information on breastfeeding and produced a brief on Prematurity Awareness.
http://fha.maryland.gov/mch/bf_home.cfm
http://fha.maryland.gov/pdf/mch/Prematurity_awareness

c. Plan for the Coming Year
The 2010 Title V Needs Assessment will be a major focus for the Maryland Title V Program in FY 2010. Preliminary steps have already been taken by reviewing MCHB Reports, as well as needs assessment logic models, and processes followed by other states. Coordinated efforts with the Office of Genetics and Children with Special Health Care Needs are underway to review available data sources as well as data gaps. An Advisory Committee has been formed, including representatives from various DHMH offices (Medicaid, Mental Health), the MD State Department of Education, the MD Health Care Commission, and local health departments.

During FY 2010, CMCH will again produce annual briefs on Asthma Surveillance, Child Fatality Review, Child Death Report, Maternal Mortality Review, Child Abuse & Neglect Expert Panel Report, and MD PRAMS surveys conducted in 2008. PRAMS will also develop additional issue briefs, including the topic areas of oral health during pregnancy, births to mothers enrolled in Medicaid, and domestic violence during pregnancy. In addition PRAMS surveys from the 5-year period 2004-2008 will be analyzed in aggregate. In 2010, sufficient data will be available to permit analysis of changes in responses averaged over two consecutive four year periods. CMCH will also continue to update online information and produce consumer briefs as needed.

In FY 2009, CMCH completed writing regulations for House Bill 535, passed by the Maryland Legislature in 2008. These regulations codify the State's Fetal and Infant Mortality Review (FIMR) Program, and establish a Morbidity, Mortality, and Quality Review Committee, under DHMH leadership, to review statewide outcomes related to pregnancy, childbirth, infancy and early

childhood. This Committee will convene in early FY2010. Additional policy or issue brief may come from the Committee's work. CMCH has also begun work with the Governor's Delivery Unit on the Governor's Strategic Goal to reduce infant mortality in Maryland by 10% by 2012. This project has 3 specific focus areas: 1. healthier women before conception, 2. earlier entry into prenatal care, and 3. improved perinatal and neonatal care. Again, work on the GDU project may generate additional briefs.

E. Health Status Indicators

Introduction

Health status indicator data is collected from several sources including Vital Statistics, the Injury and Sexually Transmitted Infections surveillance systems, and State program databases. Form 21 provides important data on the socio-demographic and socio-economic characteristics of children in Maryland. Social factors are important determinants of health. These data are used to monitor trends in social factors that may have either a negative or positive effect on the health of Maryland children. The data are distributed to MCH staff at the State and local levels to assist with program planning and policy development

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	9.4	9.2	9.4	9.1	9.1
Numerator	6992	6869	7294	7133	7133
Denominator	74500	74880	77430	78057	78057
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 data not available. Estimate taken from 2007 Vital Statistics Administration data.

Notes - 2006

2006 data is not available. Estimate is based on 2005 data.

Narrative:

According to the Maryland Vital Statistics Administration and the National Center for Health Statistics, low birthweight (LBW) births have increased over the past decade, both nationally and in Maryland. Comparing 1998 and 2007 data, LBW births are up 9% nationally, but up only 4.5% in MD. Over this period, LBW births in MD increased by 11% among white infants, but fell by 1.5% among Black infants. From 2006 to 2007, LBW births in MD decreased by 3%, from 9.4% to 9.1%. Nationally, there was a 1.2% decline in 2007.

The MD percent LBW remains above the national average (9.1% in MD vs 8.2% in the U.S. for 2007 births). Although MD's overall percent LBW is higher than the national average, race-specific percentages are lower in MD. In 2007, 7.1% of white infants and 12.9% of Black infants were LBW in MD, compared with 7.2% and 13.8% nationally. The higher overall percent of LBW in MD is the result of demographics in the State.

The Center for Maternal and Child Health (CMCH) is involved in many initiatives to reduce LBW births. The Babies Born Healthy Initiative, begun in FY 2007, emphasizes prevention services and quality improvement. Patient safety for mothers and infants in MD hospitals is enhanced through a Perinatal Collaborative, and a newly formed Neonatal Collaborative, in partnership with the MD Patient Safety Center. Standards for obstetric and neonatal care in MD hospitals, developed in 1995, were updated in Oct. 2008. CMCH continues to support the MD Advanced Perinatal Support Services (MAPSS), a statewide program of telemedicine and on-site high-risk obstetric consultation services provided by the State's two academic medical centers.

In FY 2009, CMCH completed regulations for House Bill 535, passed by the MD Legislature in 2008. The regulations codify the State's FIMR Program, and establish a Morbidity, Mortality and Quality Review Committee to review statewide outcomes related to pregnancy, childbirth, infancy and early childhood. This Committee will convene in early FY 2010.

CMCH has begun work with the Governor's Delivery Unit (GDU) on the Governor's Strategic Goal to reduce infant mortality in MD by 10% by 2012. Three project focus areas are: 1. healthier women before conception, 2. earlier entry into prenatal care, 3. improved perinatal and neonatal care. As part of the GDU project, CMCH will expand the MAPSS program to 3 new sites. CMCH will also conduct site visits at all MD Level I and II hospitals to promote compliance with the Standards. In 2010, CMCH will begin planning with the MD Institute of Emergency Medical Services Systems (MIEMSS) for the next 5-year site visit reviews of Level III centers.

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	7.3	7.2	7.3	7.2	7.2
Numerator	5219	5188	5441	5373	5373
Denominator	71502	72020	74295	75083	75083
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data for 2008 not available. Estimate taken from 2007 Vital Statistics Administration Data.

Notes - 2006
2006 data is not available. Estimate is based on 2005 data.

Narrative:
According to the Maryland Vital Statistics Administration and the National Center for Health Statistics, low birthweight (LBW) births have increased over the past decade, both nationally and in Maryland. Comparing 1998 and 2007 data, LBW births are up 9% nationally, but up only 4.5% in MD. Over this period, LBW births in MD increased by 11% among white infants, but fell by 1.5% among Black infants. From 2006 to 2007, LBW births in MD decreased by 3%, from 9.4% to 9.1%. Nationally, there was a 1.2% decline in 2007.

The MD percent LBW remains above the national average (9.1% in MD vs 8.2% in the U.S. for 2007 births). Although MD's overall percent LBW is higher than the national average, race-specific percentages are lower in MD. In 2007, 7.1% of white infants and 12.9% of Black infants were LBW in MD, compared with 7.2% and 13.8% nationally. The higher overall percent of LBW in MD is the result of demographics in the State.

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Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	2.1	1.9	1.9	1.9	1.9
Numerator	1547	1415	1473	1474	1474
Denominator	74500	74880	77430	78057	78057
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

Data for 2008 not available. Estimate based on 2007 Vital Statistics Administration data.

Notes - 2006
2006 data is not available. Estimate is based on 2005 data.

Narrative:
According to the Maryland Vital Statistics Administration (VSA) and the National Center for Health Statistics, very low birthweight (VLBW) births have increased only slightly over the past decade, both nationally and in Maryland. VLBW births accounted for 1.8% of MD births in 1998 and 1.9% in 2007. In the same years, the national figures were 1.4% and 1.5%. VLBW births in MD and nationally are unchanged from 2006 to 2007.

The MD percent VLBW remains above the national average (1.9% in MD vs 1.5% in the U.S. for 2007 births). Race-specific percentages in MD are equal to the national averages. In 2007, 1.2% of white infants and 3.2% of Black infants were VLBW in MD and nationally. The higher overall percent of VLBW in MD is the result of demographics in the State.

The Center for Maternal and Child Health (CMCH) is involved in many initiatives to reduce VLBW births. The Babies Born Healthy Initiative, begun in FY 2007, emphasizes prevention services and quality improvement. CMCH and MD VSA provide yearly hospital-specific data on VLBW births and deaths to MD hospitals. The goal is to reduce the number of VLBW births outside of Level III facilities, and to improve the quality of obstetric and neonatal care in MD hospitals. Patient safety for mothers and infants is enhanced through a Perinatal Collaborative, and a newly formed Neonatal Collaborative, in partnership with the MD Patient Safety Center. Standards for obstetric and neonatal care in MD hospitals, developed in 1995, were updated in Oct. 2008. CMCH continues to support the MD Advanced Perinatal Support Services (MAPSS), a statewide program of telemedicine and on-site high-risk obstetric consultation services provided by the State's two academic medical centers.

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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	1.6	1.5	1.5	1.5	1.5
Numerator	1179	1064	1095	1090	1090
Denominator	71502	72020	74283	75083	75083
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data for 2008 not available. Estimate based on 2007 Vital Statistics Administration data.

Narrative:
According to the Maryland Vital Statistics Administration (VSA) and the National Center for Health Statistics, very low birthweight (VLBW) births have increased only slightly over the past decade, both nationally and in Maryland. VLBW births accounted for 1.8% of MD births in 1998 and 1.9% in 2007. In the same years, the national figures were 1.4% and 1.5%. VLBW births in MD and nationally are unchanged from 2006 to 2007.

The MD percent VLBW remains above the national average (1.9% in MD vs 1.5% in the U.S. for 2007 births). Race-specific percentages in MD are equal to the national averages. In 2007, 1.2% of white infants and 3.2% of Black infants were VLBW in MD and nationally. The higher overall percent of VLBW in MD is the result of demographics in the State.

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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	6.8	7.0	5.2	6.5	6.5
Numerator	78	81	58	72	72
Denominator	1153514	1153348	1112945	1113284	1113284
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 - 2007
Source: 2006 Md. Vital Statistics Report. Data for 2007 is currently unavailable.

Notes - 2006
2006 data is not available. Estimate is based on 2005 data.

Narrative:
Influences to maintain and/or improve the death rate due to intentional injuries among children aged 14 and younger include the assessment of deaths by Child Fatality Review Teams (CFRT) in every jurisdiction in Maryland and the subsequent systems changes that are implemented. The Center for Maternal and Child Health provides administrative support to the state CFRT. The CFRT in MD receives reports from the Office of the State Medical Examiner. These teams then review and analyze each death and report any community/systems issues that impacted the death. Recommendations are made to the community to prevent any recurrences. These recommendations may include the need for community education and resource development.

The State CFRT has focused on several areas including drownings making recommendation for fences and placement issues of pools at or near playgrounds. Additionally, the teams have focus on safe sleep by hosting speakers and encouraging local CFR teams, Fetal and Infant Mortality Review Teams and others to invite speakers on safe sleep fro the Center for Infant and Child Loss (a program at the University of Maryland School of Medicine).

/2010/ During the 2009 session legislation was passed that will enable Maryland data to be shared with he National Center for Child Death Reporting to access better data collection to better understand and assess child fatalities in Maryland. Data for the past several years has fluctuated between 6.8 in 2004 to 6.5 in 2008, while in 2006 the rate decreased to 5.2 per 100,000. //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	3.4	2.4	2.5	2.8	2.8
Numerator	39	28	28	31	31
Denominator	1153514	1153348	1112945	1113284	1113284
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 - 2007
Source: 2006 Maryland Vital Statistics Report. Data for 2007 is currently unavailable.

Notes - 2006
2006 data is not available. Estimate is based on 2005 data.

Narrative:
Influences to maintain and/or improve the death rate due to intentional injuries among children aged 14 and younger due to MVC's include the assessment of deaths by Child Fatality Review Teams (CFRT) in every jurisdiction in Maryland and the subsequent systems changes that are implemented. The Center for Maternal and Child Health provides administrative support to the state CFRT. The CFRT in MD receives reports from the Office of the State Medical Examiner. These teams then review and analyze each death and report any community/systems issues that impacted the death. Recommendations are made to the community to prevent any recurrences. These recommendations may include the need for community education and resource development.

A strong effort through collaboration with the Children's Safety Network and the Partnership for a Safer Maryland provide programs to prevent MVC's among children 14 years and younger. Additionally, child safety seats is a very active program in Maryland implemented under the Center for Health Promotion within the Family Health Administration at the MD Department of Health and Mental Hygiene.

/2010/ During the 2009 session legislation was passed that will enable Maryland data to be shared with he National Center for Child Death Reporting to access better data collection to better understand and assess child fatalities in Maryland. Data for the past several years has fluctuated between 6.8 in 2004 to 6.5 in 2008, while in 2006 the rate decreased to 5.2 per 100,000. //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	22.8	19.1	21.6	22.0	22.0
Numerator	174	149	169	173	173
Denominator	762496	781675	780609	786990	786990
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 - 2007
Source: 2006 Maryland Vital Statistics Report. Data for 2007 is currently unavailable.

Notes - 2006
2006 data is not available. Estimate is based on 2005 data.

Narrative:
Influences to maintain and/or improve the death rate due to intentional injuries among children aged 15 to 24 year olds due to MVC's include the assessment of deaths by Child Fatality Review Teams (CFRT) in every jurisdiction in Maryland and the subsequent systems changes that are implemented. The Center for Maternal and Child Health provides administrative support to the state CFRT. The CFRT in MD receives reports from the Office of the State Medical Examiner. These teams then review and analyze each death and report any community/systems issues that impacted the death. Recommendations are made to the community to prevent any recurrences. These recommendations may include the need for community education and resource development.

At CMCH we address MVC deaths only to the age of 18, although the Office of Health Promotion and Injury Prevention address the older age limits. Teen MVC's have been an ongoing focus in Maryland with safe teen driving education and auto safety provided in many venues and for a variety of audiences. Issues of attention, distracted driving, interacting with friends and speed affect these age groups at a much higher rate that older adults.

/2010/ During the 2009 session legislation was passed that will enable Maryland data to be shared with he National Center for Child Death Reporting to access better data collection to better understand and assess child fatalities in Maryland. Data for the past several years has fluctuated between 6.8 in 2004 to 6.5 in 2008, while in 2006 the rate decreased to 5.2 per 100,000. //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	202.7	204.6	191.5	201.5	201.5
Numerator	2338	2360	2131	2232	2232
Denominator	1153514	1153348	1112945	1107687	1107687
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
Estimate based on 2007 data. Hospital discharge data for 2008 not yet available.

Notes - 2007
Data Source: HSCRC Hospital Discharge Dataset for 2007, MDP population estimate for 2007. Excludes Ecodes E870-E879, E930-E949 (adverse event injuries due to medical, surgical, drugs).

Notes - 2006

Data for 2006 is not available. Estimate is based on 2005 data.

Narrative:
Influences to maintain and/or improve the rate of nonfatal injuries among ages 14 and younger include similar activities that occur with the Child Fatality Review Teams located in every jurisdiction in Maryland except they are reviewing near fatality, a relatively new concept. This planning has begun so that child fatality reviews teams can also look at cases of near fatality. This will take development of a system of notification from the emergency rooms of hospitals, because there will need to be a method for the teams to learn about near fatalities occurring in their jurisdiction. The current process for notification of fatalities comes through the Office of the Chief Medical Examiner and, of course, that office only knows about fatalities, not near fatalities although there would be similarities.

/2010/The State Child Fatality Review Team (SCFRT) is beginning a new strategy for data collection from case review meetings conducted by local Child Fatality Review Teams. The SCFRT is preparing to launch a new electronic system where data collected at child fatality review meetings will be entered electronically into a national database.

The data collected will be standardized and much more detailed than the current data collected. States will be able to get state summaries from the NCCDR, so will have a quicker, better grasp on the types and causes of deaths occurring, enabling them to develop more tailor made prevention plans.

New legislation passed in the 2009 session will allow the sharing of this data with the national electronic system. The Department of Health and Mental Hygiene and leadership of the SCFRT worked to promote the legislative change out of the belief that the new electronic data system would create a better understanding of child fatalities and how to prevent them.//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	23.1	23.6	23.1	21.8	21.8
Numerator	267	272	257	241	241
Denominator	1153514	1153348	1112945	1107687	1107687
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
Estimate based on 2007 data. Hospital discharge data for 2008 not yet available.

Notes - 2007

Source: HSCRC Hospital Discharge Dataset for 2007.

Notes - 2006
2006 data is not available. Estimate is based on 2005 data.

Narrative:
Influences to maintain and/or improve the rate of nonfatal injuries due to MVC's among ages 14 and younger include similar activities that occur with the Child Fatality Review Teams located in every jurisdiction in Maryland except they are reviewing near fatality, a relatively new concept. This planning has begun so that child fatality reviews teams can also look at cases of near fatality due to MVC's . This will take development of a system of notification from the emergency rooms of hospitals, because there will need to be a method for the teams to learn about near fatalities occurring in their jurisdiction. The current process for notification of fatalities comes through the Office of the Chief Medical Examiner and, of course, that office only knows about fatalities, not near fatalities although there would be similarities.

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New legislation passed in the 2009 session will allow the sharing of this data with the national electronic system. The Department of Health and Mental Hygiene and leadership of the SCFRT worked to promote the legislative change out of the belief that the new electronic data system would create a better understanding of child fatalities and how to prevent them.//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	245.0	226.8	230.7	213.0	213.0
Numerator	1868	1773	1801	1676	1676
Denominator	762496	781675	780609	786789	786789
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
Estimate based on 2007 data. Hospital discharge data for 2008 not yet available.

Notes - 2007
Source: HSCRC Discharge Dataset for 2007, MDP population data for 2007.

Notes - 2006
2006 data is not available. Estimate is based on 2005 data.

Narrative:
Influences to maintain and/or improve the rate of nonfatal injuries due to MVC's among ages 15 to 24 year olds include similar activities that occur with the Child Fatality Review Teams located in every jurisdiction in Maryland except they are reviewing near fatality, a relatively new concept. This planning has begun so that child fatality reviews teams can also look at cases of near fatality due to MVC's . This will take development of a system of notification from the emergency rooms of hospitals, because there will need to be a method for the teams to learn about near fatalities occurring in their jurisdiction. The current process for notification of fatalities comes through the Office of the Chief Medical Examiner and, of course, that office only knows about fatalities, not near fatalities although there would be similarities.

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Additionally, collaboration with the Insurance Institute for Highway Safety (IIHS) was developed when the organization was invited to the Maryland Annual School Health Conference held in the summer of 2008. As mentioned earlier, the IIHS conducts the crash tests on automobiles and rates them on front and side impact safety. This information conveys a tremendous benefit on families, who can then make a more informed choice about the vehicles they purchase

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	35.5	32.0	35.1	40.1	40.1
Numerator	6857	6323	7163	8033	8033
Denominator	192934	197367	204122	200244	200244
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 - 2007
Source: Maryland Division of Sexually Transmitted Diseases. Data is currently unavailable for 2007. Estimate is based on 2006 rates.

Notes - 2006
Source: Maryland Community Health Administration, STD Program. Provisional population estimate.

Narrative:
•Influences on maintaining/improving HSIs include fiscal issues that affect testing supply costs and screening/prevention programs, availability of more sensitive (but more costly) detection tests, current evidence-based guidelines on routine and targeted screening, availability of urine screening, and abstinence-only messages vs. comprehensive sex education.

•The program is an active partner in the national Infertility Prevention Project. The Family Planning Program, State STD Program and State Laboratories Administration meet frequently internally and with regional IPP partners to discuss ways to improve screening, increase detection rates, promote prevention messages, and insure prompt treatment to reduce complications. Program guidelines stress the importance of screening the under 25 population, assessing those clients at highest risk, and providing prevention messages, including abstinence and correct use of condoms for those who are sexually active. The program provides condoms to local family planning/std programs as a means of promoting safer sex messages. In addition, program testing for Chlamydia is transitioning quickly to the more sensitive and accurate Nucleic Acid Amplification Test from the EIA test to further improve detection rates. Clinic sites are moving toward urine-based testing, which allows screening of young women who come for pregnancy tests or emergency contraception and do not receive a pelvic exam. Urine testing has a high level of acceptance and results in the ability to screen populations not previously screened but who are clearly sexually active. Program activities include a close monitoring of treatment activities to insure positive cases get prompt treatment and partner evaluation. A pilot project in Baltimore City is testing Expedited Partner Therapy as another means to reduce Chlamydia rates by facilitating ease of treating partners of known cases. In addition, program clinic sites participate in providing treatment to positive testing clients who have requested and received test kits online.

•Modest increases in Chlamydia rates for teens reflect both trends of concern in prevention messages and positive activities in screening. Recent years' emphasis on abstinence only education rather than comprehensive sex education, from the national level on down, has been of concern. Repeat infections among teens also are a public health issue, coupled with difficulties in accessing care for this age group. Cuts in public health spending affect expanding screening programs, or even maintaining services in the face of increasing health costs. On the positive side, detection rates increase when screening is increased, and when more sensitive tests are used, and when simpler testing is done via urine screening. These enhance the ability to treat cases and prevent serious sequelae.

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	8.5	7.8	9.8	10.7	10.7
Numerator	8568	7768	9719	10604	10604
Denominator	1005005	996115	987698	990630	990630
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 - 2007
Source: Maryland Division of Sexually Transmitted Diseases. Estimate is based on 2006 data since 2007 data is currently unavailable.

Notes - 2006
Source: Maryland Community Health Administration, STD Program. Provisional population estimate.

Narrative:
•Influences on HSIs include fiscal issues that affect testing supply costs and screening/prevention programs, availability of more sensitive (but more costly) detection tests, current evidence-based guidelines on screening, and availability of urine screening. In the defined age group, women aged 20-25 are at high risk for Chlamydia, and represent a large proportion of the clients receiving family planning/std services. In Maryland, until recently, women up to age 30 received routine screening. Evidence-based findings and the conversion to more costly tests resulted in a revision of guidelines to emphasize screening clients under 25.

•The program is an active partner in the national Infertility Prevention Project, targeting women to age 25. The Family Planning Program, State STD Program and State Laboratories Administration meet frequently internally and with regional IPP partners to discuss ways to improve screening, increase detection rates, promote prevention messages, and insure prompt treatment to reduce complications. Program guidelines stress the importance of screening the under 25 population, assessing those clients at highest risk at any age, and providing prevention/risk reduction messages to everyone, including correct use of condoms. The program provides condoms to local family planning/std programs as a means of promoting safer sex messages. In addition, program testing for Chlamydia is transitioning quickly to the more sensitive and accurate Nucleic Acid Amplification Test to improve detection rates. Clinic sites are moving toward urine-based testing, which allows screening of young women who come for pregnancy tests or emergency contraception and do not receive a pelvic exam. Urine testing has a high level of acceptance and results in the ability to screen populations not previously screened but who are clearly sexually active. Program activities include a close monitoring of treatment activities to insure positive cases get prompt treatment and partner evaluation. A pilot project in Baltimore City is testing Expedited Partner Therapy as another means to reduce Chlamydia rates by facilitating ease of treating partners. Program clinic sites also participate in providing treatment to positive testing clients who have requested and received test kits online.

•Modest increases in Chlamydia rates for women 20-44 can be seen recently. Cuts in public

health spending affect expanding screening programs, or even maintaining services in the face of increasing health costs. Costs associated with testing require focusing screening on populations most at risk, and targeting testing according to specific risk criteria. On the positive side, detection rates increase when screening is increased -- especially in the most vulnerable 20-25 age group - and when more sensitive tests are used, and when simpler testing is done via urine screening.

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	75408	41288	26172	333	4214	108	3293	0
Children 1 through 4	295784	169367	96294	1190	15922	534	12477	0
Children 5 through 9	359675	213950	114282	1414	16580	344	13105	0
Children 10 through 14	376820	223535	124887	1327	16215	241	10615	0
Children 15 through 19	408725	244719	136881	1496	16845	211	8573	0
Children 20 through 24	378064	229408	122320	1582	17393	294	7067	0
Children 0 through 24	1894476	1122267	620836	7342	87169	1732	55130	0

Notes - 2010

Narrative:
/2010/ The 2007 Maryland population was 64.2% white, 30.0% Black, 5.3% Asian / Pacific Islander, <1% American Indian, and 6.3% Hispanic. Individuals age 0 to 24 years made up 34% of the estimated total population of 5,618,344.

There are many issues related to age, race and ethnicity reflected in MD disparities. In 2007, there was a significant racial disparity in low birth weight births in the state [9.1% overall with 7.1% white, 12.9% Black, and 7.3% Hispanic infants]. There was a similar disparity for very low birth weight births [1.9% overall, 1.2% white, 3.2% Black, and 1.3% Hispanic]. These disparities impact the infant mortality rate, which overall was 8.0 per 1000 live births in 2007, with a rate of 4.6 among white, 14.0 among Black, and 3.8 among Hispanic infants. Ethnic and racial disparities are also seen in the teen birth rate (births to adolescents age 15 to 19). Teen births in the State declined steadily from 1998 to 2005, but the rate has increased for the last 2 years, as it has nationally. The largest overall decrease in the past decade occurred among Black teens, dropping by 32 percent. In 2007, the statewide teen birth rate was 34.4 /1,000 population, with a rate of 17.8 for white, 51.7 for Black, and 95.5 for Hispanic teens. The birth rate among Hispanic teens has increased by 50 percent from 2000 to 2007

CMCH supports and participates in many programs to address the needs of this age

group, and to address disparities. Patient safety for mothers and infants in MD hospitals is enhanced through a Perinatal Collaborative, and a newly formed Neonatal Collaborative, in partnership with the MD Patient Safety Center. Standards for obstetric and neonatal care in MD hospitals were updated in 2008. High-risk obstetric services are provided by the MD Advanced Perinatal Support Services (MAPSS), a statewide program of telemedicine and on-site consultation provided by the State's academic medical centers. The Office for Genetics and Children with Special Health Care Needs also supports programs for children with metabolic diseases, hemoglobinopathies and birth defects.
Other programs include the MD Asthma Control Program; MD Asthma Coalition; Teen Pregnancy Prevention; Lead Poisoning Prevention Commission; Fetal Alcohol Spectrum Disorders Coalition; Fetal and Infant Mortality Review; Child Fatality Review; Maternal Mortality Review; and a legislatively mandated Morbidity, Mortality and Quality Review Committee to review statewide outcomes related to pregnancy, childbirth, infancy and early childhood that will convene in early FY 2010. //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	64622	10786	0
Children 1 through 4	258492	37292	0
Children 5 through 9	328167	31508	0
Children 10 through 14	350039	26781	0
Children 15 through 19	384073	24652	0
Children 20 through 24	350781	27283	0
Children 0 through 24	1736174	158302	0

Notes - 2010

Narrative:
/2010/ The 2007 Maryland population was 64.2% white, 30.0% Black, 5.3% Asian / Pacific Islander, <1% American Indian, and 6.3% Hispanic. Individuals age 0 to 24 years made up 34% of the estimated total population of 5,618,344.

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group, and to address disparities. Patient safety for mothers and infants in MD hospitals is enhanced through a Perinatal Collaborative, and a newly formed Neonatal Collaborative, in partnership with the MD Patient Safety Center. Standards for obstetric and neonatal care in MD hospitals were updated in 2008. High-risk obstetric services are provided by the MD Advanced Perinatal Support Services (MAPSS), a statewide program of telemedicine and on-site consultation provided by the State's academic medical centers. The Office for Genetics and Children with Special Health Care Needs also supports programs for children with metabolic diseases, hemoglobinopathies and birth defects.
Other programs include the MD Asthma Control Program; MD Asthma Coalition; Teen Pregnancy Prevention; Lead Poisoning Prevention Commission; Fetal Alcohol Spectrum Disorders Coalition; Fetal and Infant Mortality Review; Child Fatality Review; Maternal Mortality Review; and a legislatively mandated Morbidity, Mortality and Quality Review Committee to review statewide outcomes related to pregnancy, childbirth, infancy and early childhood that will convene in early FY 2010.//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	93	25	65	0	0	0	0	3
Women 15 through 17	2200	948	1214	5	11	0	0	22
Women 18 through 19	4693	2264	2337	14	45	0	0	33
Women 20 through 34	56748	34048	18736	99	3591	19	0	255
Women 35 or older	14316	8991	3977	21	1271	4	0	52
Women of all ages	78050	46276	26329	139	4918	23	0	365

Notes - 2010

Narrative:
/2010/ Maryland had 78,057 births in 2007, with 2.9% born to mothers <18 years old, 8.9% to mothers <20, 72.7 % to mothers 20 to 34, and18.3% to mothers 35 and older. The racial / ethnic breakdown was 46% white, 34% Black, 14% Hispanic, 6% Asian / Pacific Islander, <1% American Indian. The birth rate (live births per 1,000 population) was 13.9 all races, 12.8 white, 15.6 Black, and 29.8 Hispanic.

There are many issues related to race and ethnicity reflected in MD disparities. In 2007, there was a significant racial disparity in LBW births [9.1% overall, 7.1% white, 12.9% Black, and 7.3% Hispanic] and VLBW weight births [1.9% overall, 1.2% white, 3.2% Black, and 1.3% Hispanic]. These disparities impact the infant mortality rate, which was 8.0 per 1000 live births overall, 4.6 for white infants, 14.0 for Black, and 3.8 for Hispanic. Ethnic / racial disparities are also seen in the teen birth rate (births to mothers age 15 to 19). Teen births declined steadily from 1998 to 2005, but have increased for the last 2 years. In 2007, the statewide teen birth rate was 34.4 /1,000 population, with a rate of 17.8 for white teens, 51.7 for Black, and 95.5 for Hispanic. The

birth rate among Hispanic teens is up 50% since 2000.

The percent of women receiving 1st trimester prenatal care in MD increased steadily in the 1980s and 90s. Since 1998, this percent has dropped, falling below 80% in 2007. Early prenatal care varies by race / ethnicity (88% white, 74% Black, 63% Hispanic). The recent decline in early prenatal care was 20% among Hispanic women, 5% for white and Black women. At the same time, the percent of women in MD entering prenatal care late (after 20 weeks of pregnancy) or receiving no prenatal care has risen steadily (up 62% in the past 10 years). Late or no prenatal care increased by 105% among Hispanic women, 56% among white women, and 14% among Black women.

CMCH has many initiatives to improve birth outcomes and reduce disparities. Patient safety for mothers and infants in MD hospitals is enhanced through a Perinatal Collaborative, and a newly formed Neonatal Collaborative, in partnership with the MD Patient Safety Center. Standards for obstetric and neonatal care in MD hospitals were updated in Oct. 2008. High-risk obstetric services are enhanced by the MD Advanced Perinatal Support Services, a statewide program of telemedicine and on-site consultation provided by the State's academic medical centers. CMCH supports FIMR, Child Fatality and Maternal Mortality Review programs throughout the State. A legislatively mandated Morbidity, Mortality and Quality Review Committee to review statewide outcomes related to pregnancy, childbirth, infancy and early childhood will convene in early FY 2010. CMCH has also begun work with the Governor's Delivery Unit on the Strategic Goal to reduce infant mortality in MD by 10% by 2012. Focus areas are healthier women before conception, earlier entry into prenatal care, and improved perinatal neonatal care.//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	78	15	0
Women 15 through 17	1801	394	5
Women 18 through 19	3953	731	9
Women 20 through 34	48477	8199	72
Women 35 or older	13028	1268	18
Women of all ages	67337	10607	104

Notes - 2010

Narrative:
/2010/ Maryland had 78,057 births in 2007, with 2.9% born to mothers <18 years old, 8.9% to mothers <20, 72.7 % to mothers 20 to 34, and18.3% to mothers 35 and older. The racial / ethnic breakdown was 46% white, 34% Black, 14% Hispanic, 6% Asian / Pacific Islander, <1% American Indian. The birth rate (live births per 1,000 population) was 13.9 all races, 12.8 white, 15.6 Black, and 29.8 Hispanic.

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for white infants, 14.0 for Black, and 3.8 for Hispanic. Ethnic / racial disparities are also seen in the teen birth rate (births to mothers age 15 to 19). Teen births declined steadily from 1998 to 2005, but have increased for the last 2 years. In 2007, the statewide teen birth rate was 34.4 /1,000 population, with a rate of 17.8 for white teens, 51.7 for Black, and 95.5 for Hispanic. The birth rate among Hispanic teens is up 50% since 2000.

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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	622	210	366	4	2	29	0	11
Children 1 through 4	97	45	44	1	2	4	0	1
Children 5 through 9	51	32	19	0	0	0	0	0
Children 10 through 14	74	37	33	0	0	1	0	3
Children 15 through 19	272	127	134	0	0	8	0	3
Children 20 through 24	426	206	204	1	1	11	0	3
Children 0 through 24	1542	657	800	6	5	53	0	21

Notes - 2010

Narrative:

/2010/There are many issues related to age and race reflected in Maryland disparities. The incidence of low birth weight (<2500 grams) was 9.1% in 2007. This figure was 7.18% for white infants, 12.9% for black infants and 7.3% for Hispanic infants. The incidence of very low birth weight (<1500 grams) was 1.9% overall, 1.2% for whites, 3.2% for blacks and 1.3% for Hispanics. The infant mortality rate, likewise, was 8.0 per 1000 live births in 2007 with the rate of 4.6 among whites, 14.0 among blacks and 3.8 among Hispanics.

Additionally, the overall age-adjusted death rate for blacks was 1.2 times higher that the rate for whites. Rates were higher among blacks than whites for six of the ten leading causes of death. The largest race differential by cause of death was the HIV disease, with the death rate 23.9 times higher among blacks than whites.

In Maryland deaths of infants children aged 0 through 24 years are reviewed in the Fetal and Infant Mortality Review Programs in all of Maryland's 24 jurisdictions to determine possible systems changes that could prevent a recurrence of the deaths reviewed. These reviews include gathering of information from hospital records, face to face interviews with the mothers and final review by a group of experts to assess what happened and if there was anything that could have prevented the loss.

Additionally, deaths of children age one year or older are reviewed by the local Child Fatality Review Teams. A State Child Fatality Review (CFR) Team includes a diverse group of experts (see website at http://fha.maryland.gov/mch/cfr_home.cfm). Legislation passed in the 2009 legislative session will permit the sharing of CFR data with the National Center for Child Death Reporting and result in improved data assessment and program implementation.

Local CFR Initiatives include a Teen Driving Task Force, articles in the local newspapers to promote water safety and drowning prevention, a Pediatric Window Falls Task Force, collaboration with the Department of Juvenile Justice to address juvenile crimes, trainings for the local law enforcement on juvenile crime investigation and infant death scene investigation, prevention of shaken baby syndrome (see brochure developed at http://fha.maryland.gov/mch/publications.cfm entitled "When Your Baby Won't Stop Crying") and safe sleep initiatives. The Center for Maternal and Child Health provides funding to the Maryland Center for Infant and Child Loss at the University of Maryland School of Medicine to help them provide bereavement inventions and counseling to families who have experienced a loss.//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	574	40	8
Children 1 through 4	86	11	0
Children 5 through 9	48	3	0
Children 10 through 14	68	6	0
Children 15 through 19	261	10	1
Children 20 through 24	408	17	1

Children 0 through 24	1445	87	10

Notes - 2010

Narrative:
/2010/There are many issues related to age and race reflected in Maryland disparities. The incidence of low birth weight (<2500 grams) was 9.1% in 2007. This figure was 7.18% for white infants, 12.9% for black infants and 7.3% for Hispanic infants. The incidence of very low birth weight (<1500 grams) was 1.9% overall, 1.2% for whites, 3.2% for blacks and 1.3% for Hispanics. The infant mortality rate, likewise, was 8.0 per 1000 live births in 2007 with the rate of 4.6 among whites, 14.0 among blacks and 3.8 among Hispanics.

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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	1506879	884278	494605	5874	71388	1490	49244	0	2008

0 through 19									
Percent in household headed by single parent	33.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2007
Percent in TANF (Grant) families	15.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2007
Number enrolled in Medicaid	359039	104527	220464	675	9534	183	0	23656	2008
Number enrolled in SCHIP	120906	43874	64348	240	5914	75	0	6455	2008
Number living in foster home care	9074	0	0	0	0	0	0	9074	2008
Number enrolled in food stamp program	145358	0	0	0	0	0	0	145358	2008
Number enrolled in WIC	106332	46473	52575	0	0	0	0	7284	2008
Rate (per 100,000) of juvenile crime arrests	3716.2	2556.6	6204.2	371.5	303.2	0.0	0.0	0.0	2006
Percentage of high school drop-outs (grade 9 through 12)	3.4	2.6	4.5	5.0	1.2	0.0	0.0	0.0	2008

Notes - 2010

Please Note: The percentage of children in single-parent families is unavailable by race/ethnicity.

The total number of children in single-parent families= 424,000.

Data Source: The Anne E. Casey Foundation, 2007.

Please Note: The percentage of families in TANF is unavailable by race/ethnicity.

The total number of families in TANF= 11,186.

Data Source: Center for Law and Social Policy, 2007.

Source: Medicaid data for Federal Fiscal Year 2008.

Source: Medicaid data for Federal Fiscal Year 2008.

The total number of children enrolled in food stamp program= 145,358.

Please Note: The number of children enrolled in food stamp program is unavailable by race/ethnicity.

Percent of eligible persons who receive food stamps= 55%

Data Source: Children's Defense, 2008.

This number includes both women and children. The total number of women and children receiving WIC (Supplemental Nutrition Program for Women, Infants, and Children)= 123,868.

Data Source: Children's Defense, 2008.

Please Note: The percentage of Native Hawaiian or other Pacific Islander high school dropouts is unavailable.

Data Source: Maryland State Department of Education (MSDE), 2008.

Narrative:
/2010/ In today's failing economy families are in crisis from lost jobs and the health insurance than may have been provided by these jobs. The unemployment rate in Maryland is at 7.2% and the future continues to look bleak. Federal, state and local programs have been called on the meet the need for increasing services that are just not able to provide while facing cuts of their own. Adverse outcomes disproportionately affect infants and children in foster care (some 9600 children) or in single parent homes. Among women ages 19-44 and 45064, single women are about twice as likely to be uninsured as married women in the same age group. Adults without dependent children younger that age 19 comprises the majority (58%) of Maryland's uninsured, and most of them are single. Children are 20% of the uninsured, and you adults (single or married) are 42%.

Additionally, when families are in crisis it follows that there is an increase in family violence and abuse and neglect of children. The Department of Human Resources is spearheading a three year effort to bolster 1000 new foster families by 2010 so that children can live in closer proximity to family members and their communities. Crime, too, is on the increase in metropolitan areas like Baltimore City and the greater metropolitan areas surrounding Washington, DC. Leaving high school before graduation can lead to continued poverty and higher incidence of juvenile arrests. In Maryland the graduation rate is 73%, slightly higher that the national average.

Many infants and children eligible fro Medicaid and other State programs are not enrolled. Outreach efforts are underway at both the state and local levels to meet this challenge. //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	1369254	137625	0	2008
Percent in household headed by single parent	0.0	0.0	33.0	2007
Percent in TANF (Grant) families	0.0	0.0	15.0	2007
Number enrolled in Medicaid	359039	52484	0	2008

Number enrolled in SCHIP	120906	29649	0	2008
Number living in foster home care	0	0	9074	2008
Number enrolled in food stamp program	0	0	145358	2008
Number enrolled in WIC	77137	29195	123868	2008
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	3716.2	2006
Percentage of high school drop-outs (grade 9 through 12)	13.3	4.6	0.0	2008

Notes - 2010
Please Note: The percentage of children in single-parent families is unavailable by race/ethnicity.

The total number of children in single-parent families= 424,000.

Data Source: The Anne E. Casey Foundation, 2007

Please Note: The percentage of families in TANF is unavailable by race/ethnicity.

The total number of families in TANF= 11,186.

Data Source: Center for Law and Social Policy, 2007.

Source: Medicaid data for Federal Fiscal Year 2008.

Source: Medicaid data for Federal Fiscal Year 2008.

Please Note: The number of children enrolled in food stamp program is unavailable by race/ethnicity.

Percent of eligible persons who receive food stamps= 55%

Data Source: Children's Defense, 2008.

This number includes both women and children. The total number of women and children receiving WIC (Supplemental Nutrition Program for Women, Infants, and Children)= 123,868.

Data Source: Children's Defense, 2008.

Narrative:
/2010/ In today's failing economy families are in crisis from lost jobs and the health insurance than may have been provided by these jobs. The unemployment rate in Maryland is at 7.2% and the future continues to look bleak. Federal, state and local programs have been called on the meet the need for increasing services that are just not able to provide while facing cuts of their own. Adverse outcomes disproportionately affect infants and children in foster care (some 9600 children) or in single parent homes. Among women ages 19-44 and 45064, single women are about twice as likely to be uninsured as married women in the same age group. Adults without dependent children younger that age 19 comprises the majority (58%) of Maryland's uninsured, and most of them are single. Children are 20% of the uninsured, and you adults (single or married) are 42%.

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is on the increase in metropolitan areas like Baltimore City and the greater metropolitan areas surrounding Washington, DC. Leaving high school before graduation can lead to continued poverty and higher incidence of juvenile arrests. In Maryland the graduation rate is 73%, slightly higher that the national average.

Many infants and children eligible fro Medicaid and other State programs are not enrolled. Outreach efforts are underway at both the state and local levels to meet this challenge. //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	893400
Living in urban areas	176672
Living in rural areas	436807
Living in frontier areas	0
Total - all children 0 through 19	613479

Notes - 2010

Narrative:
/2010/ Title V funds do not directly affect the geographic location of children whether rural, Metropolitan or urban. However, barrier and access to care may be influenced by geographic location. The provision of programs including outreach clinics and telemedicine would positively influence the health of those living in areas of limited access.//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	5456359.0
Percent Below: 50% of poverty	3.9
100% of poverty	8.2
200% of poverty	20.4

Notes - 2010
Data Source: U.S. Census Bureau, 2005-2007 American Community Survey: 3 year estimate

Data Source: U.S. Census Bureau, 2005-2007 American Community Survey: 3 year estimate

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Data Source: U.S. Census Bureau, 2005-2007 American Community Survey: 3 year estimate

Narrative:

/2010/ Title V funds do not directly affect the poverty level of the population. Poverty has been shown to impact the health of a population. The availability of health insurance is important to allow access to care for those living in poverty. Recent improvements in medicaid provide for health insurance for individuals in the Primary Adult Care (PAC) Program. Additionally, during the 2007 Special Legislative Session, Senate Bill 6 was passed, which provides for Medical Assistance to parents and other family members caring for children with incomes up to 116% of the Federal Poverty Level. In Fiscal Year 2009, the Medical Assistance for Families initiative was launched. On July 1, 2008, Medical Assistance benefits expanded to include comprehensive health care coverage for many more parents and other family members caring for children. Eligibility depends on family size and income. The income limit is about $21,200 for a family of three. There is no asset limit when applying, no face-to-face interview is required and there are options to apply online, by mail or by fax. The number of families now on the new program has exceeded 45,000. //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	1342351.0
Percent Below: 50% of poverty	0.0
100% of poverty	10.4
200% of poverty	0.0

Notes - 2010
Data Source: U.S. Census Bureau, 2005-2007 American Community Survey: 3 year estimate.
Note that data is for children <18 years

unable to find this data for children in Maryland

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unable to locate this information for children in Maryland

Narrative:
2010/ Title V funds do not directly affect the poverty level of the population. Poverty has been shown to impact the health of a population. The availability of health insurance is important to allow access to care for those living in poverty. During the 2007 Special Legislative Session, Senate Bill 6 was passed, which provides for Medical Assistance to parents and other family members caring for children with incomes up to 116% of the Federal Poverty Level. In Fiscal Year 2009, the Medical Assistance for Families initiative was launched. On July 1, 2008, Medical Assistance benefits expanded to include comprehensive health care coverage for many more parents and other family members caring for children. Eligibility depends on family size and income. The income limit is about $21,200 for a family of three. There is no asset limit when applying, no face-to-face interview is required and there are options to apply online, by mail or by fax. The number of families now on the new program has exceeded 45,000. //2010//

F. Other Program Activities

MCH Hotline/Children's Resource Line: The MCH/Medicaid Programs operate an 800 number telephone line for MCH outreach, information and referral (1-800-456-8900). This line is located and operated by the Medical Assistance Program and is used to provide information and education about the Medical Assistance Program as well as to refer callers to MCH providers. /2009/ The Title V Program continues to support the MCH Hotline. //2009//

Web Sites: Both the Center for Maternal and Child Health (www.fha.state.md.us/mch) and the Office for Genetics and Children with Special Health Care Needs www.fha.state.md.us/genetics) provide functional Websites. These web sites include information about all programs funded or provided, as well as information about the Title V program, including linkage to a copy of the complete Title V report for the most recent fiscal year.

Child Abuse and Neglect: The Legislature charged DHMH to establish a Child Abuse and Neglect Center of Excellence Initiative within DHMH. Responsibility for administering this Initiative was placed within CMCH. The Center of Excellence trains providers in each region of the State to diagnose and treat child abuse and neglect. Legislation passed in 2006 establishes the Children's Trust Fund under DHMH to fund the Child Abuse and Neglect Centers of Excellence using funds derived from the sale of commemorative birth certificates. CMCH is revised and updated the Commemorative Birth Certificate brochure in 2007 and will soon begin promoting the Children's Trust Fund.

Folic Acid: Legislation passed in 2006 creates a Folic Acid Supplement Distribution Program within DHMH to reduce the number of cases of neural tube defects and other birth defects in Maryland children. No funding was allocated for this fiscal year, but the expectation is that funding will be made available in the next fiscal year. The Program will be housed in CMCH and will work with the Folic Acid Council. Once operational, the Program will distribute a folic acid supplement to women of childbearing age enrolled in the State's Family Planning Program. The Program must also provide counseling and written information regarding the proper use of the supplement.
/2009/ Funding for this Initiative has not been allocated.//2009//

Emergency Preparedness: Emergency preparedness is a priority concern for DHMH. DHMH recently consolidated the Office of Public Health Response and the Office of Emergency Response into a single unit reporting directly to the Deputy Secretary for Public Health. This was done to ensure that activities are coordinated. CMCH has also began to prepare for a range of emergency situations that would benefit from a coordinated MCH approach. A CMCH protocol has been developed and staff are continuing to meet to discuss the role of MCH within the DHMH emergency preparedness program.

Conferences and Training: The MCH Program recognizes the importance of enhancing public health competency through ongoing training and education. It achieves this activity by providing training opportunities to LHD public health personnel in important MCH domains such as home visiting, school and adolescent health, screenings and surveillance and asthma education. Several conferences are annually supported by the MCH Program. These include the annual reproductive health update, the annual school health institute, an asthma summit, a perinatal health conference, and technical assistance workshops for local health departments. Conferences that address early childhood health as well as Fetal Alcohol Spectrum Disorders are planned for FY 2010.

/2010/ An MCH/Infant Mortality (Babies Born Healthy) Summit was held in October 2008. //2010//

Women's Health: An Office of Women's Health was established within CMCH in 2001 with the goal of promoting wellness for Maryland women throughout the lifespan. Activities of this Office

include the publication and dissemination of reports (e.g., chartbook on the heath status of Maryland women; postpartum depression); promotion of inter and intra-agency coordination on women's health issues, and implementation of a statewide model for integrating preventive health screening into family planning programs. CMCH hosted the annual Women's Health Steering Committee meeting in May 2007. Findings from PRAMS reports for 2004 and 2005 were highlighted.

Sudden Infant Death Syndrome: Title V monies will continue to support the Maryland SIDS Project at the Center for Infant and Child Loss, University of Maryland School of Medicine. This Center provides SIDS outreach and education as well as counseling to support families experiencing the death of a child.

Environmental Health Tracking System: The Community Health Administration continued to work with the Environmental Public Health Tracking Program's network implementation grant from the CDC. The Family Health Administration, including CMCH, will be involved in grant development. The grant references the need for collaboration with a variety of data sources important to Title V including the birth defects registry, hospital discharge data, vital statistics and the childhood lead registry. CMCH has lead responsibility for the Children's Environmental Health Advisory Council and worked to complete a Children's Environmental Health Indicator Report.

/2009/ The OGCSHCN is working with the Environmental Public Health Tracking Program' to post data on birth defects for public uses on the web as per the CDC protocol.//2009// ***//2010// The Maryland Tracking Network went live and displays birth defects data.//2010//***

Autism Spectrum Disorders: During the 2005 session, legislation was passed requiring the Maryland Dept of Education, in collaboration with the Maryland Dept of Health and Mental Hygiene, to establish a pilot program to study and improve screening practices for Autism Spectrum Disorders. OGCSHCN sits on the Advisory Council overseeing the implementation of this legislation. A qualified research organization will be awarded a contract to conduct the pilot program this year. ***//2010// Dr Panny participated in the AutismSpectrum Disorders summit sponsored by the Milbank Foundation. The Secretaries of the Department of Education and health and Mental Hygiene co-chaird the meeting.//2010//***

OGCSHCN is also funding Baltimore City to pilot a quality improvement initiative for developmental screening in 2 pediatric practices.

G. Technical Assistance

The state of Maryland is not submitting a technical assistance request at this time. Technical assistance needs may be discussed at the August review meeting with the Maternal and Child Health Bureau.

V. Budget Narrative

A. Expenditures

This section describes Title V expenditures for FY 2006 and notes trends and shifts in expenditures over the past several years. During FFY 2006, the majority of the $21,643,799 in Title V -- State partnership funds supported activities at the infrastructure and enabling levels ($17,201,196 or 79%). These expenditures met the 30-30-10 budgeting requirement. /2009/ Maryland continues to meet the 30-30-10 budgeting requirement. During FFY 2007, the majority (78.9%) of funds continued to be used to support activities at the infrastructure and enabling levels. //2009//

Several significant changes have occurred during the time period 1996-2006. First, the State of Maryland through the development of a fiscal data system has been able to monitor expenditures more effectively and efficiently. This has resulted in the expenditure of all funds during the first year of each grant cycle. Therefore, the Federal-State Title V Block Grant Partnership Total is more reflective of the actual dollars awarded and expended in the first year. This change began in FY 1998 and continues. In addition, beginning in FY 2000 the fiscal data system was refined to monitor more effectively funds within the pyramid itself. Periodically, additional refinements have been made to the system. The most recent one occurred in FY 2006 and resulted in greater accuracy in identifying both State and federal fiscal year expenditures.

The first notable shift in funding allocation occurs in FY 1999 with the advent of MCHP making children in families with incomes up to 200% FPL eligible for Medicaid services. Direct expenditures went from 61% to 28% in one year. This continues to decrease as Maryland's Medical Assistance Program assumes greater fiscal role, including covering more CSHCN unique services. The second shift occurred during that same year, with enabling services increasing from 15% in 1998 to 25% in 1999 to a high of 56% in 2000. This service expenditure has been gradually decreasing since 2000, to the current level of 38% in 2006. The reason for this dramatic increase was the need for the health care system to absorb the dramatic shift in services. Many local health departments were initially reluctant to turn over all care coordination to the newly formed Managed Care Organizations (MCO). This concern has decreased as MCO case management has been instituted and a formal communication system has been established. Most of the current funding for these services has been in prenatal and early infant home visiting of the families most at risk for poor maternal and birth outcomes. The last shift has occurred as the State Title V Agency has educated and notified local health departments that combined, the majority of Title V dollars should be allocated for population-based services and infrastructure development.

While dialogue began in 2000 during the last Title V Needs Assessment, it wasn't until FY 2002 that a significant shift began to occur. As a percentage of total federal expenditures, population-based services moved from 5% in 2001 to 10.7% in 2006, and infrastructure-based services shifted from 28% in 2001 and to 43% in 2006. This resulted in the continual decline of direct service dollars to a low of 9.8% in 2006.

/2009/ Maryland received a $120,758 reduction in federal Title V funds between FY 2007 ($12,044,593) and FY 2008 ($11,923,835). Between FY 2008 and FY 2009 ($11,931,558), there was a slight increase of $7,723 in Title V Block Grant funding. As a result of this reduction, the Maryland Title V cut is no longer able to cover the costs of services provided by a perinatalogist ($75,000) at a local hospital. The loss of funding also resulted in the elimination of a Crenshaw Perinatal Health grant to a Southern Maryland county. This grant supported the Southern Maryland Perintal Partnership, a regional partnership that provided enabling services in several counties.

In addition to the federal cuts, State budget cuts in the of approximately $350,000 resulted in cuts to local health departments for lead outreach and case management services for FY 2009.

These cuts in affected the provision of enabling services to the Title V population group of children ages 1-22. The State has set a goal of eliminating new cases of childhood lead poisoning by 2010. //2009//

/2010/ In 2010, Maryland will receive $11,955,050 in federal Title V funds. This is an increase of $23,492 over FY 2009 ($11,931,558). This slight increase does little to help the $120,750 reduction faced in FY 2007- 2008. This ongoing deficit continues to affect enabling services. However, improved outreach and education to populations serve to optimize the use of TitleV funds.//2010//

B. Budget

The Maternal and Child Health Program budgets and functions reflect an evolving public health responsibility that complements and enhances the current health delivery system, recognizes recent legislative changes in health and mandated public health functions, the uniqueness of the populations being served, and emerging research and standards of care affecting the health status of MCH populations. Maryland's Title V budget for FY 2008 totals $21,352,904 including $12,045,757 in federal funds and $9,307,147 in State funds and reflects an expected decrease in federal block grant funding.

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Maryland continues to allocate Maternal and Child Health Block Grant funds using criteria that include: (1) MCH priority needs based on statewide and community assessments, (2) local health department fiscal shortfalls within the identified core categories, (3) poverty rates and estimated size of the maternal and child population (birth-21 years of age), (4) performance measures and outcome measures and (5) the availability of other funding sources. An example of this is the MCHP expansion which enabled funds to be reallocated from direct services for CSHCN to other population groups ineligible for MCHP. Funds may be reallocated throughout the year when unexpected needs are identified. (Budgets are developed two years prior to authorized spending. For example during the summer of 2006, the MCH Budgets for FY 2008 were developed. During the 2007 Legislative Session, the FY 2008 budget was approved).

/2009/ Throughout the development and subsequent expenditure of the MCH budget, the grant is fiscally and programmatically monitored to ensure that the funding levels adhere to the "30-30-10" Title V requirement. For FFY 2009, it is proposed that funding for each Title V population will be distributed accordingly: Preventive and primary care for children -- 47%, CSHCN --38% and Administration -- 3%. The other category at 12% refers to maternal and infant health population. In addition, throughout the two-year process, but particularly during the budget development and the revision phase (based on legislative authorized budget), the MCH Offices evaluate the MCH Service Pyramid fiscal allocation to ensure that it reflects the spirit and intent of MCHB. //2009//

Throughout the year, quarterly meetings are held between the MCH Offices and the Budget

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

The State share in MCH services is considerable, and more than meet the requirements for the State match. State appropriations dedicated to MCH related activities include early intervention services, immunizations, mental health and family planning services. Federal sources of MCH related dollars other than the block grant include early intervention, Part C; Centers for Disease Control and Prevention (immunizations and the public health infrastructure); abstinence education; family planning; WIC; HIV/AIDS; and SSDI (community assessments, enhancing data and epidemiological capacity). Maryland meets the maintenance of effort requirement of Sec. 505 (a)(4).

/2009/ For FFY 2009, federal Title V funds in the amount of $1,377,908 //2009// will be allocated for programs and services for women and infants. These funds will be administered through the Maternal and Perinatal Health Program and will support infrastructure level activities, through the Improved Pregnancy Outcome Program (IPO) and the Crenshaw Perinatal Health Initiative, to improve pregnancy and birth outcomes. IPO funds are provided to each local health department to support FIMR and other activities. Crenshaw funds are competitively awarded to local health departments to support innovative strategies. Funds will also partially support promotion of breastfeeding, education about perinatal depression, and support for identification and prevention of fetal alcohol spectrum disorders (FASD).

Title V will also support local health department based home visiting and care coordination services for pregnant women and infants as well as other activities aimed at improving the health of pregnant women and infants including standards development, quality assurance, health promotion and outreach. Preventive and primary care services for pregnant women and children are administered by the Center for Maternal and Child Health. In addition, newborn screening activities are carried out by the Office for Genetics and CSHCN. Newborn Screening includes two major programs. The Newborn Screening Program screens newborns for 32 disorders that may cause mental retardation and/or serious medical problems unless treated soon after birth. The Universal Infant Hearing screening Program provides for early identification and follow-up of hearing impaired infants and infants at risk for developing a hearing impairment.

/2009//The Newborn Screening Program now screens newborns for all the disorders recommended by the American College of Medical Genetics , the Amerian Academy of Pediatrics and the March of Dimes including the secondary targets, over 54 disorders. //2009//

/2009/ In FFY 2009, a total of $5,633,869 //2009//in federal funds are budgeted to support programs and services for children and adolescents. Funds will be awarded to local health departments to support a broad range of activities to improve the health of children and adolescents. Activities include home visiting, care coordination, child fatality review, school health, health screenings, immunizations, and health education/outreach. Funds will also be used to administer the Childhood Lead Screening Program to include promotion of increased blood lead testing in 20 of the state's 24 jurisdictions, and outreach and education to increase lead awareness. Grantees include local health departments, universities, and the Maryland Coalition to End Childhood Lead Poisoning. CMCH will use these funds to support programs and activities concerned with school and adolescent health, asthma education and outreach, childhood nutrition and obesity issues, and SIDS counseling, outreach and education.

/2009/ The FFY 2009 budget includes $4,575,995 //2009// in federal funds only to support programs and services for CSHCN. These activities and programs will be administered by the Office for Genetics and Children with Special Health Care Needs. Direct care services to be

funded include payment of specialty care for uninsured and underinsured CSHCN as well as two medical day care centers for medically fragile infants and young children. Funding will go to local health departments, Parent's Place of Maryland, and University Centers of Excellence for enabling services such as information and referral, care coordination/wrap-around services, and a variety of respite activities. Population-based services funded will include the newborn screening follow-up accomplished through the Office. Specialty medical centers and some local health departments will also receive funding to support specialty clinic infrastructure, with particular emphasis on neurodevelopmental, genetic, and hematologic services.

/2010/ The FFY 2010 budget includes $5,645,175 infederal funds are budgeted to support programs and services for children and adolescents. Funds will be awarded to local health departments to support a broad range of activities to improve the health of children and adolescents. Activities include home visiting, care coordination, child fatality review, school health, health screenings, immunizations, and health education/outreach. Due to the both federal and state cuts funds used to administer the Childhood Lead Screening Program to include promotion of increased blood lead testing in 20 of the state's 24 jurisdictions, and outreach and education to increase lead awarenesshad to be severely decreased. However, grantees still include local health departments, universities, and the Maryland Coalition to End Childhood Lead Poisoning. CMCH will use these funds to support programs and activities concerned with school and adolescent health, asthma education and outreach, childhood nutrition and obesity issues, and SIDS counseling, outreach and education.//2010//

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.