



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Massachusetts**

**Application for 2009
Annual Report for 2007**



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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

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

C. Assurances and Certifications

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

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

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

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

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

//2009/ The DPH Commissioner held follow-up meetings in each DPH region similar to 2008 to report priorities and gather additional input including about MCH issues. MCH priorities and initiatives continue to be in line with Departmental priorities. The Regional Directors helped ensure broad participation and input. The information from these sessions especially in relation to early childhood and family involvement was utilized in the process of reviewing and updating the application.

Over 240 parents and family members of CSHCN provided substantial consultation through various venues for the Family Support Plan/MCH. As further described in the needs assessment section, easy access to resource information and short term support in crisis situations emerged as the most important, followed by a simplified service system (comparable agency eligibility requirements and a single point of entry for multiple

agencies). Families asked for DPECSHN help reminding providers, the community and other DPH programs that CYSHCN are still children with issues similar to their typically developing peers around sexuality, violence prevention, nutrition, physical activity, obesity, etc.

The public comment website was updated to accept comments on all priorities, measures, and key activities. Comments were consistent with existing MDPH activities. Attention to life-threatening allergies and collaboration with groups involving fathers was advocated. Persons who provide contact information with comments are sent information about related existing programs.

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

An attachment is included in this section.

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2009/ The Massachusetts Title V program continues to monitor the needs of the MCH populations and the state's capacity to meet these needs on an ongoing basis.

First, the Title V Director and senior staff participate in major state level initiatives and high-level planning groups that may impact the health of MCH populations, gaining information about needs and a channel to enhance capacity. In FY08, the Title V Director's focus included services for children with significant physical and cognitive delays, mental health, birth defects, early childhood services including implementation of universal behavioral/developmental screening and newborn screening.

Second, the Commissioner of Public Health held several statewide community-based meetings related to obtaining input to the Department Priorities and programs. The information gained especially in relation to early childhood and family involvement was utilized in the process of reviewing and updating the application.

Third, the BFHN solicits input from consumers, service providers and other stakeholders through advisory groups, focus groups, a web site (posting activities for all measures), dedicated email address, and staff attendance at meetings where outside groups and individuals articulate their needs and raise issues about capacity of the system to meet them. Input that may alter chosen state measures and priorities is raised to the BFHN leadership team for review. More specific input is reviewed within the related area (for example, nutrition or CSHCN). WIC and EI hold public hearings. Focus groups surface parent and provider needs, and strategies to meet them are developed. For example, focus groups were conducted in collaboration with the Springfield FIMR in FY08 related to perinatal disparities; analysis will occur in FY09.

For families of children with special health care needs, regular and ongoing mechanisms support involvement, including employment of parents, stipends for participation, increasing flexibility about timing of meetings and alternative formats for feedback, and specific outreach to improve diversity. This year, they were surveyed about needs. Over 240 parents and family members provided substantial consultation. Easy access to accurate resource information and short term support in crisis situations emerged as most important, followed by a simplified service system (comparable eligibility requirements and a single point of entry for services from multiple agencies). Families asked for DPECSHN help reminding providers, the community and other DPH programs that CYSHCN are still children with issues that are the same or similar to their typically developing peers around sexuality, violence prevention, nutrition, physical activity, obesity, etc. Families cited difficulty finding in-home nursing care for children with complex medical needs, problems accessing durable medical equipment, concerns about communication between primary and specialty care providers, and needs re supports in rural areas, transportation and mental health providers understanding the effects of disability. SSDI supports increasing diversity of parents involved.

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

and priorities to which the input related.

A range of data and reports regularly inform needs assessment, including:

--Major DPH and other state agency data releases (such as births, deaths, youth and adult behavioral risk factor surveillance, health insurance, hospital discharge, emergency room visits).

--Routinely-collected program data, surveillance data (e.g., in 2008: PRAMS 2007 data, Youth Health Survey/Youth Risk Behavior Survey results released, BRFSS 2006 data released), birth data, special surveys or other one-time or occasional data collection efforts, and linked data sets such as the Pregnancy to Early Life Longitudinal (PELL) data set.

--Reports by state agencies, universities, private agencies, health care providers, and advocacy groups.

--Targeted analyses, for example this year of OB/GYN availability and birth outcomes in Western Massachusetts.

The BFHN engaged in a planning effort which included the development of a revised vision, mission, and priorities to be used as a roadmap over the next 3-5 years. This process included the development of clear priorities for 2009 and a balanced scorecard for the Bureau and each Division with measurable outcomes.

In addition to planning for the Five-Year Needs Assessment, staff began work in three major areas: (1) the Title V Director, CSHCN Director and staff participated in the Region 1 Technical Assistance project organized through Boston University School of Public Health staff about the life course perspective. Region 1 is interested in how this perspective might be applied to the needs assessment. (2) Staff completed an update of data for A Shared Vision for Massachusetts Youth and Young Adults. At an initial meeting with the Governor's Council on Adolescent Health, Council members reviewed the information before release of the document and were asked to brainstorm new directions (priorities or measures) these data suggest. The Shared Vision will be the main data resource for developing adolescent health priorities. (3) The Title V and CSHCN Directors kicked off strategic planning session for CYSHCN. National Survey data were presented at a meeting of all DPH CYSHCN staff in May at which staff began revising vision and mission statements. This process is ongoing and is informed by a NICHQ Learning Collaborative on Improving the System of Care for CYSHCN.

See the block grant application for additional details about these needs activities. //2009//

III. State Overview

A. Overview

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

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

/2008/ A separate Needs Assessment and State Overview Update document is not being provided this year. However, an extensive update on Health Care Reform in Massachusetts is provided later in this overview section. This is the major change occurring in the Commonwealth and will have a great impact on both Title V and the families living in Massachusetts. //2008// **/2009/ Please see our Five-Year Needs Assessment and State Overview Update (a separate Word document attached to Part II) that updates Part II, Section C. for a review of key data and changes affecting Title V capacity.//2009//**

Geography and Demographics

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

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

Rural areas predominate in the western section of the state, where the Berkshire Mountains separate many small towns with limited health services. Franklin County in the northwest has just 102 people per square mile. About 18.5% of Massachusetts' residents live in 193 communities in the west and other parts of the state that meet one of the several federal definitions of rural.

These communities cover about 65% of the state's landmass. Farming is still a significant industry in rural areas. To facilitate understanding of rural communities, MDPH and the Massachusetts Rural Health Advisory Council have clustered geographically and historically related rural communities for analytic purposes, calling them rural clusters.

The entire state is incorporated (there are no frontier areas) into 351 cities and towns, which are the functioning units for most local services, including public health, below the state level. There are no county health systems. However, the Commonwealth's cities and towns have been grouped into 27 Community Health Network Areas (CHNAs). In each CHNA, health and human service providers come together with residents to engage in systematic community planning, building on existing coalitions and cooperative efforts. For emergency preparedness, the state has been clustered into 10 different geographic areas. The Executive Office of Health and Human Services (EOHHS) utilizes six regional clusters, which the Department of Public Health recognizes. Other EOHHS Departments use variants of these regional clusters.

The state's overall population grew slowly in the 1990s (up 5.5% from 1990 to 2000, that modest increase due only to immigration). The most recent population assessment indicates that Massachusetts has experienced a decrease in population.

Socio-demographic Factors

Immigration and Race/Ethnicity Trends

Racial and ethnic minorities made up more than 12% of the state's population in 1990 (black non-Hispanics at 5%, Hispanics at 4.8%, and Asians at 2.4%). However, a decade later in 2000, minorities made up more than 16% (blacks at 5.4%, Hispanics at 6.8%, Asians at 3.8%, and two or more races at 2.3%). By 2010, Massachusetts' population is projected to be 6,690,740 with minority populations continuing to account for population growth. Hispanics are projected to increase by more than 38% and blacks by 32%. In several Massachusetts communities, including Boston, minority groups constitute the majority of the population.

In 2000, Massachusetts ranked 8th in the U.S. in its population of immigrants -- many of whom arrived within the last decade. A 2005 report concerning Puerto Ricans and immigrants found that one in seven residents of Massachusetts was born in the U.S. territory of Puerto Rico or a foreign country. In 2004, these residents made up 17% of the labor force. Immigrants play a vital role in Massachusetts' development and will continue to play the main role in our labor force growth for the foreseeable future. In 1980, the labor market was composed of 9.4% foreign-born residents; in 2004, 14.3% of Massachusetts' workers came from other countries.

Estimates of immigrants and refugees may vary due to the inherent difficulty in counting changing populations whose language is not English and who experience cultural isolation. The following countries provided the largest percentages of Massachusetts' newest citizens: Portugal, China/HK/Taiwan, Dominican Republic, former USSR, Haiti, Vietnam, Italy, India, El Salvador and Brazil. Since the Census 2000, the hospitality industry has recruited a large number of Brazilians; almost one in five immigrants entering the state from 2000 to 2003 was Brazilian. Based on the 2000 Census, approximately 6% of Massachusetts non-Hispanic white residents were foreign-born. Immigration from Europe (overall, with exceptions noted above) and Canada has decreased over recent decades. Puerto Rican in-migration to Massachusetts has also decreased. Nearly half of all recent immigrants are from Latin America and the Caribbean; almost one-quarter from various countries in Asia. In addition, smaller numbers of populations increasingly come from varying linguistic groups in countries of Africa. Decreases in births among women born in the US simultaneously with increasing births among foreign-born women also contribute to changing demographics in the state.

Nationally, the influx of Spanish speakers has outpaced the immigration of other groups. Massachusetts differs in that its foreign-born population is diverse across multiple race and linguistic groups and within racial categories. Understanding this phenomenon helps us examine health disparities among broad race groups--white non-Hispanic, black non-Hispanic, Hispanic, Asian, and American Indian--and is crucial for understanding differences in disease risk, health outcomes, and inequities in the delivery of medical care. It is also important to look within each broad racial group, since in some instances, there are greater differences in outcomes and risk among detailed ethnicity groups within one race category than between race categories. The following sections provide a brief overview of the various population groups; additional details are provided in the Needs Assessment.

Note that Census 2000 allowed individuals to identify more than one race category when responding. In order to account for this change, MDPH created the MDPH Population Estimate for 2000 that accounted for individuals who checked "some other race alone," "some other race in combination with other races," and those who indicated more than one race. The figures below are based on this method and they may differ somewhat from others in this document.

Asian: Since the 1990 census, the Asian population has grown by 74% and now comprises approximately 4% of the total population. Asians are 26% of the foreign-born population, and 72% of Asians are foreign-born. Although the largest ethnic Asian group is Chinese (35% of the Asian population), 11 other groups have been identified (in decreasing order of Asian population share): Asian Indian, Vietnamese, Cambodian, Korean, Japanese, Filipino, "other Asian," Laotian, Thai, Pacific Islanders, and Pakistani. Each ethnicity has different customs, health beliefs and language, and differs markedly in socioeconomic indicators. Boston, Lowell, Cambridge, Quincy, Worcester and Brookline are cities with the largest Asian populations.

Black: According to this estimate, blacks are 6.2% of the MA population. About 24% of blacks were foreign-born, with 66% from the Caribbean and 26% from Africa. The birth certificate enables mothers to identify both their race and ethnicity. These include: African American, Haitian, Jamaican, Cape Verdean, Nigerian, Barbadian, Other African, Other West Indian/Caribbean. In addition, the foreign-born population has significant representation from: Western, Eastern and South Africa, Trinidad and Tobago. These ethnic groups have different languages and customs. Although some countries might have English as one of the official languages, most residents maintain tribal traditions and languages, thus making it difficult to categorize them with common attributes. An increasing number of individuals are entering as refugees or fleeing the conflicts in Africa. Blacks can be found in communities throughout the state with larger concentrations in: Boston, Springfield, Brockton, Worcester, Cambridge, Randolph, Lynn, Lawrence, and Milton.

Hispanic: Hispanics were the largest minority group identified in Census 2000 and the second fastest growing population group in MA. Of Hispanics, 31% are foreign-born and 23% born in Puerto Rico. Nearly half of all immigrants and Puerto Ricans who arrived in MA between 2000 and 2004 were from Latin America and the Caribbean. The Hispanic population grew by 49% between 1990 and 2000. As with other broadly defined groups, Hispanics are often assumed to be homogenous in language and customs. This is not the case with Hispanics in Massachusetts. Although their numbers are falling, Puerto Ricans still comprise the largest group (approximately 47% of all Hispanics) in Massachusetts. In most other US states, the Hispanic population differs from the pattern, with Mexicans being the largest group. In Massachusetts, other ethnic populations include: Other Hispanics, Dominicans, Mexicans, Other Central American, Salvadorans, Other South American, Colombians, and Cubans. Growing ethnicities within this group include Mexicans and Other Hispanics. Boston had the biggest Hispanic population, but Lawrence had the largest concentration (60% of its residents). In addition, 14 communities have Hispanic populations totaling more than 10% of the population: Chelsea (48%), Holyoke (41%), Springfield, Southbridge, Lynn, Worcester, Fitchburg, Boston, Lowell, Salem, Leominster, Framingham, and New Bedford.

Unauthorized Immigrants: A 2005 study estimates the number of "unauthorized migrants" (encompassing individuals often termed "undocumented") in Massachusetts to be between 200,000 and 250,000. The unauthorized population has been increasing since the last half of the 1990s and in Massachusetts is estimated to be between 20% and 29% of the foreign-born population. ***//2009/ As a result of a major immigration raid in February 2007, this population continues to feel threatened, with many families not seeking services readily and living in fear even if children are citizens. //2009//***

Children: Of children age 17 and under, 75% are white non-Hispanic (compared to 84% for the total population), 7% are black non-Hispanic, 11% are Hispanic, 4% Asian, and 1% other. These figures are for families who chose to select one race category only. An additional 3% of families selected more than one race category to describe their children.

Language and Linguistic minorities

The recent shift in immigration, away from European and other English-speaking countries, to those where English is not the primary language, presents challenges for Massachusetts. An increasing number of new immigrants do not speak English at all, or do not speak English well.

The 2000 Census recorded almost one in five MA residents (18.7% in MA compared to 17% in US) 5 years and older who spoke a language other than English at home. Of those, 22% spoke English "not well" or "not at all." This is a significant increase from the 1990 census when only 1 in 10 (12.4%) residents fell in that category.

It is estimated that more than 150 languages are spoken in Massachusetts. Spanish-speakers accounted for 30% of those who speak a language other than English; 51% speak some other Indo-European language; 15% an Asian or Pacific Islander language; and 4% spoke some other language. Among those who spoke Spanish at home, 27% described their ability to speak English as "not well" or "not at all." A labor market study indicates that in 2000 almost 137,000 adult immigrants and Puerto Ricans did not speak English at all, or did not speak it well.

The Massachusetts Department of Education First Language Not English (FLNE) Report provides data specific to children. It identifies those communities whose FLNE public school population was 10% or more and provides information on the smaller subset of children who are unable to perform their classroom work in English (Limited English Proficient students). These data are useful indicators of younger families who may be linguistically isolated or experience increased need due to their limited English proficiency. In 2002, one in seven public school students had a language other than English as the first language. In one out of two FLNE students, Spanish was the first language. Of these more than 37% were identified with Limited English Proficiency. In forty-two communities FLNE students make up 10% or more of their student body and in another 23 communities FLNE students comprise between 5 and 9% of the student population. Children in Massachusetts classrooms speak 132 languages. The more frequently encountered languages are: Spanish (49% of total FLNE), Portuguese (10.3%), Cape Verdean Creole (6.1%), Chinese (5.9%), Vietnamese (4.3%), Haitian Creole (3.2%), Khmer (3.19%), Russian (2.8%) and Arabic (1.2%).

Poverty and Disparities

Massachusetts is a comparatively wealthy state with a diversified economic base that includes health care, education, finance, insurance, telecommunications, computer technology, biotechnology, tourism, farming, and fishing. In 2003, the median family income was estimated at \$67,527 compared with \$52,273 for the nation; only 3 states (New Jersey, Connecticut, and Maryland) had higher median family incomes. The state had the second highest percentage of college-educated individuals (36%). The percent of children under 18 living in poverty in 2003 was estimated at 12.3 compared to the national average of 17.7; 9 states had lower poverty rates. Based on 10 key indicators measuring child well-being in 2001, the Annie E. Casey Foundation Kids Count 2004 rated Massachusetts equal or better than the national average for each of the 10 indicators, ranking ninth compared to all other states. A child born in 2003 in Massachusetts has a life expectancy of 78.5 years compared with 77.6 for the US.

Yet disparities between wealthy and poor, educated and not, persist. Massachusetts showed an improvement from 1996 to 2001 in only 4 of the Kids Count indicators. Poverty rates for families and for individuals, while lower than the national averages, have increased since the 1990 census. Significant disparities exist in poorer urban and rural areas with poverty rates for children. Although incomes are high, expenses are as well. Massachusetts has the fourth highest renter-occupied housing costs and the fifth highest owner-occupied housing costs in the nation. A 2004 report by the Massachusetts Family Economic Self-Sufficiency Project documented financial stress for low-income working families, estimating that 25% of Massachusetts families and nearly 50% of urban families, earn less than the income needed to meet their basic needs without public or private supports. The report found that the real cost of living had increased from 17% to 35% depending on the region of the state between 1998 and 2003. To make ends meet, a family with one adult, one preschool child, and one school-age child, based on the report's estimates, needed to earn 228% to 336% of the federal poverty level.

Paralleling national trends, Massachusetts has experienced an increase in the number of homeless families and individuals since the 1980's. Families constitute about 58% of the homeless population in Massachusetts and about 20,000 children in the Commonwealth are homeless (51% of them under the age of 5). An upward trend on the Department of Transitional Assistance (DTA) expenditures on services for homeless families suggests an increased pressure on shelter use as well as in the number and needs of homeless families.

The three-person income limit for the DTA Emergency Assistance Program in FY 2003 was

\$15,284. During this period, one-half of the sheltered population had an average annualized income of \$4,584, all of which was cash assistance. Over 90% of all homeless families in shelters receive food stamps. The food stamps caseload in Massachusetts increased from 153,724 in March of 2004 to an estimated 165,969 in February 2005.

After financial problems and unemployment, substance abuse was the most common reason reported for homelessness among users of the shelter system in the state. Domestic violence is one of the main reasons that women seek shelter, and is a situation affecting many homeless families in the Commonwealth.

Health Insurance, Health Services, and Health Care Reform

/2008/ The following section presents an overview of the many changes taking place through the Massachusetts Health Care Reform process.

Health Care and Health Insurance Reform Efforts

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

Key elements of the reform legislation include:

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

Implementation began in March 2006 with the expansion of coverage within MassHealth existing programs. This expansion included the following:

- Increase in eligibility for children (via SCHIP state plan amendment) up to 300% FPL as of 7/1/06
- Increase in the HIV waiver up to 200% FPL as of 7/1/06
- Increases in the enrollment caps for Essential, CommonHealth, and HIV waiver programs as of 3/9/06
- reinstatement of substance abuse treatment services, adult dental, vision, and chiropractic benefits as of 7/1/06
- addition of adult dental to the Essential benefit as of 7/1/06

- new tobacco cessation benefit for all MassHealth recipients

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

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

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

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

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

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

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

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

For children who have medical needs beyond those covered by their insurance plan, the Catastrophic Illness in Children Relief Fund was expanded to age 21 beginning July 1, 2007. //2008//

//2009// Health Care reform has been successful in providing coverage to over 336,000 residents since implementation began (in MassHealth, Commonwealth Care, and Commonwealth Choice plans). Options have been established for multiple plans and are expected to continue with only minor changes during this coming year. Coverage for young adults is in place. The individual mandate has resulted in individuals who failed to obtain insurance by January 1, 2008 receiving minimal fines. These fines will increase significantly for next year. Multiple employers have provided insurance although several small providers have elected to become part of the state plans. The system has been modified to facilitate enrollment and to provide assistance to those who need it in locating and enrolling in the appropriate plan. The Commonwealth is currently in the process of undertaking a "recertification process" for both Medicaid and all Connector subsidized health reform plans. It is not yet clear how many will no longer be eligible; will have moved from Medicaid to one of the Connector plans or vice versa. This process will be complete by late July. The state is also in the process of renegotiating with CMS the waiver which continues to be a critical component of the reform plan. A one month extension has been granted which expires on August 1. The state administration and legislature as well as providers, insurers and employers remain committed to continued implementation. //2009//

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

Nevertheless, several issues exist that challenge the current and future systems if they are not addressed. Health care costs are growing at unsustainable rates with state health care cost increases, primarily Medicaid crowding out other basic services. The cost of care for the uninsured is estimated to be more than \$1 billion annually and must be recognized as everyone's problem. The regulatory environment has limited insurer innovation and there is a lack of transparency of both price and quality.

As in other states, the Massachusetts health delivery system has been impacted by many competing and related factors over the last decade. In its 2003 release, Massachusetts Health

Care Trends: 1990-2001, the Massachusetts Division of Health Care Finance and Policy addressed six major paradigm shifts that have had and continue to have implications for services to infants, children, youth, and pregnant women:

State-initiated Increases in Access to Health Services: Interlocking state laws and programs have decreased the number of uninsured through Medicaid expansion, small group and individual insurance reform, and the Children's Health Insurance Program (CHIP). Massachusetts ranks 4th in the nation for health insurance coverage with just under 7% of the population uninsured in 2005.

Dilution of HMO Networks: Massachusetts HMOs started the decade with tightly controlled exclusive provider networks and lower premium costs to purchasers. It ended it with nearly identical universal panels of providers under pressure from consumers for greater choice, but left HMOs with deep discounts for volume and shrinking fiscal margins.

Health Care Role Blurring: Clear distinctions among providers, insurers, payers, purchasers and patients have become blurred as doctors began to share financial risks with insurers, insurers became providers who employed doctors and owned hospitals, employers became self-insured, and Medicaid moved from payer to purchaser as it expanded managed care, etc.

Changing Health Services Cosmology: Health care became less centralized around hospitals as managed care, enabled by technology and pharmaceuticals, reduced hospitalizations and inpatient days dramatically over the decade. This created a bulge in home health care and prescription drug use as well as a more fragmented health care landscape, presenting challenges to both professionals and patients.

Swings in Regulation. The decade saw a shift away from strict rate-setting to calls for a return to state involvement by patient advocates and industry experts. The cause of this is the dismal fiscal condition of many Massachusetts hospitals, nursing homes, and community health centers as well as lack of oversight over provider closings, sales of institutions to for-profits, medical errors, etc.

Increased Consumerism: The long-standing paternalistic patient-physician relationship has been challenged as patients become clients and consumers and more information and options become available.

In response to these issues, the Governor is proposing a health care reform initiative that is a "comprehensive, market-based program which will focus on controlling health care costs and increasing access." The plan has four main elements:

- Increased Medicaid enrollments (106,000 persons)
- Affordable health insurance premium for individuals and small business through a new Commonwealth Care program for those with incomes up to 300% FPL (204,000 persons -- those who can afford insurance but don't buy it, short-term unemployed and new employees)
- Safety Net Care managed care plan for those with incomes between 100-300% FPL to replace the Uncompensated Care Pool (150,000 persons)
- Transitional coverage to new employees and the short-term unemployed (36,000 persons)

In addition, two proposals have been put forth in the Massachusetts Legislature. It is expected that the active discussion related to expanding access to health care coverage will continue over the next year. There are many building blocks in place to build from and the momentum is growing. Expansion of coverage will greatly benefit both children and families.

The Uninsured and Insurance Coverage in Massachusetts

Current estimates are that 93% of the Massachusetts population is insured either through employer, individual, Medicare, Medicaid or another public source and that there are approximately 460,000 uninsured persons. Approximately 12% of the uninsured are children, remaining at 3.2% of the total population statewide and an improvement from 4.5% in 1998.

Hispanics tend to have the highest rate of uninsurance, followed by blacks and Asians, correlating with unemployment status. Although older adults age 25 and older are the majority of the uninsured, the highest proportion is in the transitioning young adult population aged 19 to 24, of whom 25% are uninsured. The northeastern part of Massachusetts had the highest proportion of uninsured residents (12%). 71% of children below 200% FPL are insured by MassHealth and 86% of children above 200% FPL are covered by their parents' employee insurance.

Massachusetts has one of the highest penetrations of managed care in the nation. The market continues to be dominated by locally based, not-for-profit organizations (there is one locally

based for-profit health plan in the state), and these health plans consistently rank highly in national consumer satisfaction ratings and on HEDIS measurements. The health plans, especially HMO-like plans, in Massachusetts (as well as throughout the country) have come under increasing pressure to expand services and reduce restrictions. Consumers and employers have demanded a broader choice of doctors and hospitals, resulting in a move away from tightly managed health benefit products, increased PPO and POS product offerings, and reduction in the number of procedures requiring prior authorizations. Consolidation among hospitals and physician groups has increased their bargaining clout. The Legislature also enacted laws mandating coverage of specific types of services and new measures for regulating health plans. These changes combined with the aging of the population, the accelerating introduction and use of new drugs and medical technologies, has led to higher health care costs. In response to the rising cost of health care and employers' desire for more choice in how they control their health care costs, health plans have continued to modify the insurance products available. This has included significant increases in deductibles and co-pays as well as tiered deductibles based on the site of care. Consumer-driven plans are currently being offered by more and more employers. Pediatricians have expressed concern that the consumer-driven plans may result in families delaying care, electing to not have follow-up care or make a choice on price only.

Medicaid and SCHIP

MassHealth, as the state Medicaid program is known, provides comprehensive services through Medicaid, SCHIP, Children's Medical Security Plan and CommonHealth. Currently 985,000 individuals are enrolled in MassHealth. Of this number, 416,500 are children up to the age of 18. With identification of approximately 106,000 individuals as Medicaid eligible but unenrolled, steps are underway to increase outreach and facilitate enrollment of all who are eligible. The newly renewed Medicaid 1115 Waiver expands coverage to some selected special populations within the existing Medicaid populations and allows the state to establish a new program referred to as Safety Net Care. This program would provide coverage to eligible uninsured individuals within certain FPLs. Currently, multiple options are being considered to redesign the health care delivery system for MassHealth managed care members and other publicly assisted populations such as Safety Net Care.

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

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

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

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

Health Services Delivery, Health Care Providers, and Shortages

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

The State continues to have a relatively large physician provider workforce, including primary care providers.

Despite the relatively large number of physicians both trained and currently registered within the State, as well as the extensive system of safety net health providers, localized health professional shortages remain in some urban and rural communities and for specific populations facing financial, linguistic or cultural barriers. Some of these disparities in the distribution of physicians and other health professionals are the result of a critical imbalance in the ability of community health centers (CHCs) and other safety net providers within these underserved areas to recruit and retain physicians. Physicians in Massachusetts continue to be negatively impacted by a high cost of living and malpractice insurance premiums. Massachusetts continues to lose obstetrical providers (including certified nurse midwives and family practitioners), with the greatest losses in Level I facilities and those in Western Massachusetts. In May of 2005, one of two in-state nurse midwifery programs also halted admissions. **//2009/ Due to health care reform there are indications of a shortage of primary care providers in several areas of the state. Both the administration and legislature are involved in activities to identify the extent of the shortages and to develop plans to address them. Due to concerns in Western MA regarding a possible shortage in obstetrical providers and neurosurgeons, the Title V program has been involved in a study to determine the extent of the problem and to identify strategies to resolve it. //2009//**

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

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

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

To assure access, rural hospital services have been a major focus of both MDPH and the Massachusetts Hospital Association (MHA). Three Massachusetts hospitals have converted to Critical Access Hospitals (CAHs). These include Fairview Hospital in Great Barrington and the

sole hospitals on Nantucket and Martha's Vineyard Islands. Two other hospitals continue to undergo financial feasibility studies to assess the benefits of conversion to CAHs. The ability to qualify for this designation is essential because CAHs receive enhanced, cost-based, federal Medicare reimbursement to assist with maintaining the viability of local health care services in the more remote and less densely populated rural communities of the Commonwealth. //2008/ The Office of Rural Health continues to promote all possible options to assure continued access to and the viability of existing services. //2008//

Community Health Centers and Safety Net Programs. As Massachusetts does not have a county- or city-based health services system, Community Health Centers (CHCs) along with a few remaining hospital outpatient departments serve as the key safety net providers. Low-income uninsured and underinsured, high-risk Medicaid recipients and other individuals facing barriers are able to access health care through a statewide network of CHCs regardless of ability to pay. CHCs are non-profit, community-based organizations that serve approximately one out of every 10 patients in the state. CHCs have experienced financial pressure due to numerous changes in the health care reimbursement and support environment.

Currently in Massachusetts, there are 19 Primary Care HPSAs, 15 Dental HPSAs, 5 Mental Health HPSAs and 44 MUAs. FQHCs receive automatic HPSA status from the federal Designation Bureau. Within the last year alone, four applications for new HPSA designations have been submitted through the PCO and are awaiting federal review: 2 Primary Care, 1 Dental and 1 Mental Health.

There are currently 58 safety-net dental clinics in Massachusetts located in community health centers, hospitals, schools, dental and dental hygiene schools and other community locations. All are MassHealth dental providers and have a sliding fee scale, and some provide free care under the state's compensated free care pool.

As part of Health Care Reform, Massachusetts' statewide system of community health centers has been designated "essential community providers." An assessment is underway of the capacity of CHCs to absorb increased patient enrollment and a profile of provider types that are key to service delivery redesign. As these redesigns unfold, with a concomitant redesign of MassHealth and uncompensated care pool funding mechanisms, it is expected that more community patients will be directed and linked to CHCs and other community based providers, particularly those providing behavioral health services. It is also anticipated that these will form the foundation for the state's new Safety Net program.

Providers of family planning services (primarily the MDPH and Title X grantees) have been very interested in the development of a Family Planning Waiver. The waiver would allow the state to expand eligibility for Medicaid covered family planning services to individuals not otherwise eligible for Medicaid and thereby expand the availability of family planning services to low-income individuals, while supplementing (or supplanting) state-only funded programs. A positive CMS report found that Family Planning Waivers do avert births and are budget-neutral; they have been adopted in 19 other states. Currently, DPH and the Office of Medicaid are meeting regularly to discuss the development of a waiver and there is also legislation pending that would mandate one.

There are approximately 2,100 school nurses in the state. School nurses act as a safety net and provide entry into the health care system as needed.

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

//2009/ The Uncompensated Care Pool has been restructured and the Community Health Centers are the key providers of service to individuals who do not qualify for Medicaid or one of the Connector health plans.//2009//

Rural Health Issues While absolute distances in Massachusetts are relatively short compared to many larger states, rural and small town culture, a lack of resources such as transportation, and family and work-life needs are such that it is difficult for many rural residents to travel to cities to receive services on a regular basis. Availability of primary care services in rural areas has improved in the past five years. Since 1997, three new CHCs have opened in rural areas and are currently opening satellite sites. Care for MCH populations is a significant component of the newly

available services at each of these CHCs. The first free-standing federally certified and state licensed Rural Health Clinic (RHC) opened last summer in Dukes County to serve as a safety net provider for the uninsured and underinsured on Martha's Vineyard. Feasibility of expanding this model to other areas is being explored. /2008/ As a result of Health Care Reform, there are anecdotal reports of primary care provider shortages emerging, particularly in rural areas. //2008// Family planning clinics are located in some larger rural towns with only limited services in more remote areas. New family planning and women's health services models are being explored for rural communities that build on the positive assets and community programs in rural communities. Special Needs Services and Shortages. In programs for Children with Special Health Care Needs (CSHCN), families, care coordinators and other providers report shortages of in-home providers of nursing and personal care attendant services. Families of children with autism report long waits and shortages of neurologists willing to accept children for diagnosis. Early Intervention (EI) staffing shortages of therapeutic and nursing personnel are the most severe that has occurred since the full implementation in MA of the Individuals with Disabilities Education Act in 1993. /2009/ **Shortages continue in speech, physical and occupational therapy, as well as for skilled providers to provide services for autism spectrum EI clients.** //2009//

Public-Private Partnerships

The Massachusetts health delivery system depends on public-private partnerships for the delivery of all services, including MCH services. The vast majority of community prevention, primary care and specialty services are delivered by private health care providers and community-based non-profit organizations. Within each city and town, local government is responsible for developing and enforcing environmental and sanitary codes. Some larger health departments also provide screenings, public health and school nursing services, and other traditional public health core functions. MDPH contracts with a wide range of these providers (both private and public), using a competitive bid process, for most of its community-based services. All vendors with MDPH contracts must report on uniform performance measures that assure a culturally competent, family-centered, community-based approach. All are required to participate in the health improvement processes of their local Community Health Network Area (CHNA). MDPH also actively collaborates with local health departments to improve their infrastructures and provide training and technical assistance.

MDPH contracts not only with CHCs, but with a wide variety of other community-based health and human service agencies that provide other MCH services such as early intervention, WIC, home visiting, teen pregnancy prevention, family planning, and health promotion. In addition, there is a broad network of HIV/AIDS and substance abuse services serving mothers, children and youth that MDPH also purchases. Title V purchased services are integrated into MDPH primary care, school health, substance abuse, HIV/AIDS, tobacco control, and other CHC programs to assure a multi-disciplinary, comprehensive, family-centered care model whenever possible. In areas of the state without CHCs, providing comprehensive, multi-disciplinary services becomes more difficult; the Bureau therefore works actively to support the development of additional CHCs or to promote access through networks of other community-based agencies and providers.

There are multiple instances of collaboration among insurers, private organizations, faith-based groups, and other state agencies such as public safety, education, and transportation. To be successful in maintaining and improving the health status of the residents of Massachusetts will depend on the continual enhancement of these relationships.

B. Agency Capacity

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

agency for the Commonwealth. //2008// /

/2009/ As the result of further organizational changes with MDPH during FY08, BFCH was split into two separate Bureaus -- Bureau of Family Health and Nutrition (BFHN) and Bureau of Community Health Access and Promotion. The BFHN continues to be the primary Title V entity for the Commonwealth. See the next section for further details. //2009//

MCH-related program areas within the Bureau are listed and briefly described in a Table organized by the MCH Population Groups that they primarily address. This table is part of a Word document that is the attachment to this Part III, Section B (Agency Capacity) The Table is called "BFCH MCH-Related Programs, Brief Descriptions, and Services Provided" and is the first 11 pages of the file. ***/2009/ This table is the first 10 pages of the file. //2009//***

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

TITLE V IN MASSACHUSETTS

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

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

/2009/ During FY2008, further organizational changes were made that affected the Title V

program. The Bureau of Family and Community Health was divided into two new Bureaus, the Bureau of Family Health and Nutrition and the Bureau of Community Health Access and Promotion, along division lines. At the same time, Tobacco Control Program was transferred to the Bureau of Substance Abuse Services and the Office of Multicultural Health (renamed the Office of Health Equity) was transferred to the Commissioner's Office.

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

See Section III.C. (Organizational Structure) for additional information about a new strategic planning and performance measurement process that the new BFHN is undertaking. //2009//

MDPH also collaborates as a sister agency within the cabinet-level Executive Office of Health and Human Services (EOHHS) with other state agencies in regular meetings, cross-agency program development, workgroups and special taskforces. Other agencies within EOHHS include the Department of Transitional Assistance (welfare), the state Medicaid agency, the Department of Social Services (child welfare), the Office of Child Care Services, the Department of Mental Health, the Department of Mental Retardation, Department of Youth Services, Commission for the Blind, Commission for the Hard of Hearing, **//2009/ Executive Office of Elder Affairs (which includes long-term care for children as well as adults and elders), //2009//** and the Division of Health Care Finance and Policy. Agencies outside EOHHS with which we actively collaborate include the Department of Education and the Executive Office of Public Safety, and the new (as of July 1, 2005) Department of Early Education and Care (DEEC). DEEC combines the functions of the Office of Child Care Services (OCCS) with those of the Early Learning Services Division at the Department of Education; the agency is to be responsible for the administration of all public and private early education and care programs and services in the state. Although no programs from MDPH were transferred to DEEC, MDPH staff have been involved in its establishment and expect to work in partnership to assure linkages and collaboration among birth to 5 services. The agency is supervised and guided by a new independent board. Massachusetts is trying to maximize systems building and minimize the potential confusion brought by multiple state plans, service networks, and community coalitions, by coordinating the development of these activities and structures across state programs. **//2009/ In March, 2008, a new Secretariat of Education was created; it includes EEC and the renamed Department of Elementary and Secondary Education as well as Higher Education. BFHN will continue to work closely with our sister agencies and programs within the new Secretariat structure. //2009//**

The Associate Commissioner, Director, Center for Community Health, who is the Title V administrator, holds a senior leadership position within MDPH and is integrally involved in collaborations and decision-making regarding both internal and cross-agency program development that affects MCH populations. The Associate Commissioner also collaborates with and seeks input from professional organizations, consumer representatives, advocacy groups, and community providers, as well as participating on multiple committees and taskforces addressing MCH issues in the state. //2008/ Under the new MDPH reorganization, Sally Fogerty remains as the Title V Administrator; her title is now Director, Bureau of Family and Community Health; the Center for Community Health no longer exists as an organizational unit. //2008// ***//2009/ Sally Fogerty remained as the Title V Administrator, with the revised title of Director, Bureau of Family Health and Nutrition. Ms. Fogerty is retiring from the Department in October 2008; her permanent replacement as Bureau Director and Title V Administrator has not yet been named. Ron Benham, Director of the Division of Perinatal, Early Childhood and Special Health Needs and the current Title V CSHCN director is the primary interim Title V contact. //2009//***

Our MCH Priorities and State Performance Measures clearly reflect the systems development and partnership philosophies articulated above and have been developed with the Massachusetts health care system context in mind.

There are no statutes in Massachusetts directly related to the establishment or operation of a Title V program as defined by MCHB/HRSA. There are, however, a myriad of statutes and regulations that address issues related to MCH and CSHCN. Many of these have been referenced in the Needs Assessment section and in the NPM/SPM annual report narratives.

The Massachusetts Title V program has historically been a leader in the development of a statewide system of services that reflect the principles of comprehensive, community-based, family-centered care for CSHCN. An extensive review of where we stand on the MCHB-defined four constructs by which to assess the service system for CSHCN and state involvement with it is included in our Five-Year Needs Assessment (Section 2F3.4).

//2009/ Further updates for selected items in the full update in 2007 have been made for 2009. They are indicated within the 2007 text, along with those for 2008. //2009// //2008/ Selected items in the full update in 2007 have been made for 2008. They are indicated within the 2007 text. //2008// //2007/ A stand-alone update to the constructs section is provided below

Four Constructs of a Service System for CYSHCN (From July 2005 MCH Needs Assessment with July 2006 updates)

The Maternal and Child Health Bureau has defined four constructs by which to assess the service system for CSHCN and state involvement with it. This capacity assessment responds to each of these four constructs in turn below.

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

Family members continue to report a strong commitment from the CSHCN program to create opportunities for involvement. Stipends for participation are always given. Families receive a high level of training and mentoring that facilitates participation. The CSHCN program encourages and supports family members to attend local, statewide and national conferences and meetings. Family members of CSHCN are valued and sought for their experience and expertise as parents. At the same time, families identified the need to increase diversity of families involved in Title V activities. Massachusetts has made improving its score on the family participation measure by increasing diversity one of its SSDI objectives.

1. Collaboration with other state agencies and private organizations

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

* The Massachusetts Consortium for CSHCN

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

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

In 2006, through MFT, MDPH and the Consortium developed a Family Professional Partners Institute, which expands on this initial pilot. Five new parent-professional partnerships have been established. These include: development of Family Advisory Councils at a community health center and at a managed care company overseeing behavioral health care; work to identify and ameliorate barriers to family centered care within a tertiary pediatric hospital ICU; development of recommendations to increase family engagement in managing childhood diabetes enrolled in one of the largest health plans in the state; and an initiative to better understand the role of health literacy for Spanish speaking families of CSHCN with a school of public health.

The Family Participation Working Group charge for FY06 was to build the diversity of the Consortium. This included conducting outreach to organizations serving diverse populations to participate in the Family Professional Partners Institute. Phone calls and visits from working group members have begun to build relationships.

The Consortium was involved in the 2005 needs assessment focus groups and analysis of

National Survey of Children with Special Health Care Needs data.

//2008/ In FY07, the Consortium began the process of developing a plan for its future focus; the plan is expected to be completed in FY08. MDPH is an active participant in this process. //2008//
//2009/ Through a recently completed new competitive procurement, the Department will be contracting with the consortium to develop and maintain a broad-based and collaborative public-private partnership to build capacity to create and sustain effective community-based systems of care for children and youth with special health needs. The partnership will work with DPH to strengthen health care systems for CYSHCN and spread the Medical Home concept, to address Healthy People 2010 goals for CYSHCN, and to build a constituency of stakeholders committed to systems enhancement for CYSHCN and their families. //2009//

* The Early Intervention Interagency Coordinating Committee.

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

The Federation for Children with Special Needs

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

* The Alliance for Health Care Improvement

The Alliance for Health Care Improvement is a collaboration of the Medical Directors of the five MA-based not-for-profit health plans. Representatives from member organizations were involved in the needs assessment through the MassHealth MCH Quality Improvement task force. MDPH has collaborated with the non-profit health insurance plans of the Alliance for Health Care Improvement (Blue Cross Blue Shield of MA, Fallon Community Health Plan, Harvard Pilgrim Health Care, Neighborhood Health Plan, and Tufts Health Plan), New England SERVE, and the Massachusetts Consortium for CSHCN, to create Directions: Resources for Your Child's Care, a health education tool for families of CSHCN. The purpose of Directions is: 1) to help families organize health records and information; 2) to provide resources and specialized information about caring for a child with special health care needs; and 3) to improve communication among families, health care providers, and health insurance plans. Content includes forms for record-keeping; resource information and parent tips related to a child's medical team, everyday home care, health insurance, education planning, transition to adulthood, and connecting with other families; and a resource directory. 7,500 English and 2,500 Spanish copies were printed in 2005 and are being distributed to families and providers of CSHCN through a variety of methods, including physician practices and health plans. Two hundred fifty Portuguese copies were printed in 2006, as were another 1,200 English copies. Copies were sent to 1,800 members of the Massachusetts Chapter of the American Academy of Pediatrics. Another 1,200 English copies are being printed in 2006. All versions are available on the web. //2008/ In FY06, 1,359 copies (in English, Spanish, or Portuguese) were distributed. //2008// **//2009/ Another 508 copies were distributed in FY07. //2009//**

Other MDPH Collaborations

* Collaboration meetings with the MassHealth Community Case Management Program.

* Participation on an interagency working group, convened by the state Department of Mental Retardation, around state agencies' Family Support Plans.

* Participation in the Governor's Commission for Employment of People with Disabilities' Youth Leadership Forum for Students with Disabilities.

* Partnership in the New England Genetics and Newborn Screening Collaborative, which is engaged in efforts to enhance genetics literacy and newborn screening systems.

* Participation on the National Disability Mentoring Council, a project of Partners for Youth with

Disabilities.

* The SSI/Public Benefits Specialist is an ex-officio member of the Statewide Special Education Advisory Council; a member of the Disability Determination Services Advisory Committee; and a participant in the SSI/Disability Coalition along with the Disability Law Center and statewide legal assistance programs.

* The BFCH also participates in the reforming long-term care initiative, Communities First. Communities First is a project to promote, encourage, and provide resources for children and adults to live within community settings.

//2009/ The BFHN has been a major participant in the implementation of the Rosie D. class action suit which has been integrated into a broader Children's Behavioral Health Initiative. The initiative will result in a comprehensive redesign of the entire children's mental health delivery system for the Commonwealth. //2009//

2. State Support for Communities

State support for communities is provided through multiple programs, projects and initiatives. Specific programs of the Division for Perinatal, Early Childhood and Special Health Needs address the special needs of children with disabilities at the community level. Initiatives in this area include intensive efforts to promote provision of Early Intervention services in natural environments (aimed not only at improved services for individual children but also at increased community understanding of and capacity to meet special needs); the MASSTART program which provides consultation to schools and families about safe school placement of very medically involved children; the Family TIES program, which provides information and referral to families of CSHCN and their providers, and also serves as the state Parent-to-Parent organization; the Flexible Family Support Fund and the Catastrophic Illness in Children Relief Fund, which provide financial support to eligible families with CSHCN; and practice-based MDPH care coordination in community-based medical practices, which helps increase the capacity to meet needs of CYSHCN at the community level.

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

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

Medicaid Managed Care

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

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

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

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

Care Coordination for CSHCN

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

Universal Newborn Hearing Screening Program

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

SSI/Public Benefits

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

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

MA Consortium for CSHCN

The collaborative relationships described above facilitate the coordination of health services with other services at the community level. Membership of and participation in the Massachusetts Consortium for CSHCN includes representatives from a variety of arenas, including early intervention, education, social services and family support services.

As part of a Champions for Progress grant awarded to New England SERVE and the Massachusetts Consortium for CSHCN, two pilot "regional affiliates" of the Consortium were developed in western and central MA. This enhances capacity to reach out to outlying parts of the state and develop greater linkages at the local and community level.

Care Coordination for CSHCN

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

Community Support Line for CSHCN

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

Family TIES

The Family TIES program provides information and referral for families and providers as well as a parent-to-parent support network, which helps promote service coordination at the community level. Nevertheless, as noted in section 3.1.2.1, program staff have reported that lack of service coordination continues to be a barrier for families. In addition, Family TIES is acting on the need to do targeted outreach to culturally and linguistically diverse families of CSHCN. Of the nearly 1,300 FY05 calls tallied for the needs assessment, 31 individuals identified something other than English as their primary language, with 26 of these callers requesting Spanish. Family TIES has secured the part-time services of staff who speak Spanish and Portuguese. These individuals respond to messages left on the toll free line in either of these languages. In addition, the training Let's Get Organized has been translated into Spanish and offered twice. For FY 2006, Family TIES has identified as a primary goal expanding capacity to effectively outreach to under-served populations by building community-based relationships at organizations, recreational and educational sites and places of worship where diverse families typically come together. Family TIES convened a focus group for the needs assessment.

In 2006, two new sections of statewide resources -- one in Spanish and one in Portuguese -- were added to the Resource Directory developed by Family TIES. This Directory reaches several thousand families and professionals either in hard copy or on-line and is in great demand.

Moving Forward Together: Partnerships to enhance integrated community systems for children and youth with special health care needs in MA

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

An attachment is included in this section.

C. Organizational Structure

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

/2009/As the result of further reorganization within MDPH, the Bureau of Family and Community Health has been split into two Bureaus, the Bureau of Family Health and Nutrition (BFHN) and the Bureau of Community Health Access and Promotion (BCHAP). The BFHN is a free-standing unit reporting directly to the Commissioner of Public Health. It remains the Title V agency for the Commonwealth. See Section III. B. (Agency Capacity) for additional information about this new organizational structure and its impact on the Title V program. //2009//

The Department of Public Health is part of the Executive Office of Health and Human Services. (See the organizational charts in the attachment to this Part III, Section C. (Organization Structure)). As part of a larger re-organization of state government, Governor Romney has implemented a major restructuring of the cabinet-level Executive Office of Health and Human Services, with the goal of being more responsive to providers, clients and communities by improving organizational efficiency, using technology more effectively to achieve coordination of services, and building on the current strengths in the system. Administrative cost savings are being achieved by eliminating duplication. Central functions such as legal, human resources, and information technology have been centralized at the EOHHS level. Four "offices" have been created within the EOHHS of which the Office of Health Services now includes Public Health, Mental Health and Health Care Finance and Policy. Title V remains within Public Health. The other three offices are the Offices of Medicaid; Children, Youth and Family Services; and Disabilities and Community Services.

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

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

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

The Bureau of Family and Community Health reports to the Associate Commissioner, Director, Center for Community Health. The Center for Community Health continues a process of

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

/2008/ With the election of a new Democratic governor in November, 2006, there have been a number of major changes in state government and within the Department of Public Health. Governor Duval Patrick named JudyAnn Bigby, M.D. as the new Secretary of Health and Human Services; she was previously an internist in active practice and a member of the Boston Public Health Commission, the governing body of the Boston public health department. In turn, John Auerbach was named Commissioner of Public Health; he was Health Commissioner for the City of Boston and had previously been with the MDPH 10 years ago. As part of his reorganization efforts, the Center for Community Health (along with other centers) was eliminated and the previous Bureau structure has been reestablished. The Bureau of Family and Community is again a free-standing unit reporting directly to the Commissioner. Sally Fogerty remains as the head of the Bureau, with the title of Director; at the moment, there are no assistant or associate commissioner titles.

The organizational structure of the EOHHS has not been changed. New commissioners at other EOHHS agencies are being named or current ones are being reappointed.

Sally Fogerty and Ron Benham continue to serve as the Title V director and state CSHCN contact persons, respectively. *//2008//*

/2009/ EOHHS Commissioners and Assistant Secretaries are currently focusing on how to better integrate programs and services across the multiple health and human services agencies. For Children with Special Health Care Needs, there is a focus on those who have the most complex needs and how to better meet their needs across the life span to minimize transition issues. //2009//

The Bureau of Family and Community Health is committed to protecting and improving the health status, functional status, and quality of life of Massachusetts residents across the lifespan, with special focus on at-risk populations, low-income groups, and cultural and linguistic minorities. After organization changes during FY05, the Bureau includes five programmatic divisions:

- Division for Perinatal, Early Childhood, and Special Health Needs (DPECSHN)
- Division of Primary Care and Health Access (DPCHA)
- Nutrition Division (including WIC)
- Division of Health Promotion and Disease Prevention (DHPDP)
- Division of Violence and Injury Prevention (DVIP)

/2008/ After the recent reorganization affecting the Center for Community Health, the following programmatic units also remain within the Bureau:

- Massachusetts Tobacco Control Program
- Office of Multicultural Health *//2008//*

/2009/ After further reorganizations in FY08, the new Bureau of Family Health and Nutrition includes:

- Division for Perinatal, Early Childhood, and Special Health Needs (DPECSHN)***
- Nutrition Division (including WIC)***

The new Bureau of Community Health Access and Promotion includes:

- Division of Primary Care and Health Access (DPCHA)***
- Division of Health Promotion and Disease Prevention (DHPDP)***
- Division of Violence and Injury Prevention (DVIP)***
- Division of Wellness (new offshoot of DHPDP)***

The following programmatic units are no longer in either Bureau:

- Massachusetts Tobacco Control Program (now in the Bureau of Substance Abuse Services)***

-- Office of Multicultural Health (now called the Office of Health Equity) //2009//

The Bureau also includes the following Internal Support Centers:

--Applied Statistics, Evaluation, and Technical Services (ASETS) /2007/ now renamed the Office of Statistics and Evaluation //2007// /2008/This office has been renamed again as Data Analytics and Decision Support //2008//

-- Administration and Finance

-- Policy and Planning

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

/2009/In late 2007, the new Bureau of Family Health and Nutrition entered into a strategic planning process to develop a "Roadmap for the Future." The purpose of this process was to review the previous vision and mission statements that had been developed for a larger Center. One goal was to develop new vision and mission statements primarily focused on maternal and child health, including children and youth with special health care needs. A second goal was to assure continued linkages and integration across the many programs serving children, youth and families now located in other Bureaus. A third goal was to better position the Bureau to complete its five-year MCH needs assessment and re-setting of MCH priorities.

This process has resulted in clear statements of Vision, Mission, Principles, Priorities, and Expected Outcomes. To promote implementation, it was decided to use a "Balanced Scorecard" process. A balanced scorecard has been developed for each Division and for the Bureau as a whole. The implementation plan utilizing these balanced scorecards is now in place.

One of the key priorities identified was the reassessment of the CYSHCN program and development of a new "Roadmap" specifically for this program area. The internal assessment process for this "roadmap" will be completed by August 2008 and preparation for a complementary external process begun. The MIHCQ leadership effort has, and will continue to, facilitate this activity.

See the final portion of the Attachment to this Section (following the org charts) for Powerpoint slides with more detailed information about the BFHN Roadmap to the Future and the Balanced Scorecard.//2009//

In addition to its central office, the Bureau maintains staff in five regional offices. Many of these staff, such as FOR Families home visitors, and care coordinators for CSHCN provide direct services to individuals and families. Others work closely with BFCH programs, providing regional and local training and technical assistance, information and referral to services, coordination of services for families, performance monitoring, and other capacity building activities, such as the regional Early Intervention specialists. Among the staff are the Family TIES parent staff. Each regional office has a manager, under whose leadership staff work closely with communities to develop a system of care that is responsive to the diverse needs of community members. These staff facilitate the systems building activities in local communities for all Bureau programs and services. /2008/ The Department is considering moving back to maintaining six regional offices and is also working very actively to create and sustain more regional local health units. Without a functioning county system, individual local boards of health exist at the city/town level (351).

//2008//

/2009/ The Department is moving forward to reestablishing a sixth regional office serving Southeastern Massachusetts and continues to work to create and sustain more regional local health units. Regional Offices now report through a new department level, Office of Local Health Services and the functions of Regional Managers and general regional support staff are being redefined and focused. //2009//

An attachment is included in this section.

D. Other MCH Capacity

As of June, 2005, approximately 257 persons (244 full-time equivalents) employed throughout the Department work on Title V programs; of these 152 (144 FTEs) are paid from Title V Partnership funds. The rest are paid from MCH-related accounts. Approximately 46 of the total are usually based in the MDPH regional offices or other off-site locations (such as physician practices); the others work out of our central office in downtown Boston. Due to the combined impact of state budget reductions on some of the Partnership programs, a round of Early Retirement incentives in FY04, and the transfer of CMSP and Healthy Start outside the Department, the number of staff paid with Title V Partnership funds, particularly those in regional offices, has been reduced over the past three years. It is expected to remain stable during FY06.

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

//2008/ As of June, 2007, approximately 266 full-time equivalent (FTEs) are employed throughout the Department work on Title V programs; of these 133 FTEs are paid from Title V Partnership funds (down from 144 FTEs in June 2005). The rest are paid from MCH-related accounts. Approximately 45 of the total are usually based in the MDPH regional offices or other off-site locations (such as physician practices); the others work out of our central office in downtown Boston. Due to the combined impacts of a substantial reduction in the MCH Block Grant allocation and the cumulative costs of union settlements, cost-of-living raises, and a 4% increase in the fringe benefit rate for FY07, the number of FTE staff paid directly by the MCH Block Grant has remained at 94 for FY08 (down from 107 in FY06), and they now represent approximately 35% of all FTEs and 70% of all Partnership FTEs (down from 44% and 75% in FY06). A higher percentage of staff working in MCH-related areas is being funded from either state or other federal grant sources. *//2008//*

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

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

19.)

Not counting short-term positions and service on task forces, the Bureau employs over 16 parents who represent approximately 12 full-time equivalent staff. /2008/ (The numbers have remained the same for FY07 and FY08.) //2008// **/2009/ The numbers are expected to remain the same for FY09. //2009//** Flexibility in both work hours and locations has enabled us to hire and retain this large group of committed and skilled people. Family TIES Coordinators work out of the regional offices and are the voices behind the statewide 1-800 number for families with children with special health care needs. More information on our extensive parent involvement initiatives is provided through our reporting on Performance Measures. The multiple types of roles that they carry out are also displayed visually in a Figure included in the Word document attached to this Section. The Figure is the last page of the document. /2008/ [More information on our extensive parent involvement initiatives is provided in Section II.B. above in our discussion of "Constructs of a Service System for CSYSHCN," as well as throughout our reporting on Performance Measures. The Figure displaying the various family roles has been updated for this application to reflect current roles and numbers and is again the last page of the Word document attached to this section. //2008//

/2008/ In scoring Form 13 for this application, families reported satisfaction with the opportunities for involvement and partnership. A caution was raised, however, to remind the state Title V program that although we are doing an excellent job of involving families there are always ways to do even more. We will continue to expand opportunities to engage an ever more diverse group of families. //2008//

/2008/ Another aspect of capacity is the availability of communication mechanisms that are broad in their reach and can be used quickly and flexibly to address public health initiatives or planning (e.g. pandemic planning). The School Health Unit (SHU) has established a community-based infrastructure to enhance communication of updated information to the school health programs and to facilitate implementation of major public health initiatives. The 102 ESHS grantees are required to have a School Nurse Leader freed from direct care responsibilities. When there is a major public health initiative (e.g., preschool vision screening, pandemic planning, review of 911 calls from the school), these Nurse Leaders are the first to pilot its implementation. In addition, post 911, the SHU established a pyramid communication system. The SHU Director compiles a weekly e-mail for school nurses and school physicians. She sends this to the 102 Nurse Leaders. They in turn send it to their 1200 school nurses, the nonpublic schools in their communities, and nurse contacts in 2-3 other designated communities for whom they are responsible. In this way updated information moves quickly to the 351 cities and towns. This system is used to communicate information on communicable disease outbreaks; updates from CDC, conference brochures from the hospitals, universities, and all DPH programs. In addition DPH programs provide ongoing information and resources to the SHU, and this is sent to the schools: injury prevention, substance abuse, suicide prevention, skin cancer prevention, healthy heart information, nutrition and physical activity, etc. More recently this system is used to provide information for the Department through brief questionnaires (e.g. compliance with preschool vision screening and numbers of AEDs in the schools). //2008//

/2009/ More information on our extensive parent involvement initiatives is provided in Section II.B. above in our discussion of "Constructs of a Service System for CYSHCN," as well as throughout our reporting on Performance Measures. The Figure displaying the various family roles has been updated for this application to reflect current roles and numbers and is again the last page of the Word document attached to this section. //2009//
/2009/ In scoring Form 13 for this application, families reported satisfaction with the opportunities for involvement and partnership. They particularly noted improvement (after several years of effort) in attracting more bi-lingual, bi-cultural parents to work with us, as a result of their working more closely with a variety of community-based organizations (CBOs). As always, they remind the state Title V program that although we are doing an excellent job of involving families there are always ways to do even more. We will continue to work with them to take up this challenge in FY09. //2009//

An attachment is included in this section.

E. State Agency Coordination

The BFCH views both intra-agency and interagency coordination as being essential to the achievement of its mission on behalf of improved maternal and child health. The Bureau maintains and promotes extensive networking and systems development relationships at the national, state, and local levels. These relationships include provider, non-profit, and other organizations; advocacy groups; coalitions, task forces, and community groups; other state agencies and governmental groups; universities and colleges; and internal MDPH working groups. Many of the activities carried out through these relationships are noted throughout the Annual Report and Annual Plan sections of this document as they related to specific performance measures or Title V priorities. The Bureau works with a broad base of constituency groups many of whom relate to specific populations or issues.

An extensive listing summarizing these relationships, categorizing them by type of agency/organization, is available in the Word document that is the Attachment to this Section. The following is a list of the major or key groups that the Bureau works with on MCH issues on a regular basis. See the attached file for details on relationships with public sector agencies, as well as a number of other private sector organizations and institutions. ***//2009/ The file has not been updated or attached for this application. It will be updated only periodically, as the bulk of the relationships do not change frequently. //2009//***

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

Collaboration with Medicaid

With the restructuring of Medicaid at the state level over the last two years, the Bureau has established partnerships with the Office of Medicaid, Office of Acute and Ambulatory Care, Office of Long-term Care, MassHealth Operations, and the MMIS and Enrollment and Eligibility Components. In every Division and throughout a significant portion of its programs, the Bureau works with one or more of the offices or components within EOHHS that are responsible for a

Medicaid activity. This continues to assure that there is a comprehensive and integrative approach in the outreach, enrollment and services provided to MassHealth, including CommonHealth, recipients. This includes involvement in waiver development, MMIS purchasing, enrollment functions and development of standards of care and quality initiatives. The Bureau strives to maximize Federal reimbursement mechanisms including FFP and municipal Medicaid opportunities.

/2007/ During the past year, the Office of Acute and Ambulatory Care has been realigned with the Office of Medicaid and Medicaid Behavioral Health has been transferred to the Department of Mental Health. Linkages and collaborations with the multiple Medicaid entities continue to be strong and regular. //2007//

/2008/ One new collaborative initiative worthy of note is the Massachusetts Special Commission on After School and Out of School Time. It is a legislative commission that is developing a comprehensive report on the need for these services, current programs, and a proposal for the Commonwealth to better address after school and extended learning needs. The Bureau of Family and Community Health is on the Commission and its three subcommittees. Release of the report is expected in early 2008. //2008//

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

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	2003	2004	2005	2006	2007
Annual Indicator	67.7	63.8	60.4	69.6	69.6
Numerator	2668	2525	2415	2699	
Denominator	393862	395662	400113	387863	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007

Hospitalization data for 2007 are not yet available from the Massachusetts Uniform Hospital Discharge Data System (UHDDS), Division of Health Care Finance and Policy. We have estimated the same rate as that for 2006. See 2006 for the most recent actual data and see the Note for 2006 for data sources and other comments.

Notes - 2006

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

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

Notes - 2005

Hospitalization data are from Massachusetts Uniform Hospital Discharge Data System (UHDDS), Division of Health Care Finance and Policy, 2005. The denominator is from the most recent 2005 population estimates for Massachusetts, as provided in MassCHIP. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere. The numerator includes hospitalizations where asthma was either the primary diagnosis or a contributing cause.

Narrative:

Asthma is a significant public health challenge in Massachusetts and an area where we continue to explore methods to collect and analyze data more effectively. The hospital discharge database remains in continuous change and improvement, with Observation Discharges and Emergency Room visits being added in recent years, but not for every data year. The multiple possibilities for capturing ICD codes at various levels (primary diagnosis, secondary, etc.) make these data more challenging to interpret over time than vital statistics. Our Asthma Planning grant is helping promote closer analyses. In addition, changes in medical care practice (and hospital/insurance policies) may create changes in where similar cases are recorded from year to year, making trend analysis complex.

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

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

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

/2009/Massachusetts is in the second year of the CDC asthma grant which includes children ages 0-4 among its four target populations, since they have the highest rates of hospitalization, observation stays, & ED visits of any age group. The goal of the grant,

being carried out in close collaboration with the broad-based Massachusetts Asthma Advocacy Partnership, is to reduce the asthma hospitalization rates by 9% or more from the 2002 baseline by 2009. Among the interventions and activities specifically addressed asthma in young children are: analyzing the Massachusetts BRFSS Child Call-Back Survey for asthma severity, environmental and home conditions, demonstration of asthma control, and knowledge of asthma management; expanding capacity to analyze Massachusetts Inpatient Hospital Discharge, Outpatient Observation Stay, and Emergency Department Discharge databases for asthma severity across the lifespan (including improving the quality of the data by de-duplicating the databases); education & training interventions to reduce exposures in homes and licensed childcare centers; and promoting the use of Child Asthma Action Plans by health care professionals, child care providers, and families.//2009//

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	2003	2004	2005	2006	2007
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	31577	29582	33012	36022	37126
Denominator	31577	29582	33012	36022	37126
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

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

Notes - 2006

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

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

Notes - 2005

Data Source: Massachusetts Division of Medical Assistance (state Medicaid agency), Medicaid Management Information System. Form HCFA 416: Annual EPSDT Participation Report for period October 1, 2004 to September 30, 2005.

Narrative:

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

Medicaid, receive comprehensive screening, assessment, and referrals.

The Title V program had been meeting with the state Medicaid (MassHealth) personnel and quality improvement staff from major MassHealth insurers on perinatal and early childhood indicators until recently, when the group was dissolved. Title V continues to meet with MassHealth personnel. Health insurance reform may be a factor over the next few years as more children and families become eligible for MassHealth. Title V will continue in discussion with MassHealth about periodic screening.

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

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	2003	2004	2005	2006	2007
Annual Indicator	NaN	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	0	1	1	1	1
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007

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

Notes - 2006

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

Notes - 2005

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

Narrative:

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

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

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	89.8	83.3	83.0	82.1	82.1
Numerator	71787	65178	63565	63568	
Denominator	79947	78232	76573	77391	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007

2007 birth data are not available. We have estimated the same rate as that for 2006. See 2006 for the most recent actual data and see the Note for 2006 for data sources and other comments.

Notes - 2006

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

Notes - 2005

Birth data are from MDPH, Vital Records for calendar year 2005 (the most recent year available). The Kotelchuck Index is calculated and reported routinely by the Department and is available in MassCHIP, which is the source for the 2005 data.

Narrative:

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

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

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

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

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

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

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

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

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	2003	2004	2005	2006	2007
Annual Indicator	93.7	93.3	93.6	96.7	97
Numerator	404918	407918	431448	457592	
Denominator	432202	437296	460826	473158	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007

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

Notes - 2006

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

uninsured through state surveys.

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

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

Notes - 2005

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

For FY05, the denominator is the sum of 431,448 children enrolled in MassHealth and an estimate of 29,378 children unenrolled eligibles under age 19. [This estimate is calculated by using the same methodology and values as for 2004 as neither updated uninsurance estimates for children nor population estimates for 0-19 are available for 2005.]

Narrative:

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

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

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

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

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

EIPP negotiated with 3 of 4 Massachusetts Managed Care Organizations (MCOs) to provide reimbursement for home visits and groups. MCOs have identified CPT codes and reimbursement rates for home visiting services to ensure that low-income women, and women living in communities with poorer birth outcomes are connected with healthcare providers early in pregnancy.

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

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	2003	2004	2005	2006	2007
Annual Indicator	46.0	48.9	50.3	51.9	56.4
Numerator	42802	43549	45318	49648	54817
Denominator	92976	89055	90075	95723	97160
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

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

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

Notes - 2006

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

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

Notes - 2005

Data Source: Massachusetts Division of Medical Assistance (state Medicaid agency), Medicaid Management Information System. Form HCFA 416: Annual EPSDT Participation Report for period October 1, 2004 to September 30, 2005.

The calculations used DMA changed in 2003, resulting in a new baseline level. Since then, there has been a modest increase each year in the percentage of children receiving preventive dental services.

Narrative:

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

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

See also NPM # 09 and SPM # 04 for additional information about activities related to the improvement of this HSCI. We work closely with Medicaid, dental professionals, schools, community-based health care providers, and advocates in a variety of ways to improve oral health services and preventive oral health measures (including fluoridation) for all children. Efforts include direct care and enabling services, population-based activities, and a great deal of infrastructure and capacity building. A focus in FY08 will be on the expansion of school-based services. These efforts will be enhanced through two competitively awarded HRSA/MCHB grants targeted at oral health workforce development and at improved systems for oral healthcare access for children.

/2009/We continue to have a SPM (#04) that specifically addresses this HSCI; see that SPM for more detailed information. A few highlights of progress this year and future plans are listed below:

The increase to the MassHealth reimbursement fee for dental sealants is resulting in more programs providing this service in school-based and school-linked preventive dental programs.

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

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

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

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	2003	2004	2005	2006	2007
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	16420	17270	18150	19129	20247
Denominator	16420	17270	18150	19129	20247
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

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

The data are from the Social Security Administration, Supplemental Security Record (Characteristic Extract Record format) and include children under age 16 and are for children receiving benefits as of December 2007.

Notes - 2006

All SSI beneficiaries in Massachusetts are automatically enrolled in Medicaid. The breadth of the Medicaid benefit package in the state leaves Title V with no residual responsibilities because "the

extent medical assistance for such services is not provided by Medicaid" is zero. To indicate the degree to which such services are available to the SSI population, the numerator is the same as the number of children on SSI.

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

Narrative:

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

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

See extensive discussions in Agency Capacity (Part III, Section B. of the Narrative) and under NPMs 2 -- 6 for details about the services and systems that are in place and in development to better meet the needs of SSI beneficiaries, along with all children with special health care needs. The Title V program works very closely with MassHealth (Medicaid), the Massachusetts Rehabilitation Commission, our other sister human services agencies, the Department of Education, health care providers, and a number of other organizations, as well as with parents and families to assure that these children and their families receive the services and supports to which they are entitled.

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

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

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

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2006	payment source from birth certificate	9.3	7.5	7.9

Notes - 2009

Birth data are from MDPH, Vital Records for calendar year 2006 (the most recent year available). 2007 birth data are not available.

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

Narrative:

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

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

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

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

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

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

INDICATOR #05	YEAR	DATA SOURCE	POPULATION
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Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2006	matching data files	6.8	3.8	4.8

Notes - 2009

Birth data are from MDPH, Vital Records, Births and Linked Birth / Infant Death files. Data are for 2006, the most recent year available. Note that the linked file for 2006 only includes 350 infant deaths, while there were a total of 369 infant deaths in 2006. The calculated rates shown here, therefore may differ from those published elsewhere.

Narrative:

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

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

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

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

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

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

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

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	payment source from birth certificate	70.9	85	81.5

Notes - 2009

Birth data are from MDPH, Vital Records for calendar year 2006 (the most recent year available). 2007 birth data are not available.

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

Narrative:

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

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

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

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

/2009/ Maternal risk factors such as substance use, domestic violence, and depression can affect both prenatal care utilization and perinatal outcomes; these risk factors are often overrepresented in Medicaid populations. In order to better address and reduce

these risks, the Women of Reproductive Age and Adolescents program model is funding 32 Community Health Centers (with both MCH and Substance Abuse funds) to provide alcohol and other drug screening, brief intervention, and referral to treatment (SBIRT) for women of childbearing age and adolescents. Staff at the Health Centers have been trained in using screening tools, providing brief interventions for those that were found to be positive, and in referring patients that needed treatment. The screening tool also screened for tobacco, domestic violence, and depression.

Again to better understand the nature of disparities in care and outcomes, BFHN ODT staff conducted a comprehensive evaluation of EIPP (a program serving very high risk women, many of them on Medicaid). EIPP data were linked with PELL data to conduct a population-based analysis comparing perinatal outcomes for EIPP participants with outcomes for a socio-demographically and geographically similar comparison group.

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

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 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	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])	2006	payment source from birth certificate	73.8	84.8	82.1

Notes - 2009

Birth data are from MDPH, Vital Records for calendar year 2006 (the most recent year available). 2007 birth data are not available.

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

The Kotelchuck Index is calculated and reported routinely by the Department and is available in MassCHIP, which is the source for the 2006 data.

Narrative:

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

level and in concert with local areas at particular risk.

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

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

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

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

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)	2007	200
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2007	300

Notes - 2009

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

Narrative:

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

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

Please see our State Overview (Part III, Section A.) for updated information about Medicaid and

other public insurance programs in the Commonwealth and the broader topic of Health Care Reform.

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

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

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

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2007	150
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2007	300

Notes - 2009

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

Narrative:

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

SCHIP has expanded by about 16,000 enrollees, including 9,300 who "convert" from the state Children's Medical Security Program and 7,000 previously uninsured children. SCHIP premiums for 200-250% FPL will be \$20/child; \$60/family maximum; for 250-300% FPL, \$28/child; \$84/family maximum. It is required that a child be uninsured for six months prior to coverage,

with certain exceptions such as special health needs, parent death, involuntary termination of prior coverage. The CMSP continues to provide preventive health coverage for children who are not eligible for MassHealth, with acute care covered through the uncompensated care pool.

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

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

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

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	2007	200
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women	2007	200

Notes - 2009

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

Narrative:

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

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

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

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	No
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> 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 - 2009

Narrative:

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

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

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

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

Linkage of births with Medicaid (including SCHIP, Healthy Start, and other programs) will require a longer timeframe. Given federal regulations, MassHealth may share identifiable data only to support MassHealth purposes. Therefore, discussions with MassHealth have focused on common purposes of the MCH and MassHealth programs. MDPH has been meeting with MassHealth about the value of linkage with births to inform a request for a Medicaid waiver. MassHealth has been very interested in related analysis from PELL longitudinally linked birth and hospital discharge data performed over the last two years of the SSDI project concerning interpregnancy intervals. Specifications for a new MassHealth information system include linkage with births as part of eligibility determination, and Title V is represented in systems planning. Absent change at the federal level, however, MCH access to these data will likely depend on a common purpose.

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

***/2009/ See Priority #4 in the Attachment to Section IV F for new data improvement projects. A few key efforts at improving the weaker areas of data linkages include:
-- PRAMS became fully operational and has already produced the first preliminary data for NPM # 15 ahead of schedule; it is our only source of population-based data for this measure.
-- Progress with linkages to WIC included the signing of a contract that formally provides funding from WIC to PELL and gives the programmers status as WIC consultants, easing access concerns.
-- MDPH legal staff assisted in negotiating a breakthrough regarding PELL linkage to special education data to better understand EI services and outcomes related to autism. The Department of Elementary and Secondary Education determined that MDPH is an educational agency for the purpose of providing EI services under the Federal Education Rights and Privacy Act.
-- MAPCP is exploring an Interagency Service Agreement with the data owners of MassHealth (Medicaid) claims data. Asthma-specific data, as identified by the needs of MAPCP and other key partners, would be analyzed by MassHealth staff and submitted to MAPCP. The MAPCP could examine asthma controller medication use/asthma control outcomes among children served by MassHealth. Use of pharmaceutical data would improve pediatric asthma surveillance in Massachusetts with the goal of increasing asthma self-management./2009/***

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

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
Youth Health Survey	3	Yes

Notes - 2009

Narrative:

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

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

- 22 Boards of Health Programs enforce youth access and secondhand smoke laws in 180 municipalities; they serve 4,568,085 residents.
- 5 Youth Access Prevention Programs (serving 93 municipalities) conduct compliance checks and provide tobacco retailer education, parent education and community education in municipalities without funded boards of health.
- A statewide youth tobacco prevention program includes 50 mini-grants, advisory group, youth summit and a short-film contest. (www.makesmokinghistory.org)

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

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

IV. Priorities, Performance and Program Activities

A. Background and Overview

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

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

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

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

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

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

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

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

//2009/ Status of Progress on Measures for FY07 Annual Report --

The status of Annual Performance Objectives for Massachusetts is summarized below. Similar summaries from our FY2007 and FY2008 Applications (for FY05 and FY06 performance respectively) have been omitted due to space constraints.

National Performance Measures (18 total):

10 Annual Performance Objectives Met or Exceeded (#01, 05, 06, 08, 09, 10, 11, 13, 14 and 16)

8 Annual Performance Objectives Not Met (# 02, 03, 04, 07, 12, 15, 17, and 18). Of these, the difference from the objective was within a margin of error in several cases (07, 12, and 17).

For one (#07 -- immunization rates), while we did not hit our target, the rate remains the second best in the country. Based on trend data, we have readjusted target objectives for future years as parental resistance to some immunizations (as opposed to lack of program outreach and service availability) is an increasing problem that affects overall results.

For #12 (newborn hearing screening), the actual rate of 98.7% (versus a previous target of 99.9%) is based on an improved data system that now allows us to get accurate unduplicated counts for both numerators and denominators -- and to have better data to estimate the percent of successful screens that is realistic. We have therefore adjusted our future projected targets, as about half of the unscreened births represent infants who die prior to discharge.

Three of the underperforming measures are those related to CSHCN with data from the National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006 conducted as part of NCHS/SLAITS. With the new data from the second survey, we have analyzed both the changes in the data being captured and the differences from our original estimates and have adjusted future targets to be both more realistic (given the new baseline) and yet challenging for us. [Note that the changes in the survey questions also produced some marked improvements above target objectives for measures # 05 and #06. See further discussion in the notes for each of these measures on the methodological issues and in the NPM sections for our plans to improve in these areas.]

State Negotiated Measures (9 total):

7 Annual Performance Objective Met or Exceeded (#02, 03, 04, 06, 07, 09, and 10)

2 Annual Performance Objective -- No new data for FY06: #1 (unplanned pregnancies; biannual survey not done in FY07) and #08 (child care consultants; survey put on hold pending new data system)

SPM #07 (Pediatric sexual assault nurse examiners) is being dropped for future years as its objectives will have been essentially met by the end of FY08. A new measure (SPM #11) is being added for FY09, related to implementation of a new regulation on informing new parents about shaken baby syndrome before hospital discharge. //2009//

B. State Priorities

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

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

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

/2007/ The placeholder has been replaced by a defined measure (SPM #08) with a revised Detail Sheet. //2007//

//2009/Please note that additional information on activities that address Priority Needs but that are not covered by NPMs or SPMs is provided in the annual Attachment to Part IV, Section F. For 2009, this attachment includes Priority Needs # 1, 2, 4, 6, 7, 8, 9, and 10. //2009//

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

//2009/Emphasis has increased on the adult "medical home" model to assure access to and use of primary care services.//2009//

Priority Need #2: Improve adolescent health through coordinated youth development and risk reduction.

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

Reducing risk behaviors and promoting youth development through all settings in which public

health programs come in contact with teens are a major priority of the Department and the Center. A new, multi-pronged approach is being embraced through a new state performance measure.

//2008/Our state performance measure (SPM #5) is being dropped. See Part IV, Section A above for further discussion of reasons.//2008//

Priority #3: Improve supports for the successful transition of youth with special health needs to adulthood.

Over 60,000 youth aged 14 to 17 in Massachusetts may need transition supports. Compared with other NSCSHCN-measured outcomes, transition stands out as problematic. Health professionals can play a critical role but nationally only 15% of respondents said their doctors provided guidance and support on transition. Massachusetts is in the same range, suggesting substantial room for improvement. The stakes for youth are substantial, given the relationships between disabilities, poor adult health, lower income, and other disparities.

The Massachusetts Consortium for CSHCN's Transition Task Force Background Brief summarizes needs, the current organization of services, strengths, and recommends next steps, noting the insufficiency and fragmentation of transition-related initiatives. Preparation for transition is complex because it is as varied and unique as the youth themselves. The adult health and human service system is ill equipped to "take on" young people with SHCN and lacks mandates. Pilot projects related to transition have taken place in MA and elsewhere and best practices are still being identified. A new 3-year MCHB grant will provide resources for a system-wide approach to the Priority Need.

//2009/A major priority for CYSHCN is the development of a comprehensive plan for successful transitions, building on experiences from the Moving Forward grant. Transition is a FY09 priority also for the EOHHS Undersecretary for Disabilities.//2009//

Priority Need #4: Integrate service systems and data, and use data to inform practice. BFCH has developed its capacity for electronic data collection and dissemination to a sophisticated level. To develop the most effective and properly targeted program services, time-sensitive, accurate information is essential. Much work still needs to be done to create truly comprehensive, timely, and flexible data systems and we continue with on-going innovation in this area.

Over the last several years, BFCH and MDPH began efforts to move to internet-based systems that would allow for the integration of data while assuring privacy for clients. More recently, EOHHS began a similar initiative and the MDPH and EOHHS efforts are now being fully integrated. The first stage of this system (known as the Virtual Gateway) began a year ago with the Information, Enrollment, and Referral component that uses a common application allowing an eligible individual to be enrolled in any state insurance program and referred to food stamps, child care, and WIC. Deployment of the more expansive DPH components -- including enrollment for other programs, service tracking, and electronic payments -- is expected to begin in January 2006. Other planned data initiatives include implementation of PRAMS, improved youth health surveys, and Center-wide use of logic models for programs.

//2007/ The initial deployment of a DPH ESM/EIM pilot began in April, 2006, with deployment to production currently scheduled for October, 2006. It is expected that rollout will continue throughout FY07 and will be complete for the majority of DPH, DMH, and DMR programs by July, 2007. Planning is now beginning to develop the linkage to Vital Records and the integration of existing surveillance systems such as birth defects and of new surveillance systems as they develop. Current plans call for data to move to a secure data warehouse at the Secretariat level. This will allow for cross-linkages with Medicaid, Food Stamps, etc. The warehouse is expected to be available in mid to late FY08. //2007//

//2008/Rollout for EIM continued throughout FY07. ESM was rolled out for SBHCs and substance abuse programs; rollout will continue to rollout for BFCH and other DPH bureaus throughout FY08. In addition, it is expected that Common Intake will be expanded to include public enrollment in late fall. EOS, the new WIC data system, will be pilot tested in FY08 and fully implemented by 7/1/08.//2008//

//2009/ Systems assessments are being completed for our birth defects surveillance

system, newborn hearing screening and other CSHCN programs for 2009 implementation. EOS will begin roll-out in late fall/early winter. Discussions are underway with the new Secretariat of Education to link EI and education special needs data initially in relation to autism.//2009//

Priority # 5: Increase capacity to promote healthy weight.

The rationale for addressing healthy weight as a Priority Need is self-evident. Massachusetts is very much a part of the national epidemic of overweight, obesity, unhealthy diets (low intake of fruits and vegetables), and inadequate levels of physical activity -- across the lifespan. The magnitude of the issue draws attention as do the potential health consequences, including diabetes, heart disease, and other chronic diseases, particularly with overweight starting early in life.

The Needs Assessment presents many statistics addressing the scope and seriousness issues related to healthy weight, including health disparities. Many programs and opportunities for intervention are in place, and policy/environmental interventions are also underway. They require ongoing support. The larger issue is system-wide capacity building, consistent messages, and approaches that continue to support local activities such as those articulated in our state plan. The roles of both health care settings and schools are particularly critical in promoting change. At the same time, improvements in key surveillance systems, could address major data and information gaps for the three priority MCH populations, allowing more timely and targeted interventions. A new, multi-pronged approach is being embraced through a new state performance measure.

/2009/Promoting healthy weight is a MDPH priority, with enhanced activities and new initiatives. A major area of focus is on employers, including promoting breastfeeding.//2009//

Priority Need # 6: Develop and implement initiatives that address violence against women, children, and youth.

The adverse physical and mental health outcomes associated with exposure to violence, as either victim, witness, or perpetrator, underscore the need to integrate violence prevention into the range of maternal and child health initiatives. Gender-based violence (domestic violence and sexual assault), are particular risks for the MCH population. Domestic violence occurs in at least 25% of families in the U.S., and one in three female trauma patients is a victim of abuse. Approximately 20% of female public high school students in Massachusetts report being physically and/or sexually hurt by a dating partner. Adolescent girls who experience dating violence are at risk for other health risk behaviors including substance use, high-risk sexual behavior and suicidality. Studies dating back to the early 1990s have correlated domestic and sexual violence with chronic pain, HIV infection, gastrointestinal disorders, delayed entry into prenatal care, unintended pregnancy, smoking during pregnancy, and more. An increasing body of literature is detailing serious consequences for children who live in homes where there is violence. Data from the Adverse Childhood Experiences (ACE) study is demonstrating links between child abuse, domestic violence and sexual abuse and range of negative health outcomes as adults, including smoking, alcohol and other drug use, suicide attempt, chronic obstructive pulmonary disease, diabetes, and more.

MCH programs and providers are in an excellent position to identify victims of violence and to refer to appropriate resources. Education about domestic and sexual violence can assist providers in addressing these issues as part of routine service provision and can insure their awareness of community resources to provide linkages for clients. MCH can also play a critical part in such infrastructure roles as data analysis, policy development, public awareness and education, and capacity building.

/2008/ A state plan has been developed related to youth violence and will be used as the basis for the development of a Youth Violence Initiative that has received \$2M in the FY08 state budget. //2008//

/2009/The Youth Violence state plan is being implemented with increased cross-program effects.//2009//

Priority # 7: Increase the integration of unintentional injury prevention into relevant MCH programs.

Injury is the leading cause of death and disability for children and adults, ages 1-44. Every day in Massachusetts approximately 7 people die, 129 are admitted to a hospital and 1,918 seek hospital emergency department treatment because of an injury. Massachusetts children aged 0 to 17 experienced 187,323 injury-related Emergency Department (ED) visits in 2003 and total charges for these visits exceeded \$122 million. Injuries were also responsible for over 4,030 hospitalizations among Massachusetts' children, costing over \$15 million. Among women aged 18-44 in Massachusetts, injuries were responsible for 148,135 ED visits and 5,052 in-patient hospitalizations costing a total of \$102 million and \$16 million respectively. Significantly for the MCH population, in Massachusetts from 1990-2003 injuries cause 1/3 of all pregnancy-associated deaths and one in 7 pregnant women experienced a "pregnancy-associated injury." Given that most injuries are highly preventable, these statistics underscore the need to intensify prevention efforts throughout the Commonwealth. Maternal and child health providers are in an excellent position to provide clients with injury prevention messages and strategies. Such messages can be routinely integrated into the work of providers with educational materials and appropriate referrals to resources. The recently developed DPH plan for injury prevention will help prioritize areas of unintentional injury and those strategies that have been proven most effective for prevention.

/2008/ The FY08 State Budget includes new funding for the Regional Poison Control Center and a Shaken Baby Syndrome Program that will be developed in collaboration with the Children's Trust Fund and the Department of Social Services. //2008//

/2009/The maternal mortality committee has developed a sub-committee to focus on both intentional and unintentional deaths.//2009//

Priority # 8: Improve oral health.

Improvements in prevention and access to oral health care are critical needs for children and youth. Access to care for children covered through MassHealth continues to be a problem due to declining numbers of Medicaid-participating dentists. The state is currently considering an increase in rates and allowing dentists to limit the number of Medicaid recipients seen in order to increase participation rate. The availability of other safety net providers providing care to low income uninsured children is being developed primarily through community health centers. Children with special health care needs, particularly the large number covered by MassHealth, have even more restricted access to care. A major concern is the lack of access for adults, especially pregnant women, since Medicaid eliminated all but emergency dental care for adults. Medicaid is involved in a class action suit related to access.

Prevention services such as fluoride mouthrinse programs for children in non-fluoridated communities and sealants are not available statewide, although they are growing. Fluoridation efforts in several communities continue to face major challenges from anti-fluoridation groups.

/2007/As the result of class action lawsuit, major efforts are currently underway to redesign how services are delivered and to provide improved access.//2007//

/2008/The state has increased rates for children's dental services and is allowing dentists to limit Medicaid recipients. Adult dental services were reinstated in June, 2006 but rates had not been increased. The expanded Joint Committee on Dental Remediation is developing implementation plans for expanding services related to fluoride varnish, childcare/Head Start programs, school programs, and guidelines/standards for portable oral health programs.//2008//

Priority Need # 9: Develop and implement public health programs, policies, and collaborations that promote positive mental health.

Across many diverse BFCH programs, mental health needs among the MCH population and a lack of mental health service capacity have been identified as critical issues.

Over the past several years a Governor's Commission has been meeting to identify the major issues, barriers, and gaps in services and to develop a plan for addressing the complex issues related to providing access to services and decreasing the number of children who remain stuck in residential services or hospitals due to lack of resources. It is expected that the recommendations will be finalized by September 2005.

The Medicaid Behavioral Health Program was transferred to the Department of Mental Health (DMH) in 2004. Recognizing the need to develop a more accessible and responsive system, including services for children and youth, the DMH is just completing a strategic plan. The Title V program will be working with DMH to continue to identify joint areas of focus and how public health programs can support and enhance mental health services.

/2007/ This transfer was completed in 2006 with both entities now co-located and jointly purchasing services from the same third party -- the Massachusetts Behavioral Health Partnership. Discussions continue as to whether or not the mental health carve-out will remain or whether Medicaid Mental Health will be integrated into the Medicaid medical component. The Governor's Commission was transferred to the Department of Mental Health in the summer of 2005 and now operates as part of an advisory committee. DPH and Title V continue to be active in multiple groups to improve access and will be involved in the implementation of the Class Action Lawsuit Remediation Plan. //2007//

/2008/The Commonwealth's plan for the Rosie D. lawsuit remediation has been accepted; a court monitor and implementation monitor have been hired. Title V staff are involved in working on the components related to early childhood and school services. SBHC mental health pilot projects will continue and may be increased. Suicide prevention efforts will be expanded due to additional state funds available in FY08.//2008//

/2009/Title V is active in the interagency workgroup that is revamping the system for children with mental health problems and their families, including universal screening, intensive case management and increased services for children with significant mental health problems.//2009//

Priority Need # 10: Reduce health disparities.

/2009/This had been a Center-wide priority since the 2005 Needs Assessment. With 2008 organizational changes, Title V has included it as an MCH priority to highlight this focus.//2009//

An attachment is included in this section.

C. National Performance Measures

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	124	100	131	102	115
Denominator	124	100	131	102	115
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
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

Notes - 2007

Data on Newborn Screening from the New England Newborn Screening Program (NENSP) at the University of Massachusetts Medical School. The data are for Calendar Year 2007. The NENSP provides all these newborn screening services and furnishes these data. See Form 06 and its

Notes also. Massachusetts screens every newborn for ten disorders: Phenylketonuria (PKU), Congenital Hypothyroidism (primary), Galactosemia, Hemoglobin Disorders (including sickle cell anemia), "Maple Syrup" Urine Disease (MSUD), Homocystinuria, Congenital Toxoplasmosis, Congenital Adrenal Hyperplasia, Biotinidase Deficiency, and Medium-chain acyl Co-A dehydrogenase deficiency (MCAD).

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

Notes - 2006

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

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

a. Last Year's Accomplishments

See also NPM #12.

Two approaches were (and are) used to assure that all babies born in MA had blood specimens collected for newborn screening.

--A statewide check made by NENSP staff using a series of data set algorithms comparing electronic birth certificate data with specimens received, finding babies over 2 weeks old with no specimens and following up to receive specimens.

--Provider-focused checks. Electronic files are submitted to the NENSP from a selected hospital NICU, Community Health Center, and pediatric practices with data on all babies either in their nursery or being seen in their pediatric practice. These files are electronically matched to specimens received: non-matched babies are reported back to get specimens

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

NENSP participated in national discussions relating to newborn screening for severe combined immunodeficiency (SCID), convened the first MA local SCID workgroup, and began to develop technical capacity to offer screening if the State determines it to be appropriate.

NENSP began using more sophisticated algorithms for various blood marker concentrations, ratios, and compound indices were implemented to improve communications with PCPs and specialists and focus specialist resources.

The NENSP began determining identified infants' continuing access to care long-term by requesting patient census data from each of the CF and Hb clinics to monitor the amount of clinic transfer and loss to follow up.

The NENSP performed geographic analysis of positive screenings that need referral to a treatment center for diagnostic evaluation. These data were provided to the state and various tertiary care centers.

NENSP studies assessed incorporating primary succinylacetone screening into testing to improve screening for tyrosinemia.

Through the New England Regional Newborn Screening and Genetics Collaboration (NERC) grant, began intensive in-state long term follow-up (LTFU) planning along with a regional component to coordinate data on affected infants across New England, including work on an interstate data-sharing agreement.

DPH named the Director of the Newborn Hearing Screening Program as liaison to the NENSP to ensure families are connected to DPH services and to participate in NENSP planning and annual meetings. Included was a new collaboration to improve handling of CMV-infected newborns, with particular focus on hearing loss. The Director also participated in NERC, NERC's LTFU workgroup, New England Public Health Genetics Educational Collaborative, and New England Regional Genetics Group (NERGG).

Table 4a, National Performance Measures Summary Sheet

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

including workshops, phone consultation and distribution of printed materials for mandated and optional screenings.				
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b. Current Activities

See Summary Sheet above and NPM #12.

Under leadership of the Title V Director, the DPH Newborn Screening Advisory Committee evaluated the 19 pilot conditions and cystic fibrosis and voted to recommend that screening become mandatory for all but 1 of the current pilot conditions and that certain conditions identified as byproducts of screening for listed conditions be reported to physicians (including 1 current pilot condition). New pilots were also recommended.

Begin dissemination of DPH materials about its special health needs programs through NENSP.

Newborn Hearing Screening Director and NENSP continue collaborations and regional meetings. For LTFU workgroup, meet with state public health privacy officers to determine legalities of data sharing.

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

The NENSP will begin offering primary succinylacetone screening, expand use of compound blood marker indices, further develop SCID screening capabilities and explore CMV and LSD screening feasibilities, continue geographic distributions, enhance its disaster preparedness through agreements with other competent newborn screening programs, update its website to better serve the medical community, and incorporate the above-noted newborn screening brochure into prenatal distribution packets at hospitals not distributing an existing lengthier brochure.

c. Plan for the Coming Year

See also NPM #12. Continue ongoing activities.

The process to amend current regulations to move screenings from pilot to mandatory status and add new pilots will begin July 2008. It will require public hearings and the approval of the DPH Public Health Council. The Title V Director will continue to provide leadership for this process, working with the DPH Newborn Screening Advisory Committee, DPH Legal Office, Public Health Council, NENSP, Director of the UNHSP and others. Implementation is expected early in 2009. To be discussed are recommendations for mandated screening of 30 conditions, pilot screening of 6 conditions (including one current pilot), identification of 22 potential conditions as byproducts of the mandated screening and 2 as byproducts of pilot screening, plus potential carrier status for mandatory or pilot conditions. (The 30 potential mandated screenings include the current 10, 17 of the 19 pilots, and "byproducts" that the Committee recommended be listed as mandated conditions.) The Newborn Screening Advisory Committee will review the current blood spot collection testing process in early fall to ensure that it is timely, efficient and effective in the provision of results.

New revised parent education materials will be developed to reflect the changes in pilot and mandated testing.

The newborn metabolic testing and Title V programs will explore enhanced efforts to assure coordination and linkage so as to assure families and children receive the services they need.

With LTFU workgroup, begin development of a charter agreement for use by all of the New

England states.

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	2003	2004	2005	2006	2007
Annual Performance Objective	64.4	65	70	70	72
Annual Indicator	64.4	64.4	57.1	57.1	57.1
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	59	60	61	63	65

Notes - 2007

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

Notes - 2006

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

Notes - 2005

UPDATED.

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

a. Last Year's Accomplishments

See NPMs #3, 4, 5, 6, and 12.

Family members participated on all DPECSHN advisory committees, receiving stipends and mentoring. They evaluated skill building activities' and participation opportunities' spillover assistance in other areas of their lives.

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

Over 750 parents attended the Family TIES co-sponsored statewide parent/professional conference and 90 parents gave feedback to a survey asking about unmet and under met public health needs. Families reported that they needed more information about resources, support during crisis periods and help navigating the system of services offered by DPH and other state agencies.

The Early Intervention Parent Leadership Project (EIPLP) received 267 calls on its toll free line, 378 calls to project staff, 6,782 website hits and distributed 6 editions of its newsletter to over 3,066 parents and professionals.

Of families with children enrolled in EI surveyed, 85.9% reported that EI helped family help their children develop and learn, 71.6% reported that EI helped the family effectively communicate their child's needs, and 74.9% reported that EI helped the family know their rights

Family TIES offered in-person training and outreach to 4,000 families and professionals, with 104 participating Spanish speakers. The Parent-to-Parent program matched 60 parents for peer support, including 1 Mandarin- and 12 Spanish-speaking parents.

Family Initiatives (FI) collaborated with the MA Chapter of Family Voices, which is the grantee for the Family to Family Health and Information Center, to provide training and support to new and emerging family leaders at the annual "Joining Voices" conference.

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

As scheduled in school year 06-07 (1/3 of districts per year), 35 Essential School Health Services (ESHS) school districts, averaging about 215 identified CYSHCN per 1,000 students, participated in a parent satisfaction survey; 1663 surveys were returned (42% response rate). Parents rated satisfaction from 90% to 96% on the 6 satisfaction questions. Written comments indicated that children could not attend school without care from the school nurse and that health information nurses sent parents was valuable. Results went to superintendents and nurse leaders.

MDPH-funded SBHCs, which serve many CSHCN, are asked to conduct periodic Patient Satisfaction Surveys to assess efficacy, identify deficiencies, and to utilize feedback in program development. In 2007, 39% of SBHCs reported completing patient surveys. Most sites set a goal of surveying a minimum of 10% of registered students from each SBHC. All sites reported positive survey results (i.e., most students surveyed found SBHC care excellent/good and/or would recommend the SBHC to a friend).

Ten Family and Professional Partners Institute (FPPI) partnerships continued from FY06 into FY07 including with Eritrean, Chinese and Haitian CBOs. Partnerships are evaluated and adjustments to FPPI made as a result. FPPI made adjustments based on evaluation, convened an Advisory Board to identify new directions and resource, and facilitated partner networking activities.

Care coordinators developed a parent advisory group with practice staff and, in Springfield, with Bay State Children's Hospital, a Medical Home Parent Resource Center.

UNHSP Parent Specialist co-chaired national committee to develop educational materials for families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Division for Perinatal, Early Childhood and Special Health Needs (DPECSHN) and its Family Initiatives (FI) Director provide leadership for DPECSHN, BFHN, and other state agency programs to enhance and extend consumer and family participation.				X
2. Increase diversity of family participants, in particular through two FI programs: Family TIES and Early Intervention Parent Leadership Projects (EIPLP).				X
3. Hire family members and consumers as paid staff/consultants to the state CYSHCN programs.				X
4. Support parents' active participation in advisory groups, including EI, Universal Newborn Hearing Screening, Family and Professional Partners Institute (FPPI, to FY09), MassCARE and New England Regional Genetics Group (NERGG).				X
5. In collaboration with Family Voices, the Director of Family Initiatives presents information about the MCH Block to family leaders and obtains family input through multiple avenues.				X
6. Provide parent support and training, including stipends, and collaborate with the Federation for CSN, NE SERVE and Consortium to develop parent participation and leadership. Offer parents opportunities to participate in all Family Initiatives.				X
7. Through the Care Coordination Program for CSHCN, increase opportunities in pediatric practices for parent-professional partnering, including development of parent advisory groups and other systems for family participation.				X
8. Require parent participation in School Health Advisory Committees in Essential School Health Services (ESHS) program sites.				X
9. DPECSHN updates, posts on the web and distributes, a resource and recordkeeping tool, "Directions: Resources for Your Child's Care" to families of CYSHCN and providers, in English, Spanish and Portuguese.				X
10. Survey families and youth accessing DPH-funded services and supports, including Community Support, Family TIES, School Based Health Centers, Essential School Health Services, EI, and MASSTART to assess satisfaction and impact.				X

b. Current Activities

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

Review NS-CSHCN 2005-2006 results, including component questions of the composite measure, responses by subgroups, comparisons to 2001 results, to assess changes and strategies to improve results (DPECSHN, data staff) and participate in NICHQ Improving the System of Care for CYSHN project related to all CSHCN NPMs.

FI works with national Family Voices and MA Family to Family Health and Information Center to collect data and support families to take on multiple roles across the health care system.

Develop action plan re family involvement and satisfaction (DPECSHN working group). The Family Initiatives Director and Family TIES recruited 60 Family Advisors; participated in

statewide EP task force and training opportunities.

Participate in UNHSP Advisory Board, the Institute for Community Inclusion Board, MA UCEDD, MA Developmental Disabilities Council, and interagency groups supporting CSHCN emergency preparedness (EP) and oral health. (FI Director)

Expand outreach to under-served populations and adapt training and mentoring activities to ensure cultural competence. Identify an additional 12 CBOs and initiate collaborations. (Family TIES)

Fully implement Part C EI Family Survey.

Evaluate the FPPI, prepare journal article, expand and strengthen networking resources for all partners and research/seek on-going funding. (MFT/New England SERVE)

Include strong parent participation focus in CSHN chapter of School Health Manual.

c. Plan for the Coming Year

See Summary Sheet and NPMs #3, 4, 5, 6, and 12. Continue ongoing activities.

Expand opportunities for family involvement within community-based pediatric practices. Work with the EI program to develop training for families on transition from EI, understanding the IFSP, and team collaboration. Restructure EIPLP to increase training capacity and revise/expand impact evaluation of EIPLP to ensure a mechanism to capture effectiveness and longevity of services.

Checklists and explanations of key times in transition planning developed through Moving Forward Together (MFT) will be made available to families.

Partnerships with CBOs will continue with support from Institute and DPH.

Increase opportunities for family advisors to take part in the 2010 needs assessment process.

Work with family organizations and the BU School of Public Health to develop training plan and potential for family professionals.

Continue ESHS client satisfaction survey cycle (one-third of districts annually).

Deepen FY08 CYSHN planning activities and begin plan implementation, dovetailing activities with participation in the broad NICHQ "Improving the System of Care for CYSHCN" initiative. This initiative and Massachusetts' planning focuses on all CSHCN NPMs as part of a project related to enhancing Title V strategic leadership activities towards improving the overall system of care for CYSHCN.

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

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	2003	2004	2005	2006	2007
Annual Performance Objective	61	65	65	65	67
Annual Indicator	61	61	45.7	45.7	45.7
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	47	49	51	53	53

Notes - 2007

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

Notes - 2006

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

Notes - 2005

UPDATED.

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

a. Last Year's Accomplishments

Care coordinators for CSHCN, located in 13 pediatric primary care practices across the state, help physicians provide family-centered care, develop care plans and establish office systems to improve quality of care. They developed tools for identifying and referral of CSHCN; helped families optimize insurance coverage, access public benefits, find parent to parent support, and become better advocates; attend school meetings; assist with transition. Care coordinators also participated in programs to train pediatric residents about medical home and services for CSHCN.

Care coordinators for CSHCN provided care coordination services to 1045 families of CYSHCN statewide in FY07.

School nurses (ESHS) arranged 142,738 primary care appointments for students during the school year including 5.8% involving referrals for students who did not yet have providers.

The School Health Unit (SHU) issued "Guidelines for the Provision of Basic School Health Services" to school districts and educational collaboratives promoting standards of care including coordination across these settings for CYSHCN. Nurses from collaboratives are included in SHU's professional development activities. MASSTART presented at all orientations for new

school nurses (235 nurses).

The MA School Nurse Research Network (MASNRN), including the SHU, pilot determined that doing peak flows in the schools on children with asthma and sending this information to their physicians increased the number of asthma action plans. The study was published in the Journal of School Nursing and is being expanded.

MASNRN, with the Infectious Disease Control Director and 40 schools, studied school nurse interventions to increase the number of CYSHCN receiving--from their PCPs--immunizations needed due to their conditions, other than those required on entry.

Through the HRSA-funded Moving Forward Together (MFT) grant's CSHCN Medical Education Project, 25 residents and 28 faculty at each of MA's 5 pediatric residency programs for CSHCN Medical Education were interviewed and analysis begun.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

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

Eleven practices have Care Coordinators for CSHCN including, after a competitive RFR, 9 new ones. Coordinators have transitioned out of most practices funded prior to the FY08 RFR to new ones, but they continue to provide these practices with offsite technical assistance and serve their families, as necessary. Three highly successful practices identified funding and hired independent Care Coordinators after the Program left.

The CSHCN Director is a member of the Consortium Steering Committee and other staff are active in Medical Home and Community-Based Systems of Care work groups.

EIPP has formal linkages with medical providers and hospitals for continuity of care.

MASNRN is piloting student use of asthma diaries, using handhelds, in schools transmitted directly to the PCP and developing a study related to life-threatening allergies.

SBHC staff conducted 10 site visits (7 high schools, 1 middle, and 2 elementary) to review medical charts and individualized care plans for CSHCN.

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

Analysis of MFT interviews and curriculum will be completed. Based on the data analysis, recommendations will be developed with the Consortium Medical Home Work Group and the MCAAP COD to enhance future provider capacity for providing medical homes to CSHCN.

c. Plan for the Coming Year

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

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

BFHN will participate with EOHHS and MassHealth in developing a state plan and policy for implementing the medical home concept for all age groups.

Convene a small expert advisory group to review current status of pediatric medical home in Massachusetts and develop a plan for moving forward.

Information from MFT CSHCN Medical Education Project will be shared with pediatric and medical education leaders in the state. DPECSHN will consider and investigate the level of support for a meeting of pediatric leaders in the state, including directors of pediatrics in the state's major children's medical centers, directors of graduate medical education in pediatrics, and leaders of the state chapters of the AAP and AAFP. DPECSHN will use Project findings and recommendations as a starting point for discussion and identification of areas for collaboration between medical education and public health at this meeting and/or other venues in order to promote medical home implementation and family-centered care.

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

A training meeting will be held for former and new (Care Coordination Program) medical home

practice providers to share successes, best practices and strategies for integrating and sustaining the model.

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

The School Health Unit and the MASN RN will improve and expand the above study efforts and work to improve care with educational collaboratives.

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	2003	2004	2005	2006	2007
Annual Performance Objective	65	65	65	70	70
Annual Indicator	65.1	65.1	63.1	63.1	63.1
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	64	65	66	68	70

Notes - 2007

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

Notes - 2006

UPDATED.

Data are from the National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006 conducted as part of NCHS/SLAITS. The 95% Confidence Intervals (CI) for the 2005-2006 and 2001 survey, from which the earlier data come, overlap (2005-2006 CI: 59.0-67.2; 2001 CI: 60.1-70.1). The overlap suggests that the figures do not differ statistically (change may be due to random survey variation). Massachusetts is also comparable to the nation. The national figure is 62.0 (CI: 61.2-62.8) for 2005-2006, and the comparable national figure for earlier years is 59.6 (CI: 58.7-60.5).

Notes - 2005

UPDATED.

Data are from the National Survey of Children with Special Health Care Needs (NS-CSHCN), 2005-2006 conducted as part of NCHS/SLAITS. The 95% Confidence Intervals (CI) for the 2005-2006 and 2001 survey, from which the earlier data come, overlap (2005-2006 CI: 59.0-67.2; 2001 CI: 60.1-70.1). The overlap suggests that the figures do not differ statistically (change may be due to random survey variation). Massachusetts is also comparable to the nation. The national figure is 62.0 (CI: 61.2-62.8) for 2005-2006, and the comparable national figure for earlier years is 59.6 (CI: 58.7-60.5).

a. Last Year's Accomplishments

See also NPMs #1 and 13.

The SSI/Public Benefits Program provided 18 training programs to 295 participants statewide of which 27% were parents. Others trained included community health providers, nurses, Early Intervention staff, case managers, pediatricians, graduate students/fellows, occupational and physical therapists and child state agency staff. Most technical assistance calls related to SSI/Public Benefits were answered beginning in FY06 by the Community Support 800#. Nevertheless, the Public Benefits specialist responded to 99 calls for technical assistance, 35% of which were from parents.

By phone or email, the Community Support 800# responded to 1,870 technical assistance requests. Community Support staff sent mailings to the families upon request with information and applications for public insurance programs.

The CICRF provided approximately \$1.2 million in financial assistance to 139 families of CSHCN with extraordinarily high out-of-pocket medical or related expenses in relation to family income (expenses exceed 10% of family income). As a payor of last resort, CICRF assisted families with payment for needed items and services not covered by insurance, including home and vehicle modifications. CICRF also negotiated with insurers or located alternate resources for additional families, obviating the need for CICRF funding and assisting families who did not meet the 10% of income requirement.

During FY07, 82 uninsured or underinsured clients received special foods assistance through PKU Special Medical Foods Program.

DPH Care Coordinators assisted 399 families through the Flexible Family Support Fund to reimburse costs of goods and services. Eligible expenses relate to raising a child with special health care needs. These expenses tend not to be medical in nature and are therefore not covered by regular health insurance.

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

Massachusetts Health Reform legislation passed in FY06 included provision of \$800,000 to create a Pediatric Palliative Care program, covering services to children with life-limiting illnesses and their families not otherwise covered by insurance. The legislation passed late in the fiscal year and specified that the funding could be used in FY07. The Pediatric Palliative Care Network contracted with 10 hospices for the first time in FY07 to provide palliative care services statewide. Unlike public benefits for hospice care, the pediatric palliative care funding does not require that treatment toward a cure be suspended, that the child have a 6-month prognosis, or that child no longer receive care by his/her current medical caregivers. DPH developed standards of care in collaboration with experts and the Hospice & Palliative Care Federation of Massachusetts. During the project's approximately 5 months of operation, 128 children were referred, 80 children served (and others referred to appropriate services). An additional 205 members of the families of these children (parents, siblings, and others) also received services.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

See also Summary Sheet and NPMs #1 and 13.

SSI and Public Benefits Outreach, Care Coordination, EI, EIPP, school health and school-based health centers, FOR Families, Pediatric Palliative Care and community health center based programs are key venues for health insurance access for CSHCN.

The CICRF Commission is discussing possible changes to the CICRF statute to permit 1) staffing that would enable service to more families and 2) use of the CICRF dollars to address certain systemic unmet needs related to CSHCN.

DPH, in collaboration with the MCAAP and the Consortium, will mail to all 1800 members of the MCAAP the newly published "Making the Case for Coverage: Tips for Helping Children and Families Get the Benefits They Need from Their Health Plans." This guide for clinicians and advocates was developed by the Consortium and NE SERVE as part of a HRSA-funded MFT grant.

The Title V Director participates as a member of the EOHHS Children's Behavioral Health Initiative (CBHI) Steering Committee and Implementation Team to provide increase coverage for behavioral health services.

c. Plan for the Coming Year

See also NPMs #1 and 13. Continue ongoing activities.

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

If funding allows, CICRF will undertake an expanded outreach campaign in FY09, in order to increase awareness of the Fund as a resource for families with extraordinary medical and related expenses uncovered by any other private or public source.

Participate in EOHHS Children's Behavioral Health Initiative (CBHI) to promote increased coverage for developmental and behavioral services by all insurers.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	79	80	80	81	81
Annual Indicator	79	79	87.6	87.6	87.6
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	87.6	89.2	89.2	90	90

Notes - 2007

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

Notes - 2006

UPDATED.

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

Notes - 2005

UPDATED.

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

a. Last Year's Accomplishments

See also NPMs #1, 2, 3, 4, 6, and 12.

DPECSHN's centralized Community Resource Program fielded information and referral calls, providing 800# service to 1,870 callers in FY07. The 800# staff helps families determine and connect with appropriate and available DPH and community-based services.

Family TIES received 1850 calls, had a total of 7500 contacts with families and professionals and 483,000 hits on its website. Staff distributed 7500 brochures in English, Spanish and Portuguese, 1950 Resource Directories and tip sheets on topics like autism, mental health, and medical home.

School nurses reported to ESHS providing CYSHCN substantial services at school, including, per month, about 76,680 scheduled (vs. on an "as need" basis) doses of medication and 64,000 SHN-related treatments (highest being blood glucose testing delivered at a rate of 5.6 procedures per month per 100 students). These figures underestimate services, especially for asthma, for which nurses gave nearly 11,000 "as needed" doses per month of prescription medications. For FY07, ESHS schools reported over 5.38 million student-nurse encounters and about 21% of students as CYSHCN. The ESHS evaluation committee extended the study of health room service utilization, including services to CYSHCN, and two software companies now offer programs for schools to provide aggregate utilization data to the Department.

Of children discharged in FY07 from EI, 41.5% were referred by EI to special education services.

The new Pediatric Palliative Care Network (PPCN) developed and printed outreach materials with consumer and provider input for statewide distribution. Providers began local outreach activities. Providers and staff at the Community Resource Program 800# received training and began fielding calls, with the 800# serving as a resource statewide to direct families to the provider serving their area.

The Program Planning Committee of the EI ICC, including DPH EI and FI leaders, worked with

the Department of Early Education and Care (EEC) to update a guide for parents and providers called "Best Practices to Transition." The guide assists families of children to plan for, take early steps towards and make a smoother transition to school from EI. Each EI program and school district received a copy, providers are encouraged to distribute it to parents, and it is available online.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All DPECSHN programs support families to more easily access resources, develop external collaborations for this purpose, and assess barriers in conjunction with consumers, parents, and providers. Telephonic interpreters and TTY are available.		X		X
2. FI programs (Family TIES and EIPLP) provide information, support families and partner with community-based services and health care organizations to improve access.		X		X
3. The Community Resource Program provides I&R and technical assistance to families and providers using its 800# and, through this centralized service, coordinates access to multiple CYSHCN programs for CYSHCN and their families.		X		X
4. DPH Care Coordinators are based in several large pediatric primary care practices across the state with additional Care Coordinators in regional offices serving CYSHCN who are outside the designated practices.		X		X
5. Disseminate printed and electronic resources (e.g., Family TIES directory, Directions) and increase resources in multiple languages (e.g., Spanish and Portuguese sections of directory and 2 articles in Spanish in each issue of the EIPP newsletter).		X		X
6. Technical assistance to families and schools, in particular through MASSTART, allows medically complex CYSHCN to attend public school.				X
7. DPECSHN staff participates actively in the MA Consortium for CSHCN and its Steering Committee, Massachusetts AAP, community-based coalitions, and other forums to encourage ease of access.				X
8. MassCARE offers a community-based system of care for infants, children, and adolescents with HIV and their families to enable families to access care from local providers and not only major pediatric hospitals.		X		X
9. FI and other DPECSHN programs conduct periodic focus groups and surveys to gather current information from parents about barriers and facilitators of access.				X
10. DPH Care Coordinators facilitate regional trainings on benefits and services for CYSHCN for parents and providers.				X

b. Current Activities

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

Through MFT, DPH continues to fund and collaborate in on-going activities of the FPPI. The Institute offers families of CSHCN opportunities to partner with health care institutions to improve ease of access. Family TIES and EIPLP staff provide training and mentoring for FPPI family

partners.

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

The PPCN printed and distributed its outreach materials in Spanish and Portuguese; also marketed the program to pediatrician offices, PICU and NICU at major hospitals, VNAs, and through Oncology Grand Rounds, Commission for the Blind, and palliative care program at Children's Hospital.

Family TIES produced the 11th edition of Family TIES resource directory. Recruit 60 Family Advisors. Participate in statewide EP task force and training opportunities.

Family Initiatives works with New England SERVE and the Consortium to identify, mentor and support diverse families to take on roles within the health care system and support health care organizations to infuse principles of family-centered care including ease of access throughout their programs. DPECSHN collaborates with the Consortium's Community Based Systems working group to improve access and engage families as partners.

c. Plan for the Coming Year

See also NPMs #1, 2, 3, 4, 6, and 12. Continue ongoing activities.

DPECSHN will strengthen existing linkages among all programs for CYSHCN in order to improve each of each family's receiving referral to needed services from any point of entry into the system.

Expand and implement mechanisms to seek family input into access issues.

Explore new, creative mechanisms to facilitate access including, "Help Me Grow."

Add two Pediatric Palliative Care providers in southeastern MA. In part, this is to increase access to volunteer services; management of and travel for volunteers are difficult over a large service area. Based on positive feedback and results in FY08, increase availability of complementary therapies (e.g. reiki, massage, music, art therapy and pet therapy) for children, siblings and families through Pediatric Palliative Care. Offer training to providers regarding qualifying diagnoses.

Work in collaboration with other child serving EOHHS agencies to create a One Child, One Family plan. Initial focus will be for children with serious emotional disorders.

It is anticipated that call volume on the Community Support 800# will continue to increase. The program will expand the linkage of public benefits training and resource staff to area hospitals and community-based providers. Resource specialists will enhance capacity in their individual areas of specialization, including mental health and transition to adulthood.

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

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	2003	2004	2005	2006	2007
Annual Performance Objective	5.8	10	10	10	15
Annual Indicator	5.8	5.8	46.6	46.6	46.6
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	46.6	47	48	49	50

Notes - 2007

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

Notes - 2006

UPDATED.

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

Notes - 2005

UPDATED.

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

a. Last Year's Accomplishments

See also NPMs #2, 3, 4, and 5.

Hired a designated Transition Coordinator .8 FTE to raise visibility and coordinate health transition policy and program development within DPH and with agencies external to DPH.

Two trainings on youth transition for parents and providers were provided by Community Support

Program staff.

As part of the MFT state implementation grant, DPH initiated a contract with the MA Consortium for CSHCN, which conducted 8 focus groups of youth and parents of YSHCN. Focus group findings helped drive the content of a training curriculum on youth transition for care coordinators/case managers and parent professionals. The Consortium convened 2 Transition Training Advisory Group meetings, also to help drive content and format of the statewide trainings.

As part of MFT, DPH established a Young Adult Advisory Council (YAAC) via a contract with Partners for Youth with Disabilities. The YAAC, comprised of 24 young adults with SHCN, has two "branches," one in western and one in eastern MA, ensuring geographic diversity. Each group met 3 times.

Information related to transition aged youth was included in Public Benefits trainings.

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

Ensured health transition was part of the agenda of the 5th Youth Leadership Forum (YLF) for high school juniors and seniors with disabilities in April 2006. Thirty youth with disabilities and special health care needs attended YLF, which was sponsored by the Governor's Commission on Employment of People with Disabilities, Harvard University and Partners for Youth with Disabilities, and co-sponsored by DPH.

All 14 youth with developmental disabilities participating in the overweight/obesity control program with the Greater Lawrence Family Health Center lost weight, averaging 5.7 pounds per participant.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Coordinator of Youth Transition Initiatives promotes the concept of "health transition" and DPH as a focal point for health transition.				X
2. Build external linkages and collaborations with agencies and organizations serving youth, including youth with special health care needs, to ensure health-related transition issues are incorporated into other transition planning efforts.				X
3. Include focus on youth with disabilities and chronic conditions in DPH youth initiatives, e.g. school-based health centers, violence prevention, tobacco, health promotion, suicide prevention and healthy weight.				X
4. Young Adult Advisory Council (YAAC), which meets 5-6 times/year, provides input into services and programs for CSHCN and addresses issues related to transition. YAAC members speak at Transition Trainings and other events.				X
5. As part of HRSA-funded Moving Forward Together grant, contract with MA Consortium for CSHCN to develop and implement transition training for care coordinators, case managers and parent-professionals, with emphasis on health.				X

6. Multiple DPH staff participates in MA Consortium for CSHCN's Transition Work Group, which also serves as advisory group for MFT transition training above.				X
7. DPH Care Coordinators work with parents, youth and other agencies to promote smooth health transition, including transition to adult medical care, and maximize youth autonomy in relation to self-management of health.		X		X
8. SSI/Public Benefits Coordinator and Community Support Program staff provide resources, technical assistance and training for agencies serving transition-age youth.		X		X
9. DPH Care Coordinators, Family Initiatives staff, and Community Support Program staff offer formal and informal training and technical assistance on transition to families and providers (English and Spanish).				X
10. School-Based Health Center (SBHC) programs for teens with chronic health problems and Essential School Health Services (ESHS) nurses foster responsibility and self-care and promote transition activities.		X		

b. Current Activities

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

The Care Coordination Transition Workgroup developed guiding principles, a timeline, assessment tool, materials to aid youth and families to work more effectively with their health providers, and flowcharts defining care coordinators' roles within the transition process for enrolled youth ages 14-22.

The Healthy Aging/Health and Disability Unit (HAH DU) worked with NPAU to include an indicator in the Planet Health (Healthy Choices) curriculum pre- and post- workshop trainings for middle school teachers, to identify teachers who work with youth with disabilities. HAH DU is currently assembling resources for the training packet for these teachers.

The Healthy Lifestyles Workgroup is identifying potential project activities such as training conferences, searching for funding sources, and content for health promotion guidelines related to nutrition and physical activity for youth and adults with developmental disabilities.

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

The 6th YLF was held in March.

YAAC is completing an awareness/educational video for health care providers and policymakers.

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

c. Plan for the Coming Year

See also NPMs #2, 3, 4, and 5. Continue ongoing activities.

Coordinator of Youth Transition Initiatives will conduct interviews and/or group meetings with parents, advocates and others, to collect information on successful strategies for incorporating health transition and goals related to self-management of health into students' IEPs. Information gathered will be compiled into materials that can be widely distributed to families.

Coordinator of Youth Transition Initiatives will collaborate with the DPH Director of Violence Prevention to develop a Request for Response for an anti-bullying prevention intervention to prevent bullying violence against youth with disabilities in selected MA high schools

The Healthy Lifestyles Workgroup will develop nutrition and physical activity guidelines for youth with developmental disabilities.

HAH DU in collaboration with NPAU will identify how to expand existing DPH Healthy Choices program to youth with disabilities and to increase the number of teachers working with youth with disabilities participating in the Healthy Choices Program.

The YAAC will distribute and promote its video, "We Are Able: Perspectives of Transitioning Young Adults with Disabilities." The video will be shown at at least one conference in FY09; copies will be distributed and available via the web site; and YAAC members will be available for speaking engagements along with video viewings.

MASNRN will develop and implement a study to assess ways of improving the self administration of epinephrine for youth with life-threatening allergies, specifically the need to carry the epinephrine at all times.

For all 47 SBHCs, efforts will be made to develop partnerships and augment access to community-based resources for youth with special health care needs.

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

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

The SAPSS program, in conjunction with the OHD, DPEC SHN, and OAHYD, will develop and implement a healthy sexuality education needs and resource assessment for children and youth with physical, cognitive, sensory and mental health disabilities. The assessment will include the culture of youth communication methods, and will retain a youth empowerment focus promoting long-range development of leadership and culturing points of view for subsequent generations.

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	2003	2004	2005	2006	2007
Annual Performance Objective	80	83	88.1	91.3	90
Annual Indicator	88	86.5	91.3	89.2	88.3
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	89	90	91	91	91

Notes - 2007

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

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

Notes - 2006

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

Although our fully immunized rate dropped slightly in 2006, Massachusetts continues to have the highest rate in the country.

Notes - 2005

Fully immunized corresponds to the CDC definition of 4:3:1:3:3 (4 or more doses of DTP, 3 or more of poliovirus, 1 or more of any MMR 3 or more of Hib, and 3 or more of HepB) by age 2 (24 months). [Note that definition of measure in Detail Sheet differs from the label on the measure which suggests immunization status among children 19-35 months of age. Data are from the National Immunization Survey, as reported by the CDC at <http://www.cdc.gov/nip/coverage/default.htm>; Table 09. All historic annual data have been revised to reflect NIP rates. Because the percentage rates are generated by the NIP from surveys, no numerators and denominators are presented in Form 11. Data are reported on a calendar year basis.

The 2005 survey results were posted in September, 2006, and this table has been updated to reflect them. Massachusetts has the highest rate in the country for 2005.

a. Last Year's Accomplishments

In the 2006 National Immunization Survey (reported 2007), Massachusetts had the highest immunization rate (89.2%) in the country for children 19-35 months of age for the 4:3:1:3:3 series. The rate was lower than our 2005 Survey estimate of 91.3% but not statistically different. Massachusetts also ranked #1 in the nation for 4:3:1:3 series (90.7% compared to the national average of 82.2%) and for the 4:3:1:3:3:1 series (85.5% compared to the national average of 76.1%).

According to the same 2006 Survey, Massachusetts WIC-enrolled children ages 19 to 35 months also lead the country, with 91% fully immunized with the 4-3-1-3 series.

The BCHAP Division of Primary Care and Health Access houses the MCH Immunization Program (MCH IP) and contracts with 32 primary care comprehensive provider agencies serving women and their families (typically community health centers). The MCH IP works closely with the Massachusetts Immunization Program (MIP) based in DPH's Bureau of Communicable Disease Control. During FY07, MCH IP and MIP conducted immunization assessments at 28 contracted sites, with MCH IP conducting 20 of these assessments alone due to decreased staffing at MIP. Of the sites assessed, 14 had failed their assessment in FY06 and 2 had failed for the last 6 years. MCH IP collaborated with the MCAAP to update providers and nurses at the 2 sites. As a result, both sites passed their FY07 immunization assessments. Six other sites also improved and passed their FY07 immunization assessment, a direct result of materials and technical assistance to sites as well as immunization education for family home visitors in community based organizations at the local level.

The annual Immunization In-Services, sponsored by the MCH IP in collaboration with the MIP, provided immunization education for outreach workers, contracted community health center staff, and Bureau program staff in 4 regions during Fall 2006. The MCH IP added another location after discussion with MIP because in past years staff in southeastern Massachusetts have had difficulty attending. A total of 184 individuals attended, with 110 nurses receiving CEU certificates and 310 packets distributed. Providing CME/CEU's has increased attendance. Evaluation results indicate that participants were generally very satisfied with all aspects of the in-service program. Over 90% of participants either agreed or strongly agreed with most of the positive statements regarding the program.

MCH IP continues to collaborate with the immunization staff of the Boston Immunization Program to better coordinate assessments and follow-up activities for the 16 contracted sites located in Boston.

The MIP in collaboration with Wellness at DPH conducted an Employee Flu Clinic on Monday December 18, 2006. A total of 188 people were screened and 179 received Flu Vaccine.

New school nurses (235) attended the Introduction to School Nursing in Massachusetts, which includes an update on immunizations. The June 2007 Summer School Health Institute provided an update on immunizations to 224 school nurses.

The School Health Unit continued collaboration with the State Lab to implement a reporting system for school nurses to report break-through varicella. The revised meningococcal regulations were to circulated schools as supporting education materials.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All BFHN and BCHAP programs that serve families of infants and young children assess for health care access and the child's immunization status. Referrals and assistance are offered to families of children who are not fully immunized		X		X
2. All WIC children receive an immunization assessment at each WIC appointment until the primary series of shots has been completed.		X		
3. The MCH Immunization Program (MCH IP) promotes regular immunization assessments in all programs and compliance with				X

immunization schedules.				
4. BCHAP MCH IP staff work closely with the Massachusetts Immunization Program (MIP) in DPH's Bureau of Communicable Disease to ensure contracted providers have regularly updated information.				X
5. EI Partnership Programs and FOR Families, serving high-risk families, promote well-child care, including immunizations; coordination and facilitates immunization knowledge and tracking.		X		
6. EI programs provide information on immunization to all families and refer when indicated.		X		X
7. Child care providers provide information on immunization to all families and refer when indicated.				X
8. MCH IP staff meets routinely with Community Health Services Program managers to coordinate a plan to address failed immunization assessments during the previous year.				X
9. Immunization-related information is forwarded to the BFHN and BCHAP staff working with family-serving programs and/or children in the community and to contracted health centers and program sites, including services for CSHCN.				X
10. Most CHCs have bilingual staff and all have access to interpreters as part of practicing cultural competence when providing outreach and health education. Immunization Vaccine Information Statements (VIS) are available in many different languages.		X		

b. Current Activities

See Summary Sheet for NPM 7.

WIC continues the Bring a Book, Get a Book campaign to encourage parents/caregivers to bring updated immunization records to WIC appointments and receive a children's book.

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

The SHU is working with the Division of Immunization Preventable Diseases to revise the school entry regulations to include (a) second varicella, (b) inclusion of the Tdap.

Developing plan for administration of universal flu vaccine for children.

c. Plan for the Coming Year

Continue ongoing and current activities.

Develop plan to monitor possible changes in immunization rates based on parental refusal.

When the new WIC MIS is in production, it will interface with the state's "Immunization Wizard" to provide immunization recommendations as part of WIC immunization assessments.

One goal for the future will be to ensure that all contracted sites have an immunization tracking system that has the capacity to identify those clients who are overdue for immunizations. The

future implementation of the Massachusetts Immunization registry will make the process of tracking immunizations easier and more cost effective for the sites. Pediatric practitioners at Community Health Centers must also implement quality improvement recommendations from MIP, collaborate with the local WIC program in planning mechanisms for same day immunizations, and implement the most up-to-date "Recommended Childhood Immunization Schedule".

Finalize and implement plan for administration of universal flu vaccine for children.

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	2003	2004	2005	2006	2007
Annual Performance Objective	15	14	12	11.5	11
Annual Indicator	12.2	11.8	11.5	10.4	10.5
Numerator	1473	1454	1440	1379	
Denominator	120889	122847	125294	132803	
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
	2008	2009	2010	2011	2012
Annual Performance Objective	10.5	10.5	10.5	10	9.5

Notes - 2007

2007 birth data are not available. We have estimated the same rate to that for 2006. See 2006 for the most recent actual data and see the Note for 2006 for data sources and other comments.

Notes - 2006

Birth data are from MDPH, Vital Records for calendar year 2006. This is the most recent year of data available.

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

Notes - 2005

Birth data are from MDPH, Vital Records for calendar year 2005. This is the most recent year of data available.

The denominator is from the most recent 2005 population estimates for Massachusetts, as provided in MassCHIP. The number of female teens ages 15-17 is roughly estimated at 60% of the standard 5-year age group 15-19.

a. Last Year's Accomplishments

With the addition of new funds from Health Care Reform, a total of 18 evidence-based teen pregnancy prevention programs were funded in high teen birth rate communities. All programs implement curriculum and provide referrals and additional services to youth and their families. Services continue to be evaluated through the cross-site evaluation managed by John Snow Inc.

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

Family Planning (FP) funding decreased by 6.56% initially with \$83,000 restored later in the year as a result of cost savings from the RFR described below. This funding change resulted in a slight decrease in adolescents (13-19) served statewide (15,576 in FY 06 to 14,141 in FY07).

The English language "Choosing a Birth Control Method" brochure was translated into Spanish and Portuguese. The Spanish and Portuguese versions were reviewed by family planning providers and focus grouped by women in the target audience to ensure cultural competency and accuracy of translation. The brochures were made available online at www.maclearinghouse.com.

To implement Emergency Contraception (EC) legislation, the Family Planning Program, in collaboration with the Massachusetts EC Network, Sexual Assault Prevention and Survivor Services Program and SANE program issued an RFR based on earmarked language to procure "a statewide hotline and other efforts to implement Chapter 91 of the Acts of 2005", the Act Providing Timely Access to Emergency Contraception, which was enacted in December 2005. The contract was awarded in April 2007 to the AIDS Action Committee and an environmental scan was initiated. The initial focus of the hotline and website was Emergency Contraception but as a result of the environmental scan and focus groups with teens, the focus was expanded to Sexual Health. The initial target population will be adolescents with the goal of providing accurate health information and referrals to family planning and related services.

In FY07, 27.0% of female clients aged 15 through 17 years who had at least one visit to the SBHC were identified to be at risk for STD/pregnancy. Of those clients, 89.45% had a follow up plan (i.e., received risk reduction counseling), as appropriate.

19.47% of clients aged 15-17 years who had at least one visit to the SBHC had a pregnancy test at least once during FY07.

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

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

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

The SBHC, CSHP and the STD Bureau collaborated with The Medical Foundation and ESE to

develop, launch and promote a teen-targeted website, URHealthstyle.com to promote STI screening and sexual health services among urban, high-risk, sexually active adolescents. Outreach to school nurses, school based health centers, and other youth providers combined with a transit ad campaign and street marketing outreach resulted in over 20,000 hits to the website by May 07.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

See also SPM 1.

An increase in state funding has allowed all 18 science-based programs to develop and begin implementing services to DSS youth, parents and providers.

The OAHYD collaborates with the DSS to develop trainings for foster parents and DSS workers to have conversations with young people around adolescent sexual health issues, and on a curriculum model to address teen pregnancy with DSS-involved adolescent males of color.

The OAHYD sponsored the first Connecting for Change Youth Summit in December. Over 500 youth obtained information about healthy decisions, sexual health, pregnancy and other public health topics. Youth led workshops that increased their skills to address community public health issues.

The state declined the federal abstinence funds for abstinence-only programming.

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

Development of sexual health website, hotline, volunteer training, and additional EC materials for adolescents.

The DPH Medical Director and staff have been providing information to support investigation of a recently publicized increase in teen pregnancies in Gloucester.

c. Plan for the Coming Year

See also SPM #1 Continue ongoing activities.

The OAHYD will continue to work with the Department of Social Services to offer statewide trainings in the Not Me Not Now curriculum to foster parents and DSS staff to increase their capacity to have discussion with young people on healthy relationships and adolescent sexual health topics.

Continue implementation of the Statewide Sexual Health Hotline and Website. The Maria Talks Statewide Hotline and Website will be implemented which will increase access to information and referrals for EC, family planning and related services. Monitoring and evaluation of services will begin.

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

Family Planning program will continue with implementation of EC legislation, including development of materials specific for consumers including adolescents, the monitoring of hospital compliance with services to sexual assault survivors and the pharmacy access program. Pharmacist and interns will continue to be on staff in FY09. EC educational materials and information will continue to be distributed to adolescent service providers in collaboration with the MA EC Network.

The FY09 Northeastern University School Health Institute Summer Institute will include additional programming on reproductive health, family planning, emergency contraception, etc.

The SBHC program will collaborate with the Family Planning program to conduct a needs assessment in response to provider concerns regarding barriers to contraceptives in the school

setting. A subsequent meeting will be held for clinicians to systematically address the findings of the assessment. During this clinical training, the SBHC program will host AIDS Action Committee to promote the launch of www.mariatalks.com.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	60	60	62.2	61	63
Annual Indicator	58	62.2	59.4	64.6	66.2
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	66.5	67	69	70	71

Notes - 2007

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

Notes - 2006

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

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

Notes - 2005

The data for 2005 are taken from the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS). A children's dental health module, containing this and other questions, was introduced in the 2001 Survey and is now being carried out every year. Prior to 2001, our only data on the use of sealants have been based on school-based surveys in only a few communities. Such surveys, on larger samples of schools, will also be continued as possible in order to help validate the BRFSS findings.

Despite the slight fluctuations in the survey reported rates between 58 and 62%, the data can be considered as showing an essentially flat rate. The survey rates within various socioeconomic categories show consistently higher rates of sealants as parental education levels rise: 51.7% (C.I. 36.8% – 66.5%) with less than high school education compared with 65.3 % (C.I. 59.8% – 70.9%) with 4+ years of college. The rates are also consistently higher as family income rises: 43.4 % (C.I. 33.5% – 53.3%) at under \$25,000 compared with 64.5 % (C.I. 59.4% – 69.6%) at over \$50,000). However, the gaps between income levels and education levels continue to decrease.

a. Last Year's Accomplishments

See also SPM #4 and Priority Need #8.

In 2003 the Office of Oral Health (OOH) did a statewide oral health assessment of 3rd graders and found that 54% had at least one dental sealant, noting that children on MassHealth (Medicaid) had limited access to preventive oral health procedures in comparison to those children with private dental insurance. In 2007, another statewide assessment of 3rd graders was conducted by an outside agency. The results of the assessment revealed an 8% decrease in the number of 3rd graders with at least one dental sealant compared to 2003. The assessment also noted that disparities exist among ethnicities, income levels and a child's access to regular dental care.

The state also measures the number of 6-17 year olds with at least one dental sealant using the annual BRFSS. According to 2007 data, 62% of children reported on had at least one dental sealant. Although this demonstrates an essentially flat rate compared to the 2006 BRFSS, though survey rates within various socioeconomic categories show consistently higher rates of sealants as parent education levels rise.

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

Due to increases in the MassHealth dental program in 2006, the reimbursement fee for dental sealants was increased and thus the number of programs providing this service in school-based and school-linked preventive dental programs has increased.

Historically, school-based and school-linked dental programs have served children who would not otherwise receive these services in a private practice. Third grade children covered by MassHealth and CMSP, as well as others with no insurance at all, are increasingly able to access preventive dental procedures such as sealants through these mobile and portable programs. In FY 2007, 14.2% of MassHealth eligible children (age 5-21) received dental sealants.

The OOH received a HRSA Workforce Grant in the fall of 2006. This grant allows the OOH to expand school-based sealant programs, targeting not only 2nd and 3rd graders, but 7th graders (HP 2010 21-8(b)). As a result, in January of 2007, the OOH collaborated with the Mount Wachusett Community College dental hygiene program and the Fitchburg Community Health Center (as the referral source for restorative needs) to implement an oral health prevention program (Fitchburg SEAL) beginning at one Fitchburg Middle School. With 68% of the consent forms returned and of that more than 50% participating (n=53), 447 dental sealants were placed.

Following up FY06 recommendations to school nurses for working with mobile or portable dental programs, a letter was sent to school nurses including care and safety considerations prior to forming a memorandum of agreement with a mobile or portable unit. Recommendations for revisions of the Board of Dentistry regulations on mobile dentists as they apply to schools were sent to the Board of Dentistry by the SHU.

The FY07 ESHS data tracks the percentage of districts and numbers of children screened by the school nurse, screened by the dentists/hygienists, third grade screenings, dental sealants, fluoride rinses, referrals to the dental provider.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MassHealth, CMSP and most other 3rd party payor dental benefits include protective sealants for children.	X			
2. Outreach and improved reimbursement rates for the MassHealth/CMSP dental provider network using the state's Third Party Administrator, Doral Dental.				X
3. The Office of Oral Health (OOH) provides leadership to improve oral health status with a focus on children and preventive services.				X
4. OOH conducts surveillance of 3rd grade children's oral health status, including sealants and provides technical assistance to schools, community programs and community health centers interested in developing sealant programs.			X	X
5. School-based preventive (sealant) programs are statewide, including all public elementary schools in Boston. OOH also provides direct service delivery of dental sealants in state-funded SBHCs.	X			X
6. The OOH collaborates with ESHS and school nurses re programs and services and provides oral health training to school nurses in ESHS-funded districts; the revised school health manual includes an oral health chapter.				X
7. Dental services provided in community health centers and other contracted primary care sites. The OOH collaborates with many CHC dental programs to develop sustainability within programs and access to restorative treatment.	X			
8. Specialist oral health consultant promotes preventive dentistry services for CSHCN.	X		X	X
9. Expansion of school-based programs to 7th graders to measure against Healthy People 2010 Objective 21-8(b).	X			
10. Weekly school fluoride mouthrinse program serves approximately 50, 000 children annually.	X			

b. Current Activities

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

Fitchburg SEAL continued in school year 2007-2008 with a slight increase in participation among the students. The Program was primarily funded through sustained funding from Year 1. The OOH implemented the CDC's SEAL data collection tool and will be determining the effectiveness of the Fitchburg SEAL program, as well as looking at retention rates.

In 2007-2008, the Office developed a collaboration with the Chicopee Board of Health and the Caring Health Center to implement a preventive (sealant) program in that community for 7th graders. The CHC is assisting with follow-up/restorative care, as well as sustainability.

The SHU is distributing the Comprehensive School Health Manual with chapter on oral health and continuing to provide guidance to schools regarding mobile dental clinics.

c. Plan for the Coming Year

See also SPM #4 and Priority Need #8. Current activities continue.

In FY 2009 (September 2008) the OOH will be expanding its school-based sealant programs serving both elementary and middle school children to high school students. In the fall of 2007, the OOH received an MCHB grant to implement programs in the 47 state-funded school-based health center schools.

The OOH will be working with MassHealth to develop a statewide oral health prevention plan to increase the number of underserved and unserved children receiving preventive services in school settings.

ESHS's new service procurement will continue to require districts to have a plan for oral health services including oral health status assessment, provision of dental sealants with referral of restorative/follow-up needs, and school-based fluoride rinse programs in communities with non-fluoridated water.

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	2003	2004	2005	2006	2007
Annual Performance Objective	1.2	1.2	1.2	1.2	1.2
Annual Indicator	1.2	1.2	1.3	1.2	1.2
Numerator	15	15	16	14	
Denominator	1229471	1222774	1214584	1202482	
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
	2008	2009	2010	2011	2012
Annual Performance Objective	1.2	1.2	1.2	1.2	1.2

Notes - 2007

2007 death data are not available. We have estimated the same rate to that for 2006. See 2006 for the most recent actual data and see the Note for 2006 for data sources and other comments.

Notes - 2006

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

estimates for the age group for the same years. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere. The denominator is from the most recent population estimates for Massachusetts, as provided by the MDPH Bureau of Health Information, Statistics, Research and Evaluation.

Notes - 2005

Data on deaths are taken from MDPH Vital Records for calendar years 2003 - 2005. This is the most recent year of data available. Rates are calculated as rolling 3-year averages. (I.e. the 2005 numerator is the sum of the 2003, 2004, and 2005 numbers of deaths (19, 19, and 10 respectively and the denominator is the sum of the most recent Massachusetts population estimates for the age group for the same years. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere.

The 2005 denominator estimate is from the most recent 2005 population estimates for Massachusetts, as provided in MassCHIP.

a. Last Year's Accomplishments

The Injury Prevention and Control Program (IPCP) accomplishments included:

- One certified child passenger safety (CPS) Technician was on staff.
- Updated and developed new materials, including the Massachusetts Child Passenger Safety Resource Directory and the 2007 Massachusetts Injury Prevention Yellow Pages, with over 20 listings on occupant protection.
- Coordinated with WIC staff to send CPS materials to WIC participants.
- Staff provided technical support and educational materials for numerous safety seat checkpoints.
- IPCP staff answered hundreds of calls on the Car-Safe Line, averaging 30 callers per month. The hotline provides general passenger safety information to Massachusetts residents. Staff sends out materials as requested by the caller and refers to relevant partnering programs (WIC, School Health).
- Facilitated 3 Partnership for Passenger Safety meetings.
- Facilitated the creation of a new statewide coalition, Massachusetts Coalition for Adolescent Road Safety, which aims to reduce motor vehicle injury to adolescents ages 12-25.
- Coordinated activities and educational outreach during Child Passenger Safety Week, including displays and mailings for over 300 health and child care professionals.
- Coordinated with School Health staff to send out CPS materials to school nurses and administrators. Literature on safety issues is routinely disseminated through the weekly email to more than 1800 school nurses. Information and pamphlets on traumatic brain injury and the dangers of second impact health injury were also included.
- Coordinated with MassMoves staff to develop a presentation on healthy transportation and the built environment's effects on injury. The presentation has been shown to the regional planning boards throughout the state.
- Attended meetings and provided technical support to coalitions, such as the Greater Boston Safe Kids Coalition, Western Mass. Safe Kids Coalition, Injury Free Coalition for Kids of Boston, Injury Free Coalition for Kids of Worcester, and the SAFE Coalition.
- Planned 3 workshops for the Annual Moving Together Conference, the statewide bike/pedestrian conference.
- Collaborated with the Executive Office of Transportation to create the Massachusetts Strategic Highway Safety Plan, with chapters on vulnerable road users, bicyclists and pedestrians, and occupant protection.
- Worked closely with other state agencies, including the Highway Safety Division and MassRides to collaborate on CPS projects and materials
- Provided expertise on traffic and pedestrian safety to and collaborated with the MA Safe Routes to School Program to expand the statewide program.

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

SBHC standards recommend that all SBHC-enrolled enrolled students receive an annual risk and resiliency assessment that includes screening for seatbelt use. In FY07, SBHC clinicians began screening students, including those 14 years and younger who had at least one visit to the SBHC for "seatbelt non-use". Those students identified as "at-risk" were required to have a follow up plan that included risk reduction counseling and/or anticipatory guidance.

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

During the school year 2006-07, ESHS school nurses were able to assess and/or treat 91% of the on-campus injuries and illnesses brought to their attention and return students to class. Of students who had to be dismissed, 8.1% had been injured. For more serious injuries nurses filed injury state and local reports, including reports of 20,948 unintentional injuries, 3,304 intentional injuries and 4,338 injuries of unknown intent. In 2,071 of these events, 911 or ambulance services were called.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

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

- Partnered with the Injury Community Planning Group and the MA Coalition for Adolescent Road Safety to create educational and marketing campaign on risky teen occupant behaviors and received funding from EOPSS Highway Safety Division to implement Teen Driver Safety Program. IPCP is currently conducting focus groups with teens to begin developing messages. The program will strengthen compliance with the Junior Operator and Safety Belt Laws.
- Coordinated with the Injury Community Planning Group (now called Mass PINN, Prevent Injuries Now Network, and Partnership for Passenger Safety for Massachusetts adoption of a Booster Seat Bill for CPS.
- Help plan the Annual Moving Together Conference, with at least one presentation on the built environment and injury.
- Distribute Traumatic Brain Injury report to child care and health care professionals with recommendations to reduce the burden of traffic related traumatic brain injury.

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

c. Plan for the Coming Year

Continue ongoing activities.

The IPCP plans a number of targeted activities:

- Create new materials and incorporate message of appropriate use of child passenger safety seats into parenting materials, including WIC materials.
- Provide leadership to the MA Injury Prevention Community Group in planning a clinical symposium on passenger safety and emphasize high risk groups, including teen drivers.
- Work with Highway Safety Division and the MA State Police to expand the child passenger safety training program to recruit healthcare and childcare workers to become certified as CPS technicians. Encourage checkpoints at community health centers and hospitals.
- Participate in the development of action plans for each recommendation listed in the Massachusetts Highway Department's Strategic Highway Safety Plan.
- Begin implementation of the Teen Driver Safety Program; add School Health Unit participation.

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

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				40	45
Annual Indicator			38.8	42.1	42.1
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	42	43	44	45	46

Notes - 2007

Data Source: CDC National Immunization Survey data are not yet available for 2007 (for the 2005 birth cohort). We have estimated a similar rate to that for 2006. See the 2006 note for more information about the data source and changes to the survey questions that have affected trend analysis.

Based on the survey methodology changes and the resultant lowering of estimated rates, we have adjusted our projected annual rates significantly lower also, as we seem to be in line with the national averages.

The newly initiated Massachusetts PRAMS survey preliminary data indicates 81.7% of women initiating breastfeeding in 2007, and 61.7% still breastfeeding at 8 weeks. These data are based on internal MDPH weighting and will be weighted and finalized by CDC during FY08.

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

Notes - 2006

Data Source: CDC's 2006 National Immunization Survey. (http://www.cdc.gov/breastfeeding/data/NIS_data/2004/state.htm), from interviews conducted through December 2006. Because they are survey data, there are no numerator or denominator values. These data, the most recent available indicate, report breastfeeding rates for children born in 2004 (Hence the date on the reference source). The data indicate a rate of breastfeeding at 6 months of 42.1% (plus or minus 6.6%) and a rate of ever breastfeeding of 72.4% (plus or minus 6.6%). These compare with national average rates of 41.5% and 73.8%. The state rates for exclusive breastfeeding at 3 months and 6 months were 32.7% (+ or - 6.4) and 11.9% (+ or - 4.2) respectively; the comparable national rates were 30.5% and 11.3%. This pattern suggests that while Massachusetts may have slightly lower rates of ever breastfeeding, those that do breastfeed may continue breastfeeding, including exclusive breastfeeding, at slightly higher rates than national trends. However, differences between any of the Massachusetts rates and the national ones are statistically insignificant, with overlapping confidence intervals. The NIS survey data suggest a lower rate of initiating breastfeeding than the data from our 2004 birth certificate data on breastfeeding at hospital discharge of 77.3%. With this most recent survey, CDC has changed both the survey questions and the way it presents the data (by birth cohort). The result of the new questions (as discussed at length on the CDC website) is an overall drop in the estimated rates. Therefore, no trend analysis should be drawn between these rates and those cited for previous years. In addition, the CDC was continuing to interview this cohort through November, 2007 and the data for 2004 births will be updated and reported in August of 2008; thus the reported rate may change.

2006 Massachusetts PedNSS data about breastfeeding among WIC participants is available. The breastfeeding rate at 6 months was 26.2% in 2006, slightly up from 26.1% in 2005.

Notes - 2005

Our Data Source for this new NPM is from CDC's 2004 National Immunization. (http://www.cdc.gov/breastfeeding/data/NIS_data/2004/state.htm) These data indicate a rate of breastfeeding at 6 months of 38.8% plus or minus 5.3%. The same survey reports a Massachusetts rate of ever breastfeeding of 74.0% (plus or minus 5.1%), which is consistent with

our 2004 birth certificate data on breastfeeding at hospital discharge of 77.3% (the previous NPM).

Data from CY2003 and 2004 from the NIS show breastfeeding rates at 6 months of 38.6% and 38.8% respectively. Based on this, we have projected a modest continuing improvement in the rate. When PRAMS data become fully available in 2008, we will be in a better position to both project rates and identify strategies to improve them.

a. Last Year's Accomplishments

According to the 2006 CDC PedNSS Report, 26.2% of Massachusetts children under five were breastfed at least 6 months, compared to 25.2% nationally. This is an increase over the 2005 rates at 6 months of 25.1% in Massachusetts. PedNSS data largely consists of data from WIC participants.

Data from the 2005 CDC National Immunization Survey, which includes participants from a more diverse socioeconomic background, shows an increased percentage of infants breastfeeding at 6 months in Massachusetts (45.2%) and nationally (39.1%).

See notes above for 2005 - 2007 for additional information about the available survey data and changes to the survey questions that have affected trend analysis. Also note that surveys released in a particular year present data on cohorts of children born several years earlier (e.g. the "2006" Survey reports on children born in 2004). We are confused as to which data set to report for which MCH reporting year; the notes contain information on all surveys to date.

31 WIC Programs with nearly 100 peer counselors with many having multiple years of service were funded for the 'Mother to Mother' Breastfeeding Peer Counselor Program, including the addition of 4 programs. The peer counseling program continued to be significantly strengthened and enhanced with the addition of federal "Loving Support" funds.

WIC offered biannual "Breastfeeding Basics" training and annual "Beyond Breastfeeding Basics" training to WIC nutrition staff and other interested staff of related programs. WIC offers Certified Lactation Counseling (CLC) to interested staff annually; 50 staff were trained.

All local WIC programs celebrated World Breastfeeding Week by distributing literature to medical providers regarding WIC breastfeeding services. Fifteen programs offered community-wide breastfeeding celebrations and activities during August to increase awareness and promotion of breastfeeding.

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

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

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

In FY07, of the 559 EIPP Participants who received an initial comprehensive health assessment, 3% (down from 17.8% in FY06) were found to have a low level of strength and an additional 36% (up from 17.5% in FY06) were found to have a moderate level of strength in the area of breastfeeding.

Also in FY07, while 48% (down from 67% in FY06) of all EIPP Participants were breastfeeding at birth and 40% were still breastfeeding at 2 weeks, only 8% continued to breastfeed at six months post partum. Barriers for mothers continuing to breastfeed include domestic violence, depression,

easy access to infant formula, lack of support at place of employment or school, mothers being prescribed psychotropic medications, and breast-related problems.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Multi-faceted approaches are used to reach health care professionals, parents/extended family, and general public.		X	X	X
2. Breastfeeding Coordinator provides active leadership to promote breastfeeding statewide.				X
3. Guidelines for Promoting and Supporting Breastfeeding are updated and promoted through all hospital maternity units and EIPP.		X	X	X
4. Nutrition Division routinely produces and disseminates educational materials to promote breastfeeding in WIC and primary care programs and provides regular trainings for primary care and WIC professional and paraprofessional providers.		X	X	X
5. Local WIC programs actively encourage and counsel all women on breastfeeding benefits, provide manual pumps, offer classes and support groups in multiple languages, establish goals re breastfeeding initiation rates for women enrolled prenatally.		X		
6. Breastfeeding peer counseling services are provided in many local WIC programs.		X		X
7. DPH is an active collaborator in the Massachusetts Breastfeeding Coalition.				X
8. EIPP provides intensive breastfeeding support and coordinates with WIC to improve initiation and duration rates through its services and referrals to advanced lactation support, and EIPP collects and manages related data to inform program development		X		X
9. The annual Partners in Perinatal Health Conference provides updated information supportive of breastfeeding to Massachusetts perinatal providers.				X
10. Through PNSS, PedNSS, other WIC resources, PRAMS, and EIPP, Massachusetts collects, evaluates and disseminates data related to breastfeeding initiation, duration and exclusivity.				X

b. Current Activities

See Key Activities for NPM 11.

The Guidelines for Breastfeeding Initiation and Support, updated by the Nutrition Division and endorsed by Massachusetts chapters or sections of AGOG, AAP, ACNM (Nurse Midwives) and AWHONN (Obstetric and Neonatal Nursing), are being distributed to all nurse managers at birth hospitals. Linkages are made to MBC for training all hospital staff.

DPH distributes the MA Breastfeeding Resource Guide to health professionals.

All WIC nutrition staff and other interested staff of related programs receive training.

Local WIC programs will celebrate World Breastfeeding Week, offering community-wide celebrations to increase awareness and support of breastfeeding.

CPCP and WIC staff coordinate to provide timely referrals and high-quality, unduplicated services to pregnant and postpartum women. Introduction of breastfeeding at the first prenatal visit is a performance measure for CPCP programs. CPCP offers breastfeeding instruction after the 32nd week of pregnancy.

WIC programs collaborate with physicians to support breastfeeding.

WIC participates in the USDA "Loving Support for Breastfeeding Peer Counseling" project, providing peer counseling services. Currently 31 local programs offer peer counseling services.

The number of local WIC programs offering peer counseling increased from 28 to 31.

BFHN and HCQ staff conduct hospital perinatal licensure visits and review hospitals' breastfeeding policies to assure compliance with regulations.

c. Plan for the Coming Year

Continue ongoing activities.

The Bureau of Family Health and Nutrition will promote its newly revised Guidelines for Breastfeeding Initiation and Support through the presentation of awards to hospitals with outstanding breastfeeding achievements and through ongoing collaboration with the Massachusetts Breastfeeding Coalition.

The Nutrition Division will distribute copies of the prenatal breastfeeding brochure *You've Got What It Takes* in an effort to improve early breastfeeding success and enhance collaboration between hospitals and community-based programs such as WIC's Mother-to-Mother Breastfeeding Peer Counselor Program.

WIC and Primary Care will collaborate with the EIPP to ensure participants have access to breastfeeding promotion, education and support prenatally and throughout the breastfeeding experience.

Four more WIC programs will offer peer counselor services, to bring the total with such services to 34 out of 35 local WIC programs.

WIC programs will focus on improving communication and collaboration with community physicians to promote and support breastfeeding among Massachusetts families and to ease the transition to the new WIC food package.

DPH will be recognizing hospitals that have comprehensive breastfeeding programs and showed an increase in percent of discharged mothers breastfeeding and eliminated formula logo bags at the annual Breastfeeding Coalition Council in fall 2008.

Employer-based breastfeeding guidelines will be included in MDPH Wellness efforts.

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	2003	2004	2005	2006	2007
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Annual Performance Objective	99	99	99.9	99	99.8
Annual Indicator	99.9	100.0	98.9	98.9	98.7
Numerator	81444	79399	76991	77656	77573
Denominator	81545	79438	77841	78511	78592
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
	2008	2009	2010	2011	2012
Annual Performance Objective	98.8	99	99.2	99.4	99.6

Notes - 2007

Pre-discharge screening rates continue to be tracked by the Childhood Hearing Data System (CHDS). See the 2005 note for further information on data sources.

Using birth data before their final de-duplication, cleaning and release ("closed" 2007 birth data will not be available until winter 2009) makes the reported data preliminary or provisional. The UNHSP preliminary numerator and estimated denominator are reported here and will be updated at a later date.

Screening rates are slightly less than 100% and will remain so due to a small number of parents who refuse the screening, infants who died prior to discharge, and unknown/missed screens. See notes for 2006 and 2005 for examples of these numbers. The majority of those not screened are unknown or missed screens, including those missed due to transfers. Our goal – which is reflected in our revised performance objectives through 2012 is to reduce the unknown/missed number to close to zero, leaving only refusals and deaths prior to discharge as unscreened.

Notes - 2006

Updated data and note for 2006:

See the note for 2005 for a description of our current data sources and other data issues.

The 2006 screening rates shown are expected to be final, as 2006 birth data have been released.

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

Notes - 2005

Updated data and Note for 2005:

Pre-discharge screening rates are now tracked by the Childhood Hearing Data System (CHDS). CHDS uses a daily download of "live" electronic birth certificate (EBC) data for the denominator and the numerator. The denominator is occurrence births and the numerator also includes rescreens and out-patient screens as systems are in place to ensure they are entered into the EBC. Screening (and follow-up) data have been available from the EBC beginning with 2004. Prior to 2005, screening data from an annual survey of hospitals appeared to be of better quality than EBC data and was used for reporting on this measure, but EBC data are now reliable and the annual survey has been suspended.

The 2005 data shown are now final, as the final 2005 birth file (after de-duplication and cleaning) has been released.

Screening rates are slightly less than 100% and will remain so due to a small number of parents who refuse the screening (e.g. 29 in 2005), infants who died prior to discharge (303 in 2005) and unknown/missed screens (529 in 2006).

a. Last Year's Accomplishments

The UNHSP tracked the approximately 78,600 infants born in MA to ensure that 98.7% were screened for hearing loss. Of the infants that did not pass the screening in one or both ears, 216 were diagnosed with hearing loss. A Parent Outreach Specialist, who has two children with hearing loss, provided parents experiencing this loss with support and technical assistance. Outreach staff actively followed up with phone calls and letters to other families. The Childhood Hearing Data System facilitated tracking, outreach, follow-up and documentation of the results.

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

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

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

Held bi-annual UNHSP Advisory Committee Meetings.

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

Amended MA law to enable MA to share screening information when children are born in MA and reside in another state.

With the DPH Legal Office, other NE state attorneys and privacy officers framed a model data sharing agreement for use by all states.

Translated the Parent Information Kit into Spanish and gained access to the Telephone Translation Language Line to enable outreach to families in numerous languages.

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

Published "Evaluating Families Satisfaction with Early Hearing Detection and Intervention Services in Massachusetts" in American Journal of Audiology (June 2007) based on results from a statewide parent survey.

Developed a manuscript "Evaluating Loss to Follow-up in Newborn Hearing Screening in Massachusetts" and completed DPH internal review process for journal submissions.

Collaborated with EPSDT Program to update Massachusetts policy guidelines.

Assisted with implementation of Section 8 of Chapter 433 of the Acts of 2004, An Act Relative to the Certification of Speech-Language Pathology Assistants and Audiology Assistants.

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

Completed Research Triangle Institute (RTI) Lost to Follow-up Project. Participated in planning, identified 400 families for phone interviews, sent them study letters, identified 2 birth facilities to conduct a Maternal Exit survey, reviewed and commented on the final report "An Evaluation of

Loss to Follow-up in State EHDl Programs: Findings from the Massachusetts Universal Newborn Hearing Screening Program".

Director served as president of Directors of Speech and Hearing for State Health and Welfare agencies and assisted in planning the National Early Hearing Detection and Intervention Conference.

Presented at the national EHDl Conference "Factors Associated with Loss to Follow-up in Massachusetts".

Provided DPH lobby display for Deaf Awareness Week.

Participated in several workgroups to identify hearing loss early.

Gave interview and provided program materials for an American Public Health Association article, met with colleagues from British Columbia and Israel re MA UNHSP, and offered 20 trainings at various conferences, universities, and other forums.

Table 4a, National Performance Measures Summary Sheet

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

level in the family's chosen communication mode.				
10. UNHSP evaluates its program, including surveying families and primary care providers, analyzing data re screening and loss to follow-up and publishing findings.				X

b. Current Activities

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

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

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

Publish "Evaluating Loss to Follow-up in Newborn Hearing Screening in Massachusetts" in Pediatrics v. 121, no 2, 2/2008.

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

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

Develop testable QI methods to reduce loss to follow-up. Begin participation in the HRSA-funded Improving the System of Care for Children and Youth with Special Healthcare Needs Learning Collaborative, National Initiative for Children's Healthcare Quality (NICHQ), with focus on home births and discharges of reverse transfer infants home from community hospitals.

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

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

Submit MCHB and HRSA grant proposals.

Develop a Memorandum of Agreement with the MCDHH to ensure families with children with hearing loss receive comprehensive unbiased and culturally sensitive information.

c. Plan for the Coming Year

See also NPM #1. Continue ongoing activities.

Implement new loss-to-follow-up quality improvement methods and initiate strategies to test their effectiveness and continue NICHQ project.

Collect screening results from bordering states and assess new strategies to assure services for babies born in a state other than the one in which they reside.

Re-survey birth facilities to ensure screening equipment and type of equipment meet new recommendations in the JCIH statement.

Provide in-service training to NICUs to ensure newborns that are transferred receive hearing screening and data is entered.

Provide scripts to birthing facilities and audiological centers so families receive appropriate messages and follow-up appointments.

Formalize protocol to follow families in EI.

Work with the AAP Champion to disseminate updated information to pediatricians on protocols to ensure infants at higher risk of developing later onset hearing loss are connected back to services and medical homes.

Staff implementing the new Memorandum of Agreement in collaboration with the Massachusetts Commission for the Deaf and Hard of Hearing (MCDHH) will develop systems to ensure families with infants with hearing loss are connected to the MCDHH soon after birth and assisted to make informed choices. A consent form to share information with the MCDHH will be developed and provided by the DPH Approved Audiological Centers to families at diagnosis.

Complete review of current data system and recommend new system, with expectation of implementation in late FY09 or early FY10.

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	2003	2004	2005	2006	2007
Annual Performance Objective	3.5	3.5	3	2.5	2
Annual Indicator	2.3	3.2	3.2	2.5	2.3
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	2	2	1.5	1.5	1

Notes - 2007

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

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

As a result of the major health care reform currently getting underway in the Commonwealth – which is designed to achieve universal health care coverage - we have set Performance Objectives reflecting a further drop in the rate, although with a higher residual uninsured percentage than previously projected. We will continue to monitor and adjust these projections as needed, as the economic downturn affects more families and federal decisions on Medicaid

policy (e.g. the maximum FPL that can be covered) and the Massachusetts Medicaid waiver may affect the insurance situation for children.

Notes - 2006

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

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

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

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

Notes - 2005

The primary data source for this indicator is health insurance status surveys of Massachusetts residents conducted by the Massachusetts Division of Health Care Finance and Policy (HCFP) biannually. Because the survey was not done in 2005 (and the 2006 survey is currently being completed), we have no new data to report. Therefore, the rate of 3.2% is the rate reported by the 2004 HCFP survey.

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

Another comparative data source is the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS), which now includes questions on insurance coverage for household members under the age of 18. These questions are asked every year. The 2005 BRFSS survey reported a rate of 2.4%. The BRFSS rates have historically been consistently lower than those found in the HCFP surveys, but the trend in the BRFSS rates has been useful. After rising for two years to 2.6% in 2004, the BRFSS rate has improved again.

As a result of the major health care reform currently getting underway in the Commonwealth – which is designed to achieve universal health care coverage - we are setting Performance Objectives reflecting a sharp and steady drop in the rate to essentially no children without insurance by 2009.

a. Last Year's Accomplishments

Massachusetts Health Care Reform legislation passed in the Spring of 2006. The BFCH participated throughout FY07 in implementation discussions and monitored the impact on children. The HCFP survey has become an annual one and should provide even more information about who is uninsured and how various aspects of health care reform affect children and their health care utilization in particular.

The coverage rate had remained at just over 93% for some years but rose in FY06 to over 96%,

with the expansions under health care reform of Medicaid eligibility for children up to 300% of the FPL. There has been increased public outreach and information to inform families both to the benefits they are now eligible for and to their responsibilities under the new law (e.g. purchasing insurance under various subsidies).

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

Uninsured children enrolled in EI decreased from 1.7% in 2006 to 1.3% in 2007; that is, virtually all children in EI had either public or private insurance.

DPH Care Coordinators assisted 399 families through the Flexible Family Support Fund to reimburse costs of goods and services related to raising a child with special health care needs. These expenses tend not to be medical in nature and therefore not covered by health insurance.

Of the 559 EIPP participants who received an initial comprehensive health assessment, 70% had low or moderate strength in access and utilization of care, including health insurance.

The SHU presented a program on Health Care reform to 102 School Nurse Leaders.

The ESHS programs referred 142,738 students to primary care providers; of these 8,213 were linkages with new primary care providers. A total of 7,949 students were referred for health insurance.

Use of the Virtual Gateway for program intake as a single point of entry across EOHHHS through its "common application" continued to expand. The Virtual Gateway ensures more consistent access to all benefits, including insurance, for which a child and family are eligible. BFCH completed testing and piloting its ESM/EIM project for enrollment into the first DPH programs to use ESM/EIM, integrated with Virtual Gateway.

SBHC examined insurance issues through 26 in-depth interviews in 10 SBHC sponsoring agencies (overseeing 39 of 49 MDPH-funded SBHCs). MDPH SBHC Quality Standards required (and continue to require) SBHCs to assist uninsured students in determining eligibility for and enrollment into a state health insurance plan. Some electronically enroll students in MassHealth on-site using the Virtual Gateway at the SBHC (all are offered training) and others refer patients to another community location where they can be enrolled. All see patients regardless of insurance status and assume the costs.

Massachusetts Health Care Reform legislation includes a chapter (#58) mandating an extensive statewide investigation of the community health worker (CHW) workforce, an integral part of the effort to insure all of the state's residents and, more generally, assure access to care. In FY07, infrastructure building accomplishments towards building an effective and stable CHW workforce in the state included: identifying key stakeholders for statewide CHW Advisory Council, in addition to those mandated in statute; designing multi-pronged statewide CHW workforce investigation; investigating other state and national CHW research and policy initiatives, including the 2007 HRSA national CHW workforce study. DPH's participation focused on: workplan development, including identification of resources needed, and establishment of collaborative partners; assessment of statewide CHW training infrastructure; technical support to Massachusetts Association of Community Health Workers in the areas of training, professional development, organizational development, strategic planning, policy development and fund raising.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

See also Summary Chart and NPMs #2 and 4.

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

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

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

The integration of additional more programs and sites into the ESM/EIM/Virtual Gateway systems continues, along with training (e.g., at SBHC sites to assure that all potentially eligible children are enrolled promptly in public insurance programs.

The Mass. Community Health Worker Initiative is completing recommendations from a survey for a sustainable CHW program and is finalizing a report for the Legislature.

c. Plan for the Coming Year

See also NPM #4. Continue ongoing activities.

In FY09, DPH will submit to the legislature the report on CHW workforce development. The report will include the findings from the extensive workforce investigation conducted during FY08, as well as recommendations for a sustainable CHW program in Massachusetts. In addition to the legislature, the report will be widely disseminated both in Massachusetts and nationally to key stakeholders. Recommendations have been identified in the following areas: establishing a statewide entity/infrastructure to oversee implementation; conducting a statewide professional identity campaign; expanding existing core CHW training infrastructure to address identified gaps; designing a certification program; and implementing a series of identified financing strategies. DPH will continue to convene a statewide advisory body, and work in close collaboration with the Massachusetts Association of Community Health Workers to implement recommendations.

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

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

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	2003	2004	2005	2006	2007
Annual Performance Objective				34	34
Annual Indicator			34.1	34	34
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	34	33.5	33	33	32

Notes - 2007

Data Source: Massachusetts WIC Program data, as reported through PedNSS. 2007 PedNSS data are not yet available. We have estimated the same rate as 2006.

Notes - 2006

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

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

Notes - 2005

The 34.1% recorded for 2005 on a preliminary basis represents FY04 data from WIC and PedNSS.

We are projected only modest improvements for the years through 2010.

a. Last Year's Accomplishments

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

WIC Program FY07 participation includes: 31.5% Hispanic, 19% Black, 5.6% Asian/Pacific, and <1% Native American; 44% are White. In FY06, WIC served a total of 204,874 participants: 62,737 women, 61,206 infants and 80,931 children.

According to calendar year 2006 Massachusetts PedNSS data from the CDC report, 16.4% of 2-5 year olds had a BMI >95% for their age and 17.3% were between 85th and 95th percentile of BMI for age. For comparison, in 2005 the rates were 17.1% and 17.0% and the national 2006 PedNSS findings were 14.7 % and 16.1% (national 2004 - 14.8 and 16.1) respectively. This data indicates that Massachusetts rates for overweight in children have remained stable.

In 2007, the Massachusetts WIC Nutrition Program continued activities related to the "Weigh of Life...Taking Action Together Initiative." This initiative promotes collaborations with medical providers to promote healthy eating behaviors and healthy weights in children. Materials distributed through this initiative included: a toolkit for providers to establish successful partnerships and promote consistent messages and nutrition messages which utilized an innovative advertising style to effectively interact with WIC families. Medical providers received individual visits from WIC nutritionists. There was overwhelmingly positive support from the providers, acknowledging appreciation for knowing the messages provided by WIC. They valued efforts of shared messages. In follow-up with providers, over 70% believed that it was important to share the same messages with WIC and 50% are utilizing the 'Steps to a Healthy Weight for Children'.

The Massachusetts WIC Nutrition Program completed statewide implementation of "Touching Hearts and Minds: Using Emotion-Based Messages to Promote Healthy Behaviors," a new project which increased WIC nutrition counselors' ability to provide nutrition education that results in families adopting healthy dietary, parenting and physical activity behaviors. The Touching Hearts project developed 30 eating, parenting and physical activity messages that combine relevant, emotional "pulse points" with current nutrition science to better connect with WIC families and promote the adoption of healthy behaviors. All staff received intensive training to provide this new format of interacting with families - emotion-based services -- and are using this style in both individual appointments and in facilitated group discussions with WIC parents.

Implementation of USDA's Value Enhanced Nutrition Assessment (VENA) was initiated, establishing standards for nutrition assessment for WIC eligibility.

The statewide Nutrition Education Task Force (NETF) and Targeting Obesity Through Education (TOTE) Workgroup -- representing 21 local WIC programs - provided activities to promote healthy

weights through good dietary and physical activity practices throughout the year.

Submitted for a three-year USDA Special Projects Grant, "Getting to the Heart of the Matter: Using Emotion-Based Techniques to Implement VENA" (GHM) to expand on the success of the Touching Hearts, Touching Minds project by enhancing the use of emotion-based techniques in WIC eligibility determination process to use as a springboard to meaningful and productive nutrition education sessions. This process will build on staff's current skills in rapport building, establishing counselor-participant trust, creating an environment for open discussion and effective identification and prioritization of the participant's personal goals and needs regarding nutrition behaviors.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC local programs screen and assess BMI and provide caregivers with information regarding child's weight.	X			X
2. Provide caregiver messages included in "Steps to Healthy Weight in Children" which promote good nutrition and feeding patterns and encourage physical activity.		X		X
3. Partner with medical providers to coordinate nutritional care and provide consistent nutrition and physical activity messages to promote healthy weights, utilizing both the Weigh of Life and Touching Hearts messages and materials.	X	X		X
4. Provide training to nutrition staff on approaches to talking effectively with parents about their child's weight and ways to ensure a healthy weight for their child.				X
5. WIC staff utilizes emotion-based service methodology to provide WIC families with messages about healthy eating, increased physical activity, and healthy weights, utilizing Touching Hearts, Touching Minds materials.		X		X
6. Monitor state and local WIC program rates for children with BMI's at or above 85th percentile.				X
7. Implement USDA's Value Enhanced Nutrition Assessment initiative to ensure the completion of a participant-centered nutrition assessment process.				X
8. Through the Getting to the Heart of the Matter grant activities identify ways to achieve a nutrition assessment interaction that is emotion-based and participant-centered.				X
9. Develop weekly messages for Mix 98.5FM Nutrition Buzz promoting healthy eating and physical activity.			X	X
10.				

b. Current Activities

Nutrition services utilize emotion-based, participant-centered model developed through the Touching Hearts project. All staff received follow-up training on the use of the techniques and messages in counseling and facilitated group discussions.

Expanded the Touching Hearts Project by training other nutrition professionals, who work in Health Centers, Growth and Nutrition, Head Start, EFNEP, and other nutrition programs, promoting consistent messages and materials and counseling styles.

Implementation of VENA continued. Staff combined Touching Hearts techniques for the VENA nutrition assessment to ensure the completion of an assessment that targets relevant nutrition

education and counseling for positive health outcomes.

Initiated GHM activities which included ethnographic research to identify and examine current assessment techniques to target areas of improvement.

Continued implementation of the "Weight of Life...Taking Action Together" Initiative materials, partnering with medical providers and focusing on the shared use of the messages in "Steps to Healthy Weights in Children".

The NETF and TOTE provided activities to promote healthy weights, reviewed education materials, and distributed a newsletter promoting staff wellness and information for counseling/education.

Fifty-two messages for young children were developed for Mix 98.5FM Nutrition Buzz promoting healthy weights.

c. Plan for the Coming Year

Continue ongoing activities.

Continue the utilization of emotion-based, participant-led service delivery model. Staff will continue to receive follow-up training and technical assistance to ensure skill development.

Staff will expand the use of facilitated group discussions for follow-up nutrition education for WIC families.

Through the GHM grant, will initiate 6 pilot programs to test new assessment techniques to enhance WIC service delivery and accuracy of data collected.

Continue implementation of the "Weight of Life...Taking Action Together" Initiative materials, partnering with medical providers and focusing on the shared use of the messages in "Steps to Healthy Weights in Children."

The NETF and TOTE will continue to review and propose educational activities to promote healthy weights in children and will develop the annual staff wellness initiative.

Will communicate baseline BMI for children data, comparing rates over the last 12 months, to review current efforts to improve rates and strategize individual program activities and initiatives for implementation.

Continue to develop messages for young children for Mix 98.5FM Nutrition Buzz promotions.

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	2003	2004	2005	2006	2007
Annual Performance Objective				6	6
Annual Indicator			6	6	9.2
Numerator					
Denominator					

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
	2008	2009	2010	2011	2012
Annual Performance Objective	9	8	7	6	6

Notes - 2007

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

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

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

Notes - 2006

We have no new data to report for 2006, so are reporting the same rate as 2005 (which was estimated from data from the PRAMS pilot test. Based on our progress in increasing the % of women who report not smoking during their pregnancy (see SPM # 2), we are projecting a further slight decrease in this rate through FY11. More solid statewide estimates will be available from PRAMS beginning in 2008.

Notes - 2005

The estimated, provisional rate for 2005 is based on data from our recent PRAMS pilot test (which found a rate of 4%, with a confidence interval of 2% - 5.8%). Based on our progress in increasing the % of women who report not smoking during their pregnancy (see SPM # 2), we are projecting a further decrease in this rate over the next 5 years. More solid statewide estimates will be available from PRAMS beginning in 2008.

a. Last Year's Accomplishments

See State Performance Measure # 2, which monitors the percentage of women who report not smoking at any time during their pregnancy. Most of the Commonwealth's extensive efforts to reduce smoking during pregnancy are reported under that measure. In addition, given that teen mothers are more likely to smoke than older women, see state priority #2, improve adolescent health through youth development and risk reduction, which highlights adolescent-related smoking prevention and cessation. This report for NPM #15, smoking in the third trimester, highlights activities that are focused on smoking cessation after a pregnancy begins.

Data about smoking during the third trimester are not available on the Massachusetts birth certificate. PRAMS, which asks a representative sample of Massachusetts women who gave birth about smoking in the third trimester, began its first full-year of data collection.

2006 PNSS data indicated that 12.4% of low income women participating in the Massachusetts WIC program smoked during their last 3 months of pregnancy.

With extensive technical assistance from the Massachusetts Tobacco Control Program (MTCP), MassHealth designed a smoking cessation benefit that provided counseling and pharmacotherapy for pregnant women and women with young children. The benefit was extended to all MassHealth members due to Health Reform legislation July 1, 2006. MTCP developed a "True Stories" campaign promoting cessation among women of childbearing age and co-branded with MassHealth to promote the new benefit. A radio and transit campaign ran in numerous cities and rural counties and was formally evaluated by MTCP. Of smokers who quit, most reported that medications were important in helping them.

MTC funded pilot programs at 2 rural birth hospitals in Western Massachusetts to train hospital and community-based healthcare providers to conduct and track brief interventions with pregnant smokers. The programs also collected baseline data from hospitals and community practices and provided supportive counseling to women who accepted referrals. Health providers asked hundreds of pregnant women if they smoked. Three-quarters of those who were advised to quit smoking were offered treatment.

MTCP funding was also awarded to 8 of the CHCs with Women of Reproductive Age and Adolescents contracts to improve provider reminder systems to support tobacco use interventions and to implement the MassHealth cessation benefit.

The statewide QuitWorks program revamped its telephone counseling protocol to deliver a pregnancy-specific module for the smoking woman who calls during pregnancy.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Community Based Services for Women of Reproductive Age and Adolescents program provides screening and health education for smoking and referrals to community services for smoking cessation.		X		
2. FOR Families and EIPP home visitors screen and assess for tobacco use at regular intervals during pregnancy and postpartum, and make referrals as needed. Formal collaboration with MTCP and QuitWorks provides smoking cessation services.		X		X
3. WIC services assess for smoking during pregnancy and provide information and counseling on smoking cessation, offering enrollment into QuitWorks, a smoking cessation program and assisting interested women enroll.		X		X
4. PRAMS collects information from women postpartum, specifically assessing the proportion of women giving birth in Massachusetts who smoke in the last three months of pregnancy.				X
5. The MCH program works closely with the Massachusetts Tobacco Control Program (MTCP) on program development, new initiatives, training and technical assistance.				X

6. EIPP home visitors collect this data element for all EIPP enrolled pregnant and postpartum women.				X
7. See also State Performance Measure #2, which reports additional Massachusetts activities to prevent smoking at any time during pregnancy.				X
8. See also State Priority #2, improve adolescent health through coordinated youth development and risk reduction, for adolescent-focused activities.				X
9.				
10.				

b. Current Activities

See State Performance Measure # 2 and state priority # 2, where most of the Commonwealth's extensive efforts to reduce smoking during pregnancy are reported.

MTCP programs continued at the 2 rural birth hospitals conducting the 2007 pilot and one more rural birth hospital was funded for the program.

PRAMS staff are conducting preliminary data analysis for this measure and continue ongoing data collection.

c. Plan for the Coming Year

See additional plans under State Performance Measure # 2 and State Priority #2. Continue ongoing activities.

PRAMS analyses for 2007 will be finalized in collaboration with the Centers for Disease Control and Prevention PRAMS team, and analyses (stratified by demographic and other maternal characteristics and experiences) conducted to better understand associations between third trimester smoking and pregnancy/infant outcomes.

We plan to report the prevalence of cigarette smoking in the last 3 months of pregnancy over 3 years when available (2 years for FY09), to improve the precision of our estimates and continue the validation study which is underway comparing smoking reported on birth certificate and PRAMS.

Given that the prevalence on birth certificates is likely to be an underestimate, the Massachusetts Tobacco Control Program (MTCP) has conducted analysis to assess the amount of underestimate and they will develop their analysis and interpretation further into a publication in FY09.

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	2003	2004	2005	2006	2007
Annual Performance Objective	5	5	5	4.3	4.3
Annual Indicator	4.4	4.3	4.5	3.7	4.3
Numerator	18	18	19	16	

Denominator	410255	414020	420641	431669	
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
	2008	2009	2010	2011	2012
Annual Performance Objective	4.3	4.2	4.2	4.1	4.1

Notes - 2007

2007 death data are not available. We have estimated a 2007 rate higher than for 2006 that is more in line with the secular trend. See 2006 for the most recent data and see the Note for 2006 for data sources and other comments.

Notes - 2006

Data on deaths are taken from MDPH Vital Records for calendar years 2004 - 2006. Rates are now calculated as rolling 3-year averages. (I.e. the 2006 numerator is the sum of the 2004, 2005, and 2006 numbers of deaths (19, 18, and 11 respectively) and the denominator is the sum of the most recent Massachusetts population estimates for the age group for the same years. The denominator is from the most recent population estimates for Massachusetts, as provided by the MDPH Bureau of Health Information, Statistics, Research and Evaluation. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere.

Notes - 2005

Data on deaths are taken from MDPH Vital Records for calendar years 2003 - 2005. Rates are now calculated as rolling 3-year averages. (I.e. the 2005 numerator is the sum of the 2003, 2004, and 2005 numbers of deaths (21, 19, and 18 respectively) and the denominator is the sum of the most recent Massachusetts population estimates for the age group for the same years. The denominator is from the most recent population estimates for Massachusetts, as provided in MassCHIP. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere.

a. Last Year's Accomplishments

See also Priority Need # 9.

MDPH received its 5th year of state funding for a Suicide Prevention Program and hired a full-time director and program assistant. With leadership and funding from the Program, activities for adolescents, their parents, teachers and caregivers included:

- The 2-day, Fifth Annual Suicide Prevention Conference was attended by 500 providers and advocates
- A full-day conference for Clergy and Funeral Directors guided 50 of these professionals in their work with people who have lost a loved one to suicide
- An "Aiding Suicide Survivors Guide" for Clergy and Funeral Directors was created, translated into Spanish and Portuguese, and distributed (over 7,000 copies)
- A SAMHSA-funded youth suicide prevention program trained 950 foster parents and DSS social workers in suicide prevention
- 2 Question Persuade Refer (QPR is a nationally recognized Gatekeeper Training) Instructor Certifications Trainings, were held at no cost to 80 service providers and clinicians. Certified instructors agreed to train others. One training targeted college and university health, counseling and residential life staff. There were more applicants than could be accommodated. The certified QPR trainers conducted 15 trainings in which 325 individuals participated
- DPH staff participated in all activities with the Massachusetts Coalition for Suicide Prevention and provided technical assistance and funding for a full time coordinator

- DPH continued distribution of Suicide Prevention materials
- Questions were included on the 2007 BRFSS survey specific to suicide and survivors in order to gather additional data on suicidal behavior in the Commonwealth
- A Coalition member was certified in the Assessment and Management of Suicide Risk (AMSR) Training curriculum. This curriculum was created by the American Association of Suicidology and the Suicide Prevention Resource Center and is intended to be a national model for the education of mental health professionals
- 2 pilots and 3 full-day AMSR trainings by a coalition member who is a nationally certified instructor were held for 150 clinicians at locations in various parts of the state - 5 graduate schools of social work were awarded planning grants to develop strategies to include suicide prevention training in their curricula
- 150 high school and middle schools received Signs of Suicide program kits and 125 school personnel participated in a half-day implementation training to learn how to use the program.
- 35 facilitators were trained to lead survivor support groups through a partnership with the American Foundation for Suicide Prevention.

The ESHS school districts reported 111,411 encounters in which mental health counseling was the primary reason for the visit; 41% of the ESHS districts had emotional support groups for students, with an average of 98 meetings and 173 student participants monthly. In addition, 24% of the ESHS districts provided anger management support groups with an average of 35 group meetings and 162 student participants monthly. Nurses reported diagnoses of depression at a rate of 9.4 per 1,000 students in the ESHS districts.

The Northeastern University School Health Institute provided the following mental health programs: (a) 7 programs on depression prevention curriculum training with 132 multidisciplinary attendees, (b) a summer institute on Children: Impact of War with 189 school nurse attendees, (c) a summer institute on bipolar disorders with 221 school nurse attendees, (d) a summer institute on pediatric psychological evaluation tools with 218 student nurse attendees.

Of students aged 15 to 19 years with at least one visit to a SBHC, 13.76% were identified as at risk for depression and 2.8% as at risk for suicide attempt. Of the students, 73.4% were assigned a follow up plan by the SBHC clinician, 18.9% of those at risk for depression were referred to of mental health clinician for follow-up, and 1.4% were referred to student support services. SBHC standards require clinicians to develop expensive referral networks in their communities and to identify the level of acuity/response needed.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Suicide Prevention Program carries out a comprehensive array of suicide surveillance, intervention and prevention activities, seeks to identify adolescents at risk for suicidal behavior and intervene with an appropriate preventive strategy.	X	X		
2. Safe Spaces for Gay, Lesbian, Bisexual and Transgender Youth Program addresses suicide risk amongst GLBT youth; working with community based providers to create safe spaces within schools and communities that promote healthy youth development.			X	X
3. Extensive training and technical assistance is provided to SBHC clinicians and school nurses (ESHs) in mental health and suicide screening and prevention, and they screen and refer for treatment.				X
4. Collect input from adolescent residential facility program managers about their suicide prevention needs, develop			X	X

curriculum and provide ongoing training.				
5. Provide postvention services with suicide survivors and affected schools through a statewide contract.	X			
6. Sponsor trainings, an annual conference, and seminars on suicide prevention; promote and use curricula for various providers. Distribute Signs of Suicide® (SOS) program kits and train schools to implement. Update data and prevention resources.				X
7. School nurses do assessment and referral for depression and other mental health issues for children in grades K-12. This is a requirement of the ESHS grants and the new School Health Manual provides information on this subject.		X		X
8. SBHC standards require annual risk and resiliency assessments with validated screening instruments. All clinicians are trained in the child symptom checklist. Several use SOS and others use additional validated instruments.		X		X
9. Implement a federal SAMHSA grant focused on at-risk youth in the DSS and DYS population. Train DSS foster parents and case managers in suicide sign recognition and intervention skills and strategies.				X
10. Through the SAMHSA grant, guide families of DYS youth in how to help their suicidal sons and daughters and train DYS staff in suicide sign recognition and intervention skills and strategies.		X		X

b. Current Activities

See also Summary Chart and Priority # 9

The Sixth Annual Suicide Prevention Conference was held with participation by 750 providers and advocates.

SOS (Signs of Suicide) kits were received by 150 Massachusetts middle schools and 125 staff trained to implement the program.

A Depression Wellness Guide was developed and distributed to high school students and parents.

The Massachusetts Strategic Plan for Suicide Prevention is being revised by Program staff and the MA Coalition for Suicide Prevention.

DMH and the Program are collaborating to offer suicide prevention training to staff of the 500 residential programs who serve children and youth.

The 2nd update of Suicide Prevention Resource Guide will be available on line.

Nine AMSR trainings were held for 450 mental health clinicians.

The SAMHSA grant trained 2400 foster parents and Department of Social Service social workers in suicide prevention. The Department of Youth Services served 55 families and trained 255 DYS staff.

QPR certified gatekeeper instructors conducted 36 trainings for 3045 participants. More than 80% of attendees reported an increase in knowledge of signs of suicide and confidence in intervening with a person at risk.

American Foundation for Suicide Prevention training was given to 60 facilitators on how to lead survivor support groups.

The Program continues to disseminate suicide prevention materials.

The Program applied for a second round of SAMHSA funding for youth suicide prevention.

c. Plan for the Coming Year

See also Priority Need # 9.

Continue ongoing activities to build sustainability of substantial new activities implemented in this area during FY07 and FY08.

Complete suicide prevention strategic plan revision and implement changes/enhancements.

Implement ongoing training of adolescent residential facility program managers based on the curriculum developed from a 2008 survey of their suicide prevention needs.

The SBHC program will support enhanced mental health/substance abuse services in the funded SBHCs with the goal of disseminating identified best practices throughout the state network of SBHCs.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	85	85	86	88	86
Annual Indicator	86.1	88.2	85.6	85.5	86
Numerator	907	946	887	826	
Denominator	1054	1072	1036	966	
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
	2008	2009	2010	2011	2012
Annual Performance Objective	86	86	86	86	86

Notes - 2007

2007 birth data are not available. We have estimated the same rate as that for 2006. See 2006 for the most recent actual data and see the Note for 2006 for data sources and other comments.

Notes - 2006

Data on VLBW, birth hospitals, and resident births are from MDPH Vital Records for calendar year 2006. The nine Level III units are at Baystate Medical Center, Beth Israel Deaconess, Boston Medical Center, Brigham and Women's, Massachusetts General Hospital, Medical Center of Central Massachusetts, New England Medical Center, South Shore Hospital, and St. Elizabeth's Medical Center. Data include only those resident births that occurred in-state at Massachusetts hospitals, as the birth file used for analysis does not contain the necessary information (specific hospital of birth) for births to residents at out-of-state facilities to be

categorized by Level III facility. In one region of the state enough births occur out-of-state (in Rhode Island) to distort the statistic otherwise.

Revised Hospital Licensure Regulations for Maternal-Newborn Services did not change the hospitals that we consider to have Level III units. Therefore the data reported are from the same nine hospitals as in previous years. The percentage of VLBW infants delivered in these 9 sites continues to fluctuate slightly but remain essentially unchanged. The impact of the new regulations on the perinatal regional system and the facilities considered to be appropriate for high-risk deliveries and neonates is still to be seen. It is likely that new baselines will be established for 2007 births. The impact of the regulatory changes on the system and on the resulting data is described in the narrative and will be monitored in future years.

Notes - 2005

Data on VLBW, birth hospitals, and resident births are from MDPH Vital Records for calendar year 2005. The nine Level III units are at Baystate Medical Center, Beth Israel Deaconess, Boston Medical Center, Brigham and Women's, Massachusetts General Hospital, Medical Center of Central Massachusetts, New England Medical Center, South Shore Hospital, and St. Elizabeth's Medical Center. Data include only those resident births that occurred in-state at Massachusetts hospitals, as the birth file used for analysis does not contain the necessary information (specific hospital of birth) for births to residents at out-of-state facilities to be categorized by Level III facility. In one region of the state enough births occur out-of-state (in Rhode Island) to distort the statistic otherwise.

The Revised Hospital Licensure Regulations for Maternal-Newborn Services did not change the hospitals that we consider to have Level III units. Therefore the data reported are from the same nine hospitals as in previous years. The percentage of VLBW infants delivered in these 9 sites continues to fluctuate slightly but remain essentially unchanged. The impact of the new regulations on the perinatal regional system and the facilities considered to be appropriate for high-risk deliveries and neonates is still to be seen. It is likely that new baselines will be established for 2007 births when the initial impact of the new level regulations and designations will be seen. The impact of the regulatory changes on the system and on the resulting data is described in the narrative and will be monitored in future years.

a. Last Year's Accomplishments

See also NPM 15 and SPM 9.

After concerns about the smaller percentage of VLBW infants born at Level III facilities in Massachusetts, revised state Hospital Licensure Regulations (105 CMR 130.000) governing maternal and newborn services were promulgated by MDPH and put into effect in March 2006. In FY07, the BFCH and the Bureau for Health Care Safety and Quality (BHCSQ) collaborated on a system of reviewing services in each birth hospital to determine an appropriate level designation. DPH has convened the Perinatal Advisory Committee (PAC) whose members represent all hospital levels of care, all regions in Massachusetts, and each professional organization identified as a key stakeholder (e.g. MA ACOG, MCAAP, MNA, Mass Medical Society). The PAC advises DPH on maternal and newborn policy and regulation, advises on regulation waiver requests and monitors the impact of the regulatory changes on care.

In her presentation "Disparities in Massachusetts Early Intervention Referral: Does Maternal Foreign-Born Status Affect Newborn Referral?" (Local presentation and Poster Presentation at the Pediatric Academic Societies Meeting in Toronto, Canada: May, 2007), Philomena Asante, a Fellow at DPH, described disparities in referral to EI for infants born at level III hospitals likely to be eligible for EI found disparities among VLBW infants born to Black non-Hispanic women and women born outside the US. Analysis led to increased programmatic efforts to work with hospitals to improve rates of referral to EI.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Perinatal regulations promulgated to ensure women and infants receive the most appropriate care for their medical needs and to reflect current state of practice at Level II and Level III hospitals.				X
2. Perinatal primary care providers screen for risk conditions and refer to appropriate level of care.	X	X		
3. The Perinatal Advisory Committee (PAC) brings multiple hospital level and professional discipline perspectives to bear on ongoing implementation of the regulations.				X
4. Per the regulations, hospitals collect infant and maternal indicators. Level IIIs must participate in the Vermont Oxford Network, providing NICUs reliable, confidential data for quality management, improvement, internal audit and peer review.				X
5. The PAC data subcommittee functions as a research body that operates under the guidance of a 24AB and reports relevant (aggregated – de-identified) results to the PAC to inform their decision-making/policy development process.				X
6. In collaboration with DPH Bureau of Health Care Safety and Quality (BHCSQ), a special project status has been established through the hospital regulatory process that allows a Level II B hospital to provide Short Term Mechanical Ventilation (STMV).				X
7. BFHN and MDPH BHCSQ survey/conduct site visits participate of hospitals and review compliance with new regulations.				X
8. Home visiting programs screen for risk conditions and refer to appropriate level of care.		X		
9. Through the Perinatal Disparities project, MDPH works with communities to use local data on VLBW infants to identify program priorities and policies to address VLBW and preterm birth (see SPM #9).				X
10.				

b. Current Activities

Level III hospitals and those with an identified concern for the standard of care being provided were prioritized for on-site surveys by BFHN/BHCSQ staff of hospitals requesting a change in level of care. Of 49 operational facilities subject to the regulations, 19 were surveyed and, of these, 15 designations were complete as mid-June; 6 received new level designations and 1 received a waiver.

With the advice of the PAC, DPH continues to design and implement a perinatal data review project to determine the impact the revised regulations have had on assuring mothers and infants receive care at a hospital with the most appropriate level of care.

DPH staff and the PAC data subcommittee developed a 24AB application draft to use PELL for a more indepth look at morbidity and mortality at each hospital level to monitor the impact of the regulations.

A cost study of EI services using PELL demonstrated that EI costs must be included when considering the long-term costs of prematurity and low birth weight. Data informed a comprehensive review of EI and its costs.

DPH staff and the newly appointed chairman of the Neonatal Quality Improvement Collaborative (NeoQIC) met, and the NeoQIC chairman was invited to be a member of the Perinatal Advisory Committee for FY09.

The Betsy Lehman Center for Patient Safety and Medical Error Reduction convened an expert panel on obstetrics, with a focus on labor and delivery. Title V has been participating in the planning and initial convening.

c. Plan for the Coming Year

Continue ongoing activities.

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

Submit the PAC data subcommittee 24AB PELL application and work with the DPH Privacy and Data Access Office (PDAO) for approval and implementation of the project. The goal of the perinatal data review project is to 1) monitor outcomes of mothers and infants over time to measure the success of the revised maternal and newborn hospital licensure regulations in assuring all mothers and infants receive care at a hospital licensed at the appropriate level for their needs and 2) to measure whether the regulations help reduce maternal, fetal and infant morbidity and mortality.

The meeting with the NeoQIC chairman identified projects of mutual interest to DPH and NeoQIC for potential collaborative analyses using PELL data. Specific topics of interest that have been identified thus far include retinopathy of prematurity, late-onset infections, and coordination of hearing screening follow-up for NICU graduates. It is anticipated that there will be opportunities for DPH, the PAC and NeoQIC to collaborate in the future.

Discussions have been on-going between MDPH, CDC, Massachusetts ART facilities, and Boston University to undertake a project to better understand the effects of artificial reproductive technology on birth outcomes. An MOU is expected to be signed in early FY09.

MDPH will continue to implement hospital surveys in all Massachusetts birth hospitals and will make a final determination of each hospital's level to ensure an effective system of care for neonates in Massachusetts. The MDPH will work closely with each hospital to implement an improvement plan based on the outcome of their survey. MDPH staff will provide technical assistance as needed in implementing hospital based improvement plans and will assess the ratio of VLBW infants in each Massachusetts region to determine whether an adequate number of NICU beds exist in each region, or that a well functioning system of transfer of VLBW requiring level III services is in place to ensure that high-risk deliveries are managed in these hospitals.

A manuscript including findings about EI costs by birthweight/gestational age group will be published, contributing to discussion and the literature about effects through early childhood of low and very low birthweight.

MDPH will convene a workgroup composed of internal staff, providers, and academics to review birth statistics and identify two to three areas for greater focus.

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	2003	2004	2005	2006	2007
Annual Performance Objective	84	85	85	83	83
Annual Indicator	83.3	82.8	82.5	81.5	82
Numerator	66789	64958	63410	63326	
Denominator	80167	78460	76824	77670	
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
	2008	2009	2010	2011	2012
Annual Performance Objective	82	82	83	83	83

Notes - 2007

2007 birth data are not available. We have estimated a similar rate to that for 2006. See 2006 for the most recent actual data and see the Note for 2006 for data sources and other comments.

Notes - 2006

Data are from MDPH Vital Records for calendar year 2006. This is the most recent year of data available.

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

The percentage of women receiving prenatal care in the first trimester in Massachusetts continues to decline, from 84.3% in 2001 to 82.5% in 2006.

The continued lack of significant improvement in this measure continues to be of concern and is part of the perinatal disparities work that is reflected in our SPM #9. However, another major factor is that women are increasingly receiving appointments for their first prenatal visit after twelve weeks of pregnancy, often because they no longer need a health care visit to confirm a pregnancy due to the availability of accurate over-the-counter tests. This factor is not readily susceptible to change and we have adjusted our future performance objective goals to reflect a lower baseline of first trimester visits even among healthy and well-insured women.

Notes - 2005

Data are from MDPH Vital Records for calendar year 2005. This is the most recent year of data available.

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

The percentage of women receiving prenatal care in the first trimester in Massachusetts has slightly declined from 84.3% in 2001 to 83.2% in 2005. To better understand this decline, we used the Join Point Regression technique to conduct trends analyses between 1989 and 2005. Our analyses show that the percentage of women receiving prenatal in the first trimester declined from 1997-2005. However, this decline was not statistically significant, the Annual Percent Change (APC) was -0.04%. Further quantitative analyses describing differences including by race/ethnicity, education, type of insurance, and geography are being conducted and will be reported in FY08. Additional information to inform work in this area, for example, about OB/GYN availability, effects of insurance changes, and cultural beliefs affecting women's choices, will be sought as part of Title V needs assessment.

The continued lack of significant improvement in this measure continues to be of concern and is part of the perinatal disparities work that is reflected in SPM #9.

a. Last Year's Accomplishments

See also SPM #9 and State Priority Need #10.

Given the appearance of a decrease in percentage of Massachusetts women receiving first trimester prenatal care, the MCH epidemiologist conducted detailed analysis of birth data to examine the trend back to 1989. She applied joinpoint analysis to determine years when the trend changed significantly. The percentage increased until 1994, then decreased in 1997 and then remained level (the line continued downward but decrease was not statistically significant) through 2005, the most recent year for which data were available. Years and directions of significant changes varied by race/ethnicity. For black non-Hispanic women, the downward trend began in 1993 with a significant decrease of .56% annual percentage change (APC) in the joinpoint line as of 2005. For Hispanics, the upward trend continued with an APC of .81% from 1997-2005. There is, however, a dip at the end of this line that requires monitoring to determine whether it is becoming a downward trend. From 1989-2005, American Indians experienced an increase of 1.13% APC; the actual line has many ups and downs reflective of small numbers.

Massachusetts Pregnancy Nutrition Surveillance 2006 Statewide Summary Data Report" indicated that 34.9% of pregnant women enrolled in WIC by the first trimester and nearly 74% of women on WIC entered prenatal care in the 1st trimester. Prenatal care initiation during the first trimester improved since 1992 when the figure was 63.8%; this trend has leveled off or declined in recent years from over 75% in 2003.

All WIC clinics tracked, through quarterly reports, their progress for enrolling prenatal women in WIC in the 1st trimester. WIC outreach coordinators sought appropriate settings and strategies to outreach to women in early pregnancy. The state office worked with community coordinators to identify and implement innovative outreach strategies. Specific strategies to reach the prenatal population early were incorporated into each local programs annual outreach plan.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC and EIPP reach out in communities to pregnant women to encourage early enrollment into their programs, helping to reach women at risk of late entry to prenatal care.		X		
2. WIC services statewide refer for prenatal care at first contact with pregnant women.		X		
3. EIPP and FOR families programs provide assistance with accessing prenatal care and optimizing health benefits.		X		
4. BFHN continues to strengthen collaborations with state and community partners to identify and address barriers to getting				X

early prenatal care, for example, local federally-funded Healthy Start programs.				
5. The state Healthy Start Program administered by MassHealth insures pregnant women not eligible for MassHealth at or below 200% FPL, in order to improve access to early, comprehensive, and continuous prenatal care.	X			
6. MassCARE provides prenatal care to HIV infected pregnant women through 3 regional perinatal centers. The regional coordinators, all high-risk obstetric nurses, engage in case finding and educate community providers in treatment guidelines.	X			
7. Family Planning and other DPH-contracted programs that include among their clients pregnant teens as well as others at risk of late entry to care, encourage and help clients access prenatal care as early as possible.		X		
8. ODT performs statistical analyses with state birth data to monitor trends and assess populations at higher risk for late entry into prenatal care and related factors.				X
9. WIC disseminates quarterly reports to assist programs in tracking progress for enrolling women in the first trimester of pregnancy. Outreach strategies that have proven successful are shared and discussed among program outreach staff.				X
10. The Perinatal Disparities Project (see SPM #9) partners with selected Massachusetts communities to address disparities in prenatal care and other perinatal health indicators.				X

b. Current Activities

See also Summary Chart above and State Priority Need #10.

EIPP developed relationships with Managed Care Organizations (MCO's) to reimburse for home-visits to pregnant women to ensure that low-income women, and women living in communities with poorer birth outcomes are connected with healthcare providers early in pregnancy.

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

Collect PRAMS data about prenatal care timing and related factors to use for ongoing assessment. Obtain preliminary counts and percentages for 2007 first trimester care.

At local WIC program request, a poster emphasizing the benefits of early WIC enrollment was made available to all WIC outreach staff in September. Programs continue sharing of successful strategies and quarterly reporting schedule.

c. Plan for the Coming Year

See also SPM #9 and Priority #10. Continue ongoing activities.

Expand analysis of data related to delay in prenatal care and develop processes to better understand the current environment, including barriers, in order to develop a plan to assure women obtain prenatal care as early as possible. Current information to suggests that some providers are not booking first appointments until the beginning of the second trimester. Additional information to inform work in this area, for example, about OB/GYN availability, effects of insurance changes, availability of home pregnancy testing, and cultural beliefs affecting women's choices, will be sought as part of Title V needs assessment

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

Complete and submit to Legislature a report on OB access and availability in Western Massachusetts.

Determine feasibility of expanding EIPP to additional high risk communities in FY10.

Although the number of women responding to the PRAMS survey reporting that they entered prenatal care after first trimester is small for extensive analysis (preliminary N=138 women for 2007), further analysis of demographics and reasons for late entry to care within the limits of the one year of available data will be conducted.

D. State Performance Measures

State Performance Measure 1: *The percentage of pregnancies among women age 18 and over that are intended.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	72	75	76	76	76
Annual Indicator	75	75.6	75.6	78.4	78.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	79	79	80	80	82

Notes - 2007

There are no updated data for 2007. The data for this measure are available every other year from the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS). The most current survey data are for 2006. They will be updated from the survey in the field during 2008. See the Detail Sheet (in Form 16) for this measure for definitions, data source and issues, and a discussion of its significance.

Our projected target rates have been raised, based on the 2006 improvements.

Notes - 2006

The data for the measure are available every other year from the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS); the current survey data are for 2006. See the Detail Sheet (in Form 16) for this measure for definitions, data source and issues, and a discussion of its significance.

The weighted percentage has been revised - to 78.35% of pregnancies being intended -- to correct a typographical error in last year's application.

Notes - 2005

The data for the measure are available every other year from the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS); the current survey data are for 2004. See the Detail Sheet (in Form 16) for this measure for definitions, data source and issues, and a discussion of its significance. The 2000, 2002, and 2004 BRFSS survey results exceeded our expectations (only slightly in FY04), and our annual Performance Objectives for 2006 and beyond have been raised.

a. Last Year's Accomplishments

See also NPM #8 and SPM #3.

Family Planning (FP) services decreased slightly in FY07 due to funding reductions; 42,800 clients were served, a 6% decrease from FY06 (45,651 clients).

A 4-year pilot sharing arrangement among hospital physicians to improve women's access to termination services statewide became an ongoing program. The FP Access Coordinator provided counseling and referral services to 30% more women than in FY05. While the number of procedures scheduled was relatively constant from FY05 to FY06, there was a 35% increase between FY06 and FY07; 519 calls were received in FY 2007, a 16% increase over FY06.

FP, in collaboration with the Massachusetts Emergency Contraception (EC) Network, Sexual Assault Prevention and Survivor Services Program and SANE program issued an RFR based on earmarked language to procure "a statewide hotline and other efforts to implement Chapter 91 of the Acts of 2005", the Act Providing Timely Access to Emergency Contraception, which was enacted in December 2005. The contract was awarded in April 2007 to the AIDS Action Committee and an environmental scan was initiated. The initial focus of the hotline and website was Emergency Contraception but as a result of the environmental scan and focus groups with teens, the focus was expanded to Sexual Health. The initial target population will be adolescents with the goal of providing accurate health information and referrals to family planning and related services such as sexual assault and rape crisis.

The English language 'Choosing a Birth Control Method' brochure was translated into Spanish and Portuguese. The Spanish and Portuguese versions were reviewed by family planning providers and focus groups of women in the target audience to ensure cultural competency and accuracy of translation. The brochures were made available online at www.maclearinghouse.com.

Because of the increased risk of unintended pregnancy among women experiencing domestic violence, an initiative was started in FY07 to train all of the state funded family planning programs. This work was an enhancement of DVSCRIP activities that became possible due to the Safe Families initiative and collaboration with the national organization, the Family Violence Prevention Fund. Staff in most programs received the four-hour training on intimate partner violence, connections to reproductive health issues and how to assess and care for family planning clients regarding domestic and sexual violence.

The 2006 BRFSS report was released. The Family Planning module was analyzed, including questions on pregnancy intentions and new questions on Emergency Contraception. In 2006:

- 22% of Massachusetts women ages 18-44 reported having had an unplanned pregnancy. This is a decrease since 1998 when 30.9 % of MA women ages 18-44 reported having had an unplanned pregnancy
- 80% of Massachusetts women ages 18-44 reported that they or their partner use some form of birth control.

Planning occurred for the FP sections of future BRFSS surveys and report and PRAMS.

DPECHSN perinatal programs focused education on reproductive life plan for all women of childbearing age, with emphasis on preconception and interconceptual care within home-based

and center based programs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Comprehensive clinical reproductive health care, community education and outreach is provided through a statewide family planning provider system.	X			
2. Reproductive health services are provided through Community Based Services for Women of Reproductive Age and Adolescents program sites, School Based Health Centers, and most ESHS programs.	X			
3. Family Planning and perinatal programs participate in planning and national, state and local collaborations to assure continued availability of basic reproductive health care.				X
4. Family Planning standards are set by MDPH; programs are monitored for adherence, including vendor site assessments and technical assistance.				X
5. FOR Families and EIPP home visitors assess women to determine family planning information and referral needs and follow-up referrals to family planning or primary care providers.		X		
6. Increase access to emergency contraception and sexual health services through the development of a statewide website and hotline, and inclusion of EC information and protocols in all sexual assault evidence collection kits.	X	X		
7. Collaborate with BSAS in substance abuse prevention and services (including those for youth).			X	X
8. Improve surveillance of women of reproductive age through implementation of PRAMS, as well as questions already included in the BRFSS.				X
9. Implement statewide sexual health hotline and website.		X		X
10. Train and support Family Planning providers to screen for and respond to intimate partner violence and sexual assault.				X

b. Current Activities

See also NPM #8, SPM #1 and #3 and "Summary Sheet"

Family planning services funding was increased by 14% in FY08. With the implementation of health care reform, fewer women are uninsured and family planning agencies will use more of their funding for community education and outreach efforts. By late FY08, funding for these efforts had increased from 5% to 21% of total funding, while funding for clinical services decreased from 95% to 79%.

A downloadable "Choosing a Birth Control Method" factsheet for the web was posted, with new content on additional FP methods (e.g., Implanon and Cycle beads), after review for medical accuracy and literacy level. Translation and/or medical/literacy review and focus-group testing of draft translations are underway or planned into Chinese, Haitian Creole, Khmer, Russian, Vietnamese and Arabic.

FP staff coordinates the Abortion Advisory Committee, a forum for clinicians, health care organizations, public health advocates and government agencies to advise the DPH on the implementation of legislative mandates and on strategies that support reproductive healthcare and reduction of unintended pregnancy.

The Family Planning Program is collaborating with Ibis Reproductive Health on a research grant to do a preliminary analysis of the impact of health care reform on low-income women's access to contraception.

Family planning programs not trained re screening for violence in FY 07 were trained, with a follow-up meeting scheduled for June 2008.

c. Plan for the Coming Year

See also NPM #8, SPM #1 and #3, and continue ongoing activities.

Continue implementation of the Statewide Sexual Health Hotline and Website. The Maria Talks Statewide Hotline and Website will be implemented which will increase access to information and referrals for EC, family planning and related services. Monitoring and evaluation of services will begin.

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

Family Planning program will conduct 3-4 vendor site assessments in FY09.

Family Planning program will continue with implementation of EC legislation, including development of materials specific for consumers including adolescents, the monitoring of hospital compliance with services to sexual assault survivors and the pharmacy access program. Pharmacist and interns will continue to be on staff in FY09. EC educational materials and information will continue to be distributed to adolescent service providers in collaboration with the MA EC Network.

Materials and follow-up training on violence screening in family planning clinics will occur in the fall of 2008.

State Performance Measure 2: *The percent of births to women who report not smoking during their current pregnancy.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	91	91	91	92.5	92.5
Annual Indicator	85.5	92.4	92.5	92.5	92.5
Numerator	68551	72518	71098	71813	
Denominator	80167	78460	76824	77670	
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	93	93	94	94	94

Notes - 2007

2007 birth data are not available. We have estimated the same rate as that for 2006. See 2006 for the most recent actual data and see the Note for 2006 for data sources and other comments.

See also NPM # 15 and its 2007 note for other data issues that are being reviewed. Due to differences between reported smoking rates from the birth certificate and PRAMS (which do not contain data items for precise comparison), there are some discrepancies between the future performance objectives shown for SPM #02 and NPM #15 at this time. One result of the

analyses mentioned above and described in our FY09 Planned Activities for these measures, will be a more formally coordinated set of projections.

Notes - 2006

Maternal smoking during pregnancy and resident birth data are from MDPH, Vital Records for calendar year 2006. This is the most recent year of data available.

See the Detail Sheet for this measure for definitions of the numerator and denominator and a discussion of the limitations of the data. Early success slowed or reversed in 2002 and 2003, as funding for tobacco control activities was significantly reduced. Funding has become stabilized again and is growing, but at a lower level, and we believe that our target levels are achievable. The rates on Form 11 may differ from those published elsewhere, due to how missing data are handled. For comparability with other MCH Core Performance Measures related to pregnancy outcomes and birth statistics, we have defined the denominator for this Negotiated Measure as all resident births during the referenced year. In other Massachusetts publications (such as Massachusetts Births), percentages are usually reported based on denominators from which birth records with information missing about the variable have been removed. The result is a lower apparent rate.

Notes - 2005

Maternal smoking during pregnancy and resident birth data are from MDPH, Vital Records for calendar year 2005. This is the most recent year of data available.

See the Detail Sheet for this measure for definitions of the numerator and denominator and a discussion of the limitations of the data. Early success slowed or reversed in 2002 and 2003, as funding for tobacco control activities was significantly reduced. Funding has become stabilized again and is growing, but at a lower level, and we believe that our target levels are achievable. The rates on Form 11 may differ from those published elsewhere, due to how missing data are handled. For comparability with other MCH Core Performance Measures related to pregnancy outcomes and birth statistics, we have defined the denominator for this Negotiated Measure as all resident births during the referenced year. In other Massachusetts publications (such as Massachusetts Births), percentages are usually reported based on denominators from which birth records with information missing about the variable have been removed. The result is a lower apparent rate.

a. Last Year's Accomplishments

See also NPM #15 for smoking cessation accomplishments targeting women after they become pregnant and Priority #2 for additional adolescent-focused accomplishments.

The MTCP funding increased from \$4.3M in FY 06 to \$8.3M in FY07.

The QuitWorks program, which served a total of 6,288 callers and received 3,962 faxed referrals from providers and 2,326 self-referrals in FY07, is a collaboration of the Department's Massachusetts Tobacco Control Program (MTCP) with all major health plans linking providers and their patients who smoke to the state's cessation services. It continued to promote services and materials tailored for pregnant women who smoke.

In FY07, eight community health centers received grants to implement systems-level, evidence-based interventions to address tobacco use. The initiative was expanded to include nineteen community health centers in FY08. In FY07, two rural birth hospitals received grants to pilot systems change strategies to refer pregnant women to tobacco treatment. In FY08, another rural birth hospital was funded.

"Ready Set Quit" projects enrolled 1,350 of Worcester's and 24,000 of Lawrence's heavy smokers in 2006. A follow-up survey in FY07 found that 4 of 5 participants had made a serious quit attempt and 20% had remained quit over a month, a rate about 4 times that of "cold turkey" quitters.

In Lawrence and Worcester, Community Smoking Interventions (CSIs), which address disparities in high need communities, promoted smoking cessation among women of childbearing age by training WIC and Head Start providers to integrate brief interventions into their work.

MTCP targeted low-income women aged 18-49 for a quit-smoking radio and transit advertisement campaign called "What's Your Story?" A random-digit-survey found that 80% of the target audience recalled the ad and 95% said it gave good reasons to quit smoking.

Providers from EIPP, CHCs, and rural hospitals were trained in the 5A counseling approach and learned of the resources available to help mothers who wish to quit smoking.

In FY07, school nurses in ESHS districts provided the following tobacco prevention/cessation services:

- 2,408 tobacco group prevention meetings were held in 29 districts, in which attendance summed to 13,560 students and 401 adults.
- 235 tobacco group cessation meetings were held in 20 districts, in which attendance summed to 646 students and 31 adults.
- 3,756 individual tobacco cessation counseling sessions were delivered to 2,533 students and 281 adults in 71 districts.
- In 38 of the districts, students were referred to other tobacco prevention/cessation services 371 times, and adults were referred to outside sources 90 times.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Community Based Services for Women of Reproductive Age and Adolescents contracted sites provide screening and health education for smoking and referrals to community services for smoking cessation.	X	X		
2. Training and technical assistance are provided to prenatal care providers on screening and brief intervention for substance use.				X
3. WIC, EIPP, and FOR Families assess pregnant women for smoking, and counsel and refer to smoking cessation services (Quitworks), in collaboration with MTCP.		X		
4. Continue surveillance of smoking among women of childbearing age, including adolescents and pregnant women, through PRAMS, the BRFSS, YRBS, and YHS.				X
5. Continue Massachusetts Tobacco Control Program (MTCP) birth hospital-based: Systems-Based Interventions to Decrease Smoking Across the Childbirth Continuum.		X		X
6. Implement other MTCP interventions to assure that all health care providers who serve pregnant and postpartum women and their children are trained or retrained in the implementation of the 5A's tobacco counseling method.		X		X
7. Initiate system-wide changes to incorporate the 5 A's counseling method into the care of all women along the childbearing continuum, including documentation, coding, and tracking.				X
8. Through MTCP projects, pregnancy-specific support interventions are provided to address the woman's life circumstances.		X		
9. The QuitWorks program, a collaboration of MTCP with all		X		

major health plans, links providers & their patients who smoke to the state's cessation services, promoting services & materials tailored for pregnant women who smoke (e.g. "Ready Set Quit").				
10. See also NPM # 15 and state priority #2.				X

b. Current Activities

See summary chart of activities and also NPM #15 for smoking cessation activities targeting women after they become pregnant and Priority #2 for additional adolescent-focused activities.

Ready, Set, Quit projects were implemented in Worcester and Lowell. Additional CSI projects were funded.

The MTCP media campaign expanded to broadcast and cable television in FY08 by reviving the personal story of Ronaldo Martinez and a series of other commercials.

The number of community health centers that implement improved provider reminder systems increased from 8 to 19; these include OB/GYN and Pediatric practices

An RFP was released for a new campaign designed to reduce exposure to second-hand smoke (SHS) to children by promoting "no safe level of exposure" in the home and training human-service providers to advise parents not to smoke anywhere near their children. The RFP provides for pilot interventions in three cities using the CEASE model (an MGH program that encourages pediatricians to ask about exposure to SHS).

Implement PRAMS data collection to improve capacity to survey reproductive aged women throughout the Commonwealth, including the capacity to assess smoking within the last 3 months of pregnancy among Massachusetts women.

The UMass/SHU school nurse intervention study to assist students to stop smoking will continue in its second year.

EI is collaborating with the Institute for Health and Recovery on the Massachusetts Smoke -- Free Families Initiative.

c. Plan for the Coming Year

Ongoing activities continue. See also NPM #15 for smoking cessation activities targeting women after they become pregnant and Priority #2 for additional adolescent-focused activities.

Begin to analyze UMass/SHU school nurse intervention study results.

In FY09, MTCP plans to continue funding the quit smoking media campaign, the systems change initiatives in community health centers and rural birth hospitals, and community grants to local grantees (CSIs). Initiatives to provide free nicotine patches through the quitline will be expanded in FY09. An increase in the cigarette tax of \$1.00 which became law and went into effect July 1, 2008 will require expanded cessation services for smokers. MTCP has planned a set of targeted initiatives to provide free nicotine patches to special populations of smokers -- veterans, substance abuse recoverers, and those living in certain communities -- to help them quit. The community smoking intervention demonstration program will add two new communities in FY09 to begin tobacco-related disparity projects.

EI will continue an on-going collaboration with the Institute for Health and Recovery on the Massachusetts Smoke -- Free Families Initiative to promote home visits and other services to at-risk families in order to integrate secondhand smoke awareness and cessation messages. The

project is currently targeting a few communities such as Springfield and Boston that are willing to pilot the initiative.

State Performance Measure 3: *The percentage of women with an interpregnancy interval (IPI) less than 12 months.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				17	13.5
Annual Indicator		13.8	13.8	13.5	13.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	13.5	13.4	13.4	13.3	13.3

Notes - 2007

2007 birth data are not yet available for linkage. Therefore, no PELL analysis can be done to calculate I.P.I. for 2007. We have estimated a slightly lower rate than that projected for 2006.

Notes - 2006

Data Source: PELL (Pregnancy and Early Life Longitudinal) linked hospital discharge, birth and fetal death data. We have estimated a slightly lower rate than that projected for 2006. The latest data available are for 2005. We have projected a similar rate for 2006.

Data for 2006 have not been linked to PELL due to the loss of the PELL lead programmer. A new programmer has been identified and interviewed and will be hired by mid-July. The 2006 birth data are expected to be linked to PELL by the end of August 2008.

Notes - 2005

Interpregnancy interval (IPI) was calculated using PELL. Starting with all deliveries from 2005, women were linked to previous deliveries between 2005 and 2000. For those who had delivered twice in 2005, the latest delivery was included. Then for all women with deliveries in 2005 we linked back to the most recent delivery if available or to the last reported live birth if we were unable to link to any earlier pregnancies. IPI is calculated as the time passed between the delivery date of the first pregnancy and the start of the second pregnancy, as defined by the delivery date minus gestational age.

We calculated IPI two different ways. First we calculated it based on the delivery date of the most recent pregnancy linked. We also calculated it based on the reported date of last live birth. When we were able to calculate IPI using the most recent linked pregnancy, we used that as the final IPI. When we were unable to link any earlier pregnancies, we used the IPI as calculated based on reported date of last live birth, if available, as the final IPI. For those women for whom we could not identify an earlier delivery and who did not report an earlier live birth, IPI was not calculated.

Of the 77,638 women with deliveries in 2005, we identified 30,973 earlier deliveries. Of the 77,638 women, 75,368 were MA residents, for whom we identified 29,998 earlier deliveries. Although we were able to link back to only 29,998 earlier deliveries for MA residents, we were still able to calculate IPI for many of the women for whom we could not find deliveries because we were able to use their reported date of last live birth. Consequently, the total number of MA residents for whom IPI was calculated was 41,713 out of the 75,368.

Of the 41,713 MA residents for whom IPI was calculated, 13.6% had a short IPI defined an IPI less than twelve months. This is the final estimate for 2005.

a. Last Year's Accomplishments

Also see NPM#8 and SPM#1 for programmatic accomplishments related to this measure.

Medicaid, in collaboration with the Family Planning Program, submitted a Medicaid waiver for family planning services to CMS in June 2006. Regular meetings throughout the year explored and developed the program which will expand Medicaid coverage for family planning services to all men and women who are income eligible or who may lose Medicaid coverage. IPI data were considered during discussions and used to inform the application decisions. In FY07, this waiver was deemed not applicable by CMS due to the implementation of health care reform.

Interpregnancy interval data was included in the 2005 annual birth report released in 2007. This report uses data from the Birth records alone, which includes the hospital's report of the date of last live birth. Inclusion of IPI as a measure in the Birth Report (using birth certificate data only) became ongoing, which highlights the issue for a larger public.

For this measure, IPI is calculated using the Massachusetts PELL (Pregnancy and Early Life Linkage) database. A 2-part retrospective methodology was developed (see Detail Sheet and Note above). In FY07, a cutoff for retrospective analysis was set at 4 years (2000 for 2004 births), in order to not artificially affect the calculation as each year of data is added to PELL. The performance measure for 2004 was updated and moved to final status, with revised projections. Of 79,188 women with deliveries in 2004, PELL identified 28,495 earlier deliveries. With additional live births recorded on the birth certificate, a total of 42,209 of the 76,873 women were identified with a prior pregnancy. Of the 42,209 women, 13.8% had an IPI less than 12 months. Using PELL enables calculation of IPIs prospectively and retrospectively with improved data about date of last pregnancy compared to birth certificates.

Through a collaboration with DMR, the DPH Primary Care Office created a unique loan repayment program for dentists in order to increase access to oral health care for adults and children with developmental disabilities and mental retardation.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. FOR Families and EIPP provide assistance to pregnant women with accessing prenatal health care and optimizing health benefits.		X		
2. FOR Families and EIPP offer family planning counseling and referrals to all enrolled women of childbearing age.		X		
3. Improve surveillance of IPI and identification of high-risk groups and geographic areas through use of PELL data, PRAMS data, and Massachusetts Birth Data.				X
4. Encourage integration of IPI into needs assessments and program RFRs.				X
5. Integrate IPI measures into annual birth report and other MDPH publications and presentations to provide forums to discuss this issue.				X
6. Family planning and Community Based Services for Women of Reproductive Age and Adolescents providers counsel individual women pre- and inter-pregnancy about spacing	X	X		

pregnancies to achieve best outcomes.				
7. Report IPI related to birth outcomes in the annual release of birth certificate data.				X
8.				
9.				
10.				

b. Current Activities

Also see NPM#8 and SPM#1 for discussion of most programmatic activities related to improving pregnancy spacing.

The Family Planning program monitors changes in data by community and informs providers.

The Title V agency was interested in calculating IPI and monitoring this indicator in order to get a Medicaid waiver to pay for postpartum family planning services. In the meantime sweeping health reform legislation was passed in MA; all women should be covered. We will continue to monitor this indicator to make sure the goal of universal coverage is realized in Massachusetts.

IPI less than 6 months was also calculated this year. In this analysis, 5.5% of Hispanic women were identified as pregnant again within 6 months postpartum and this finding noted for further study.

c. Plan for the Coming Year

See NPM#8 and SPM#1 for most activities related to improving pregnancy spacing. Continue ongoing activities.

DPH will analyze this finding about Hispanic women with IPI less than 6 months in depth, examine 2006 data when available, and try to encourage programs to use IPI for quality improvement.

PELL will pilot linkage with data submitted from community health centers about primary care and, if successful, the responsible program director will present findings about IPI to the CHC Women of Reproductive Age and Adolescents programs, to encourage attention to pregnancy spacing and brainstorm ideas re prevention of second pregnancies as appropriate.

Organize one or more meetings to present IPI data to MCH programs funded by the Department and brainstorm on strategies and initiatives to prevent or delay the second pregnancies.

An increased emphasis will be placed with WIC and EIPP providers to assure that women return for their 6 week postpartum visit, including discussion on family planning.

State Performance Measure 4: *Percent of children and youth (ages 3 - 18) enrolled in Medicaid who receive preventive dental services annually.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				41	45
Annual Indicator	37.4	39.6	40.8	42.5	45.9
Numerator	139759	143959	151089	165682	180416
Denominator	373525	363162	369993	389674	392765
Is the Data Provisional or Final?				Final	Final

	2008	2009	2010	2011	2012
Annual Performance Objective	50	55	60	60	60

Notes - 2007

See the Detail Sheet for this measure for definitions of the numerator and denominator and a discussion of data limitations. The data correspond to those reported by DMA to HCFA on Form HCFA 416, Annual EPSDT Participation Report; the most recent data are from the period October 1, 2006 - September 30, 2007.

Notes - 2006

See the Detail Sheet for this measure for definitions of the numerator and denominator and a discussion of data limitations. The data correspond to those reported by DMA to HCFA on Form HCFA 416, Annual EPSDT Participation Report; the most recent data are from the period October 1, 2005 - September 30, 2006.

Notes - 2005

See the Detail Sheet for this measure for definitions of the numerator and denominator and a discussion of data limitations. The data correspond to those reported by DMA to HCFA on Form HCFA 416, Annual EPSDT Participation Report; the most recent data are from the period October 1, 2004 - September 30, 2005. The 416 report now reports data in detail by children's age.

This measure is a modified version of one that Massachusetts had prior to the latest 5-Year Needs Assessment. The previous measure attempted to capture both Medicaid and Children's Medical Security Program (CMSP) data on preventive dental services. CMSP is no longer included in the measure, both because it is no longer in the Department of Public Health and because the data quality had proven to be poor and not an accurate picture of children's oral health care. We have reposted annual results for 2003 and 2004 using only the Medicaid data, so that some trend information can be seen.

a. Last Year's Accomplishments

See also NPM # 9 and Priority Need #8

The EPSDT rates were increased in October 2007, in compliance with a judgment (Health Care For All, Inc. et al v. Governor Mitt Romney, et al). In FY07, 469,472 children (ages < 21) were eligible for MassHealth (Massachusetts Medicaid); an increase from FY'06. The utilization rates of dental services by MassHealth eligible children are very low, although there was an increase the percentage of children receiving dental examinations and preventive services since the judgment and rate increase. The percentage of MassHealth eligible children who received preventive dental services are as follows:

- Dental Examination: 45.23%
- Prophylaxis: 41.7%
- Topical fluoride: 39.4%
- Dental Sealant: 14.2%

In addition to increasing rates, Massachusetts also contracted with a third-party administrator (TPA) to coordinate Medicaid dental services and payments to providers. Also, a cap of one patient was placed on the number of dental patients that a dentist has to accept to become a MassHealth provider. In FY07, no marked increase in providers (FY06= 845; FY07= 939) was seen as a result of these changes, and 23% of providers have put a limit on the number of MassHealth members they will accept into their practice.

Most recent available ESHS data (school year 2006-2007) indicate that school nurses increasingly participated in oral health related activities. The typical district participating in oral health screening activities screened students at an annual (median) rate of 22.4 per 1000 students. Over half of screenings were performed by school nurses. Of the ESHS districts

conducting oral health activities, 30% had dental sealant services (reaching 5,969 students); 58% had fluoride rinse programs (reaching 27,827 students); and 56% made referrals to dental providers for 11,433 students.

The OOH supports the delivery of comprehensive oral health services to teens (average age 16 years), in Department of Youth Services' custody. Through the coordination of the delivery of the services via the OOH, more than 4,147 total patient visits occurred in FY07, with more than 9,000 dental sealants being placed. In FY 09 these services were put out to bid and in FY 2009 they will be contracted with one provider/program.

In FY07 the OOH developed "Neighborhood Smiles" an early caries risk assessment tool-kit to be utilized by non-dental professionals serving children with special health care needs (CSHCN) who are 0-3 years of age. The tool-kit is comprised of an early caries risk assessment and anticipatory guidance cards. The tool-kit, available in English and Spanish, is geared to those families who are served by Early Intervention (EI). The OOH provides the tool-kits, supplies, and technical assistance to the EI professional who is using "Neighborhood Smiles." In collaboration with Partners for a Healthier Community, a dental hygienist is also available to work with the family and refer to a dental home as needed for these children, most of whom are recipients of MassHealth.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Office of Oral Health coordinates and provides leadership for oral health planning and activities.			X	X
2. Training and technical assistance are provided to school nurses and school-based health center (SBHC) clinicians re: screening for oral health needs.				X
3. WIC distributes dental health education materials as well as child and adult toothbrushes.				X
4. SBHCs, Essential School Health Services sites (ESHS), and other pediatric primary care sites screen for oral health needs, and refer for care. Some SBHCs and ESHS sites offer preventive oral health care on site.	X	X		
5. CHCs screen and refer for care and many provide on site care. Women of Reproductive Age and Adolescents contracts require CHCs to provide dental services on site or through contracted dental providers. DPH annual site visits review compliance.	X	X		
6. EIPP, FOR Families and Care Coordination for CSHCN assess and refer children for oral health needs.		X		
7. Work closely with Medicaid, providers, and other interest groups on issues of facilitating access, oral health services options, rates, and promoting preventive care.			X	X
8. Some Early Intervention sites offer oral screening, anticipatory guidance and referrals for needed dental care.	X	X		
9. See also activities for NPM #9 and Priority Need #8.	X		X	X
10.				

b. Current Activities

See also ongoing activities Summary Sheet above.

The Office of Oral Health (OOH) collaborates with dental and health professionals interested in

developing school-based oral health programs and increasing the number of MassHealth children served in this venue. Recent collaborations for education, screenings, sealants and fluoride are: Mount Wachusett Community College and the Fitchburg CHC targeting Fitchburg 7th graders; the Chicopee Board of Health and the Caring Health Center serving Chicopee 7th graders. In Fitchburg, more than 50% of participants were on MassHealth.

SBHC sites perform a number of oral health activities. Annual or biannual dental screenings are offered. Patients identified with dental problems such as cavities or needs for cleaning or braces are referred to either an SBHC sponsoring agency, a community agency or university that offers low-cost dental care to SBHC students. Some SBHCs offered dental services through collaboration with mobile dental programs; others had on-site dental clinics that included cleanings, exams and sealants. One site requested training from a local Oral Health Initiative for an SBHC physician and nurse practitioner to screen for dental problems and apply varnish. Some sites conducted classroom-based education on dental health. One site conducted a quality assurance review of their dental program which resulted in the development of comprehensive safety training with per diem staff, interns and residents.

c. Plan for the Coming Year

See also NPM #9 and Priority Need #8. Current activities will continue.

Currently in the Massachusetts Legislature there is a oral health workforce bill (H2085 An Act to Increase Access to Oral Health Services) that would assist in increasing the number of children provided preventive oral health services in public health settings, such as schools. The bill would allow licensed dental hygienists to work in public settings without the supervision of a dentist. This bill, already in place in 22 other states, would also allow dental hygienists to bill MassHealth for their services directly, increasing the number of children receiving preventive oral health services, including dental sealants. It is felt that this legislation could facilitate the provision of services as it has in other states.

The Massachusetts Oral Health Action Plan for CSHCN has been revised and with a recently MCHB grant, the plan will be implemented.

While some SBHC sites already offer on-site dental care ranging from on-site screenings and referral to on-site comprehensive dental care, some do not have the capacity. Thus for the coming year, the MDPH dental program and MDPH SBHC program will be partnering to provide preventive (sealants) oral health services to the 47 state-funded SBHC sites.

Enhance the dental health component of pediatric well-child physical exams including the development of a program for the application of fluoride varnish provided in conjunction with oral health screenings by pediatricians and other qualified health providers. Work with Mass Health and the MCAAP to implement the recommendation of each child having an oral health assessment at 1 year. Beginning in the fall of 2008, pediatricians will be reimbursed by MassHealth for fluoride varnish applications at well-child visits.

The OOH continues supports the delivery of comprehensive oral health services to teens (average age 16 years), in Department of Youth Services' custody. In FY 08 these services were put out to bid and in FY 2009 they will be contracted with one provider/program.

State Performance Measure 6: *The extent to which the Commonwealth is making progress in developing a system to promote healthy weight, including nutrition and physical activity, as measured on a unique scale from 0 - 87.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				24	1
Annual Indicator				24	56
Numerator				24	56
Denominator	87	87	87	87	87
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	64	73	80	84	85

Notes - 2007

This measure is scored from a Checklist that includes five components (some with several subcomponents), each scored on a separate scale; the maximum total score is 87. See previous year's note and Notes to Form 16 (Detail Sheet) for details on components and scoring. See the Detail Sheet (in Form 16) for this measure for definitions and discussions of its significance and development.

The Checklist itself, with the FY07 scoring by component shown, is provided as an Attachment to the "Last Year's Accomplishments" sub-section of the narrative for this Measure.

The details on the specifications and scoring system for this measure were modified after it was proposed in our FY06 Application; it has not been modified this year.

Due to a glitch in the previous version of the EHB/TVIS software, we were not able to directly enter our Annual Performance Objectives for future years. This bug has been corrected and Annual Performance Measures are now shown for Years 2008 - 2012. However, we could not correct the FY07 Objective – which was 53. Our actual FY07 annual score was 56, above this target.

Notes - 2006

This measure is scored from a Checklist that includes five components (some with several subcomponents), each scored on a separate scale; the maximum total score is 87. The components are: 1) establishment of active internal task force to assure implementation of healthy weight systems as developed; 2) establishment of consistent nutrition and physical activity messages across core DPH programs and others as appropriate; 3) promotion of these consistent messages across all core DPH programs and others, including active engagement with external partners; 4) improved policies and systems for nutrition and healthy weight in schools; and 5) capacity to measure weight status and change in key programs: Essential School Health schools, school-based health centers, and WIC programs (through PNSS). See Notes to Form 16 (Detail Sheet) for details on components and scoring. See the Detail Sheet (in Form 16) for this measure for definitions and discussions of its significance and development. It has not been modified for FY07.

The Checklist itself, with the FY06 scoring by component shown, is provided as an Attachment to the "Last Year's Accomplishments" sub-section of the narrative for this Measure.

The details on the specifications and scoring system for this measure were modified after it was proposed in our FY06 Application. Further modifications – both in its content and scoring – are possible for future years. If it is modified, any objectives and previous scoring will be adjusted if possible for accurate trend analysis.

How checklist is scored: A lead person with knowledge of the topic being measured works with a team to score the checklist and to propose target scores for future years. Team members may be responsible for different elements on the checklist, depending on the nature of the element and their expertise; some elements may be jointly scored. Checklists include multiple types of elements. Some come from survey results or other instruments, which directly translate into rating

scheme on the checklist. Checklist elements have been designed to be as objective as possible, e.g., specifying a number of sites in which a program should be implemented to attain a given score. For example, the person with knowledge of the number of sites implementing the program scores that element and communicates the score to the lead person. When an element has some degree of subjectivity to it (e.g. if a question is raised about what constitutes program implementation), the team members negotiate a joint score. The proposed current and projected scores are reviewed and approved by the Title V director before being finalized.

Because of a glitch in the EHB software, if we directly enter our current annual indicator, all of our objectives can be no greater than 1. Our FY06 annual score was 24, in line with our target. Our projected annual performance objectives for 2007 - 2011 are 53, 63, 72, 80, and 84 respectively.

Notes - 2005

As this measure was only adopted for FY06 and beyond, there is no scoring for the measure for FY2005.

The details on the specifications and scoring system for this measure have been modified since it was proposed in our FY06 Application. Further modifications – both in its content and scoring – are possible for FY07 or future years. If it is modified, any objectives and previous scoring will be adjusted if possible for accurate trend analysis.

Our projected annual performance objectives for 2006 - 2010 are as follows (out of the total possible score of 87):

2006 - 24

2007 - 42

2008 - 61

2009 - 70

2010 – 81

a. Last Year's Accomplishments

The internal task force membership included representatives from the Nutrition Division, Primary Care, EIPP, Diabetes, Nutrition and Physical Activity Unit (NPAU), SHU, SBHCs, ESHS, and Women's Health. Related work/policy groups were for BMI, including the Coordinated School Health Program (CSHP), SHU, and NPAU; a standing policy subcommittee of the statewide Joint Chronic Disease Coalition; and in the Nutrition Division (WIC, Growth & Nutrition, Folic Acid, Office of Nutrition) promoting consistent use of "Steps to Healthy Weight in Children" (age-appropriate messages endorsed by MA AAP promoting good nutrition and physical activity for children 0-5) with medical providers.

With \$150,000 of state funding, 3 school food vendors made changes to school meals, snack and/or ala carte meals to increase access to and promote selecting healthy foods during lunch, reaching over 16,000 students in 25 elementary and middle schools. All schools considered the project a success--new food had wide appeal and increased awareness of healthier food.

ESHS surveyed its 102 programs on their nutritional environment: 43% had nutrition/physical activity support groups with 91.7 meetings attended by 556 students in an average month; school nurses averaged 298 presentations with 6784 students attending per month; 89 districts reported 167,971 BMI screenings; overweight for screened students ranged from 14.8% to 20.3%, and at risk from 15.6% to 18.3%.

Of Healthy Choices public middle schools, 98% reported at least 1 policy/environmental change and 93% implemented 2 or more. On average, 4.2 policy/environmental changes were reported per school (e.g., 60% of schools developed policies to add nutritious foods to menus, 55% to eliminate non-nutritious food as rewards or fundraisers). Almost all schools completed at least 1 school-wide promotion, 95% implemented a before/after school program, and 86% reported teaching the Planet Health curriculum.

2006 Pregnancy Nutrition Surveillance data (released 2007) indicated that the % of women overweight pre-pregnancy increased from 28.9 in 1992 to 40.3 in 2006. The percentage of WIC enrollees with greater than ideal weight gain during pregnancy rose from 39.2% in 1992 to 46.2% in 2006.

WIC provided all local WIC programs data regarding prenatal weight gain patterns of pregnant WIC enrollees and initiated on-going monitoring and evaluation of these rates.

The WIC Program implemented the Touching Hearts Project materials and materials.

DPH participated in the AMCHP/CityMatch Healthy Weight Action Learning Collaborative (HWALC) with Boston Public Health Commission and 7 other states to develop provider approaches to effectively counsel women and to identify community approaches for increasing healthy foods and physical activity. The HWALC conducted provider interviews and focus groups with black and Latina women, ages 18-45, designed to inform provider practices and other HWALC teams across the country on healthy weight interventions, and to help frame perinatal healthy weight recommendations from a life course perspective.

Massachusetts Partnership for Healthy Weight (MPHW) provided state and regional educational conferences, networking opportunities and technical assistance to public and private organizations on healthy eating, active living and obesity prevention.

Through the MA Health Promotion Clearinghouse, 165,049 free nutrition and physical activity materials were distributed.

The Physical Activity Club (PAC) program, found to successfully decrease BMI in a FY05 pilot, was implemented in 12 sites.

96% of SBHC's reported BMI through ESM; 9.93% of students with at least one visit to the SBHC had an overweight or obesity-related diagnosis code.

After a roundtable of the Executive Committee of School Physicians with community physicians, Blue Cross/Blue Shield and representatives from the DPH and DOE, BC/BS developed a tri-part form for the PCP to review an individual child and family plan on physical activity and nutrition changes, sending a copy to parent and school nurse. The Executive Committee will reinforce the 5-2-1 message.

The SHU, CSHP and Office of Nutrition, published and distributed Comprehensive Growth Screening Guidelines for schools.

The SHI provided programming on obesity prevention & growth screening guidelines for 97 school nurses and other staff. The growth screening guidelines were presented to 102 school nurse leaders.

The new DPH Commissioner set wellness as one of 6 priority areas.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Through the task force—with work groups for pregnant women, young children, school age/youth, and adults--establish consistent nutrition and physical activity messages across programs and monitor their use and effectiveness.				X

2. Assure that all relevant BFHN and BCHAP programs document, monitor and evaluate the use of standard nutrition and physical activity messages.				X
3. Focusing on each population group, develop and update guidelines and standards for BFHN and BCHAP direct service programs regarding nutrition screening, education and referral.		X		X
4. Improve systems in schools with multiple initiatives through Mini-grants, Healthy Choices (HC), School Based Health Centers (SBHC), Essential School Health Services (ESHS), School Health Unit (SHU), and Coordinated School Health Program (CSHP).				X
5. Systematically engage with school personnel and affiliated groups in improving school policies and systems for nutrition and healthy weight, provide training and guidelines, and annually survey the schools to document ongoing improvement.				X
6. Implement and continuously improve systematic collection and reporting of BMI in school age children, with a BMI workgroup including the CSHP, SHU, ESHS, and the Nutrition and Physical Activity Unit (including its program, HC).				X
7. Local WIC programs identify and implement strategies to promote healthy weight gains for pregnant women, including to improve local program baselines set FY08 for monitoring weight gain among pregnant women.		X		X
8. WIC and EIPP assess participating pregnant and postpartum women for nutrition, BMI, and physical activity and provide appropriate counseling and referrals.		X		X
9. Implement consistent messages on healthy eating, physical activity and healthy weights in BFHN and BCAHP program services, targeting children birth to five, and evaluate the implementation and utilization of messages in program service delivery.				X
10. Continue the Massachusetts Partnership for Healthy Weight network to promote healthy nutrition and increased physical activity by fostering policy, systems, and environmental changes using evidence-based strategies and surveillance.				X

b. Current Activities

See summary chart and NPM #14

The Nutrition Division ensured consistent message for young children; the NPAU for youth and across chronic disease programs. CHSP organizes the School Health Collaborative convening MDPH youth-centered programs and the MA ESE.

WIC implemented in all local programs new advertising style messages connecting with parents' emotional "pulse points" for behavior change.

NPAU collaborates with many external partners to promote healthy weight including MA AAP Obesity Subcommittee for review of screening/assessment tools, MA Dietetic Association, Boston Steps Healthy Eating committee on healthy snacks and school physical activity, and others.

Mini-grants of \$150,000 were awarded to 3 food service vendors serving 26 school districts to promoting healthy foods.

NPAU worked with MA Action for Healthy Kids to pilot in 5 middle & high schools to student leadership in making policy and environmental changes.

The DPH Commissioner convened an obesity task force with public and private organizations represented to identify and prioritize key strategies for coordinated action.

DPH funded 26 organizations to implement wellness activities in community, school and workplace.

Participating in Children's Museum effort to revamp museum messages and programs to encourage physical activity and healthy eating, especially for children ages 1-5; these efforts will continue in FY09.

c. Plan for the Coming Year

Continue ongoing activities.

A new Wellness Division, established in spring 2008 within the BCHAP and encompassing NPAU, Obesity Prevention and Control, and a new Worksite Wellness program, will set and implement its priorities to advance wellness activities, one of the Commissioner's priority areas.

FY08 outcome evaluation of 49 Healthy Choices Middle Schools will be reported.

In FY09, the SBHC program is collaborating with the Wellness Division to implement two interventions. The "Students Taking Charge" toolkit is a positive youth development-approach to the assessment of the school environment as it relates to 3 areas of the School Health Index- nutrition, health and physical activity. SBHCs plan to implement it in two high schools with SBHC clinicians taking the lead role in mentoring the students. At the elementary school level, SBHCs plan to implement the "Eat Well & Keep Moving" curriculum in two schools with the leadership for this project to be provided by the SBHC clinician. SBHC clinicians will continue to measure BMI for all sports physical and well-child exam, and standards require clinicians to make a referral for elevated BMI's to a hospital or community-based nutritionist.

New ESHS contracts require BMIs in grades 1-4-7-10. DPH staff for the ESHS program will analyze BMI data. SHU will continue to distribute the School Health Manual with chapters on physical education and nutrition, and will engage with school physicians, nurses and others re the 5-2-1 message and growth screening in schools.

The Nutrition Division will continue to ensure the use of consistent messages for women and young children through the use and promotion of Touching Hearts, Touching Minds nutrition education materials and "Weigh of Life...Taking Action Together" Initiative materials focusing on partnering with medical providers and the messages in "Steps to Healthy Weights in Children".

WIC will continue the utilization of its emotion-based, participant-led service delivery model. Staff will continue to receive follow-up training and technical assistance to ensure skill development and effective utilization of techniques. Staff will expand the use of facilitated group discussions for follow-up nutrition education for WIC families.

The GHM grant will fund 6 pilot programs to test new assessment techniques to enhance WIC service delivery and accuracy of data collected.

Mini-grants of \$150,000 will be made to 3 food service vendors to promote healthy foods with elementary and middle school children.

WIC will communicate baseline prenatal weight gain data, comparing rates over the last 12 months, to review current efforts to improve rates and plan individual program activities and

initiatives for implementation.

Develop messages for women for Mix 98.5FM Nutrition Buzz promotions to maintain good health, aiding in the adoption of healthy habits that will contribute to healthy weight gains during pregnancy and returning to normal BMI's postpartum.

State Performance Measure 7: *The degree to which Pediatric Sexual Assault Nurse Examiner (Pedi-SANE) services have been implemented statewide, as measured on a unique scale from 0 - 20.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				7.5	13
Annual Indicator				8	15
Numerator				8	15
Denominator	20	20	20	20	20
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	18	18	18	19	19

Notes - 2007

This measure is scored from a Checklist that includes a sequence of five implementation steps, each of which is scored on a separate scale; the maximum total score is 20. See previous year's note and Notes to Form 16 (Detail Sheet) for details on components and scoring. See the Detail Sheet (in Form 16) for this measure for definitions and discussions of its significance and development.

The Checklist itself, with the FY07 scoring by component shown, is provided as an Attachment to the "Last Year's Accomplishments" sub-section of the narrative for this Measure.

The implementation steps outlined in this measure will have been essentially met by the end of the current FY (FY08) and it is being dropped as one of our Negotiated Performance Measures. It is being replaced by a new state Performance Measure #11 that addresses another violence prevention issue, shaken baby syndrome.

Notes - 2006

This measure is scored from a Checklist that includes a sequence of five implementation steps, each of which is scored on a separate scale; the maximum total score is 20. The components are: 1) completion of clinical training and preceptorships of current pediatric sexual assault nurse examiner (Pedi-SANE) candidates; 2) pilot of Pedi-SANE kit and protocol and dissemination/implementation in all hospital emergency rooms [note criteria expanded for FY06 and beyond from just piloting in three clinical settings]; 3) implementation of Pedi-SANE services with 5 child advocacy centers (CACs); 4) implementation of Pedi-SANE services in other venues in remaining 6 jurisdictions; and 5) delivery of Pedi-SANE services with 90% quality assurance based on standards and protocols. See Notes to Form 16 (Detail Sheet) for details on components and scoring. See the Detail Sheet (in Form 16) for this measure for definitions and discussions of its significance and development.

The Checklist itself, with the FY06 scoring by component shown, is provided as an Attachment to the "Last Year's Accomplishments" sub-section of the narrative for this Measure.

How checklist is scored: A lead person with knowledge of the topic being measured works with a team to score the checklist and to propose target scores for future years. Team members may be responsible for different elements on the checklist, depending on the nature of the element and

their expertise; some elements may be jointly scored. Checklists include multiple types of elements. Some come from survey results or other instruments, which directly translate into rating scheme on the checklist. Checklist elements have been designed to be as objective as possible, e.g., specifying a number of sites in which a program should be implemented to attain a given score. For example, the person with knowledge of the number of sites implementing the program scores that element and communicates the score to the lead person. When an element has some degree of subjectivity to it (e.g. if a question is raised about what constitutes program implementation), the team members negotiate a joint score. The proposed current and projected scores are reviewed and approved by the Title V director before being finalized.

Notes - 2005

As this measure was only adopted for FY06 and beyond, there is no scoring for the measure for FY2005. Related information on the measure is also not available for earlier periods because the Pedi-SANE program itself was funded for the first time in FY06.

This measure is scored from a Checklist that includes a sequence of five implementation steps, each of which is scored on a separate scale; the maximum total score is 20. The components are: 1) completion of clinical training and preceptorships of current pediatric sexual assault nurse examiner (Pedi-SANE) candidates; 2) pilot of Pedi-SANE kit and protocol in three clinical settings; 3) implementation of Pedi-SANE services with 5 child advocacy centers (CACs); 4) implementation of Pedi-SANE services in other venues in remaining 6 jurisdictions; and 5) delivery of Pedi-SANE services with 90% quality assurance based on standards and protocols. See Notes to Form 16 (Detail Sheet) for details on components and scoring. See the Detail Sheet (in Form 16) for this measure for definitions and discussions of its significance and development. The Checklist itself is provided as part of an Attachment to Part IV, Section B. of our Narrative Application. In future years, the Checklist will also be provided as an Attachment to the "Last Year's Accomplishments" sub-section of State Performance Measure 5 (in Part IV, Section D. of our Narrative Application), with the relevant annual fiscal year scoring by component shown.

Although the details on the specifications and scoring system for this measure have not been modified since it was proposed in our FY06 Application, such modifications – both in its content and scoring – are possible for FY07 or future years. As the Pediatric SANE system becomes operational, it has become clear that some changes to our model of where services will be offered and other changes to the original implementation plan may improve program effectiveness. If the measure is modified, any objectives and previous scoring will be adjusted if possible for accurate trend analysis.

a. Last Year's Accomplishments

See the Attachment to this subsection for a copy of the complete checklist being used and details on scoring of this measure for FY07 by component.

The Mass Office for Victim Assistance (MOVA) continued to operate the direct service component for Pediatric SANE.

The contract with the Massachusetts Children's Alliance was continued to support the infrastructure of children's advocacy centers in all district attorney jurisdictions in order for them to be able to work effectively with pediatric sexual assault nurse examiners and to create on-site medical suites for the provision of the forensic evidence exam.

A Quality Assurance protocol was developed for the use of the pediatric kit and documentation forms were finalized.

SHU sent Information on the SANE program and also the location of the Rape Crisis Centers to all school nurses. The Northeastern University Summer School Health Institute provided a program on SANE for 74 school nurses.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Pediatric SANEs have been hired for 6 child advocacy centers (CACs).			X	X
2. Operational guidelines for pediatric SANEs developed for CACs.				X
3. Pediatric non-acute documentation and consent forms developed, piloted, and implemented.				X
4. Discussions underway with additional CACs on hiring of a pediatric SANE.				X
5. Training on use of the pediatric evidence collection kit has been completed in three regions of state.			X	X
6. Pediatric kit is being used within Lawrence General Hospital by fully trained pediatric SANEs and is being implemented in Northeast, Southeast, and Central regions.			X	X
7. Capacity-building and technical assistance, as well as funding is provided to CACs through the Massachusetts Children's Alliance.				X
8. Quality assurance and clinical oversight are being provided to all SANEs within CACs.				X
9. School nurses are receiving education on the SANE program.				X
10.				

b. Current Activities

See "Key Activities" and the Attachment to Section IVB for a copy of the checklist being used and the scores for each component.

Pediatric training responsibilities were transferred from the Massachusetts Nurses Association to key expert staff at the MOVA (the Assoc. Director for Pediatric SANE).

Training was provided for hospital staff in the Boston and Western regions of the state on the use of pediatric evidence collection kit. All hospitals in all regions of the Commonwealth receiving and using the MAPSAECK have now received training.

Ongoing implementation of pediatric services in Barnstable, Berkshire, Plymouth, Suffolk, Norfolk, Bristol, and Essex counties continued. Norfolk County experienced a staff resignation and a new hire is planned.

Pediatric SANEs continued to utilize 2nd Opinion software and Q/A procedures were implemented.

The program continues to explore appropriate protocol/kit/techniques for adolescent victims of sexual assault ages 12-16. Changes to the algorithm developed for appropriate response for pre-pubescent youth may be needed for the adolescent protocol. Practitioner training needs will be determined if protocols change. The option of utilizing adolescent/adult SANEs for an Emergency Department response for pediatric victims, especially those who are peri-pubescent, is being explored.

The Comprehensive School Health Manual includes information on SANE.

The NEU-SHI will include the SANE program in its single-day presentation on violence

prevention.

c. Plan for the Coming Year

This measure will be dropped as of FY09 because its developmental objectives have been met. Programmatic activities will, however, continue. In future years they will be reported under Priority Need #6.

Memoranda Of Understanding (MOUs) with all adolescent SANE sites will be renegotiated in FY09 and a plan for site designation and MOUs will be implemented for pediatric SANE.

Ongoing development of algorithm for decision making in borderline pediatric/adolescent cases (ages 9-16) and ongoing discussion of an emergency response for pediatric patients.

Continued conversations with developing CACs regarding possible incorporation of pediatric services at new sites

Examination of funding limitations on continued program expansion, particularly for an emergency response. This work will benefit from newly hired staff at DPH who will serve as liaison with direct service components at MOVA.

State Performance Measure 8: *The percent of licensed child care centers serving children age birth to five who have on-site health consultation*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				20	22.5
Annual Indicator			20	20	22.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	25	30	40	50	50

Notes - 2007

The annual indicator percent is an estimate based on the previous year's numbers. Much of our work in capturing this data has been put on hold as EEC is currently in the process of developing an electronic record system for all licensing information, which should yield a clearer picture of ECE program CCHC utilization.

Notes - 2006

The annual indicator percent is an estimate by program staff based on information about past and current utilization of child care health consultants and surveys of child care consultants being initiated by MDPH. For 2006, responses to a preliminary survey were obtained from consultants serving approximately 50% of all child care sites.

Notes - 2005

As this measure was only adopted for FY06 and beyond, there is no objective for the measure for FY2005. The annual indicator percent is an estimate by program staff based on information about past and current utilization of child care health consultants.

a. Last Year's Accomplishments

Plans were discussed to complete a more thorough census of all licensed programs, yet in initial phase of previous study, it was found that EEC does not have an electronic database of the CCHCs. Although licensed programs are required to provide their CCHC's name, phone number, and registration number, review of the paper licensing applications was deemed too problematic. EEC recently received funding to develop and implement an electronic record of group and family child care licensing information. It is our hope that this will also then provide an electronic record of existing child care health consultants, which may then be used as a networking opportunity for trainings and other professional development opportunities.

The Northeastern University School Health Institute continued to offer trainings in the new preschool vision screening protocols for pediatricians, health consultants to day care providers, and school nurses: 103 new school nurses and 460 pediatricians/consultants/school nurses were also trained.

A telephone sample of PCPs was interviewed regarding their use of the preschool vision protocols; 73% of the respondents reported using the protocols. In the school nurse survey (FY 07), 45.3% of those entering kindergarten were screened by the PCP and 54.7% by the school nurse.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Staff and complete the HRSA-funded Massachusetts Early Childhood Comprehensive Systems (MECCS) projects, including the following:				X
2. With the Head Start (HS) Quality Initiative & regional Healthy Child Care New England collaborative, provide annual, comprehensive training of Child Care Health Consultants (CCHCs), HS Health Managers and related consultants, reaching 40 per year.				X
3. Provide technical assistance to the Department of Early Care and Education (EEC) as it undertakes reform of the child care licensing regulations and begins to plan a tiered Quality Rating Scale.				X
4. Contact child care centers and CCHCs to update the MECCS database, originally created from a 2007 survey, of CCHCs' activities and barriers and supports to their work, and clean and maintain the CCHC database.				X
5. Complete the final report from the survey and build awareness of CCHCs by disseminating it.				X
6. Further build awareness by developing a brochure on How to Choose a Child Care Health Consultant, adapted from a National Training Institute for Child Care Health Consultants (UNC, Chapel Hill) brochure.				X
7. Develop a web page to share key resources for health and safety in child care with CCHCs and other Early Care and Education staff.				X
8. Convene leaders in various disciplines working with young children and their families, build on existing collaborations, develop system-wide goals and outcomes, and implement effective strategies utilizing these strong partnerships.				
9. In collaboration with Boston University and the Massachusetts Society of Eye Physicians and Surgeons, promote preschool			X	X

vision screening protocols, provide training on them, and monitor their implementation at kindergarten entry.				
10.				

b. Current Activities

See also Summary Sheet for SPM 8.

MECCS continues to contact centers to update the existing CCHC database. The final report has been completed and is currently being reviewed internally. Discussions are currently being held as to how to disseminate the report, possible audiences and how best to utilize the information contained in the report.

MECCS provided TA on the roles of CCHCs to EEC, which has updated its child care licensing regulations and will promulgate them soon. New proposed regulations include an Individualized Health Care Plan requirement and enhanced medication administration training.

MECCS completed a text-only version of a health and safety website for child care consultants and providers. MECCS director is currently discussing next steps with IT department.

In collaboration with the BU Department of Pediatric Ophthalmology, the Massachusetts Medical Society sent a CD on the new preschool vision screening protocols to all primary care providers. The SHU gave copies to the Early Childhood Division for the health consultants.

For preschool vision screening, 61.8% of children entering kindergarten were screened by the PCP, 26.4% by the school nurses and 11.5% were not screened.

A telephone survey to a sample of PCPs was completed regarding their use of the preschool vision protocols and an electronic survey of school nurses regarding status of implementation was sent; results of both are currently being analyzed.

c. Plan for the Coming Year

Continue ongoing activities.

MECCS plans to further develop, clean, and maintain a database of CCHCs, which will be used to disseminate health and safety information, as well as an urgent health alerts and updates.

MECCS will support EEC in developing the infrastructure and training to support any final regulatory changes, as well as any criteria about CCHCs that might be adopted in EEC's planned Quality Rating System. MECCS will utilize current and future CCHC data and databases to help determine any needed changes to policy or regulations regarding CCHCs and their roles.

MECCS plans a campaign to build awareness of CCHCs through the dissemination of the CCHC study report and the development of a brochure or online resource on How to Choose a Child Care Health Consultant, adapted from a brochure developed by the National Training Institute for Child Care Health Consultants, at the University of North Carolina at Chapel Hill.

MECCS plans to "go online" with the health and safety in child care website, including the development of an interactive process for gathering users' opinions and assessing areas for improvement.

The School Health Unit will continue analysis of the above surveys of school nurses and primary care providers re vision screening with a goal of identifying gaps and improving rates. The preschool vision screening protocols will be placed on a new web site developed for the school

Health manual.

State Performance Measure 9: *The extent to which perinatal health disparities are addressed at the state and local levels, collaboratively with stakeholders and community partners, as measured by a unique scale from 0 - 33.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				8	1
Annual Indicator				8	11
Numerator				8	11
Denominator	33	33	33	33	33
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	14	16	17	19	19

Notes - 2007

This measure is scored from a Checklist that includes a sequence of six components (some with subcomponents or steps), each scored on a separate scale; the maximum total score is 33. See previous year’s note and Notes to Form 16 (Detail Sheet) for details on components and scoring. See the Detail Sheet (in Form 16) for this measure for definitions and discussions of its significance and development.

The Checklist itself, with the FY07 scoring by component shown, is provided as an Attachment to the “Last Year’s Accomplishments” sub-section of the narrative for this Measure.

Details on the specifications and scoring system for this measure were modified after it was proposed in our FY06 Application. Further modifications will be made to this measure during FY09, based on our first several years experience.

Due to a glitch in the previous version of the EHB/TVIS software, we were not able to directly enter our Annual Performance Objectives for future years. This bug has been corrected and Annual Performance Measures are now shown for Years 2008 - 2012. However, we could not correct the FY07 Objective – which was 11 (not 1).

Notes - 2006

This measure is scored from a Checklist that includes a sequence of six components (some with subcomponents or steps), each scored on a separate scale; the maximum total score is 33. The components are: 1) development & implementation of a state plan & other support for programs that address perinatal disparities [Sub-components include: 1a) establishment of statewide advisory group to develop a state plan; 1b) revision & promulgation of state perinatal regulations; 1c) development of protocols to address racism in all state-supported perinatal programs; & 1d) development of statewide strategic plan with community input;]; 2) establishment of functioning community-based advisory groups in at least 5 communities with high perinatal disparities; 3) increased use of state & local data to develop community-based strategic plans; 4) MDPH engagement with communities with high perinatal disparities in development of their strategic plans; 5) completion & approval of strategic plans to address perinatal disparities in high disparity communities; and 6) the implementation of these plans. See Notes to Form 16 (Detail Sheet) for details on components and scoring.

The Checklist itself, with the FY06 scoring by component shown, is provided as an Attachment to the “Last Year’s Accomplishments” sub-section of the narrative.

Details on the specifications and scoring system for this measure were modified after it was proposed in our FY06 Application. Further modifications are possible for future years. If it is modified, any objectives and previous scoring will be adjusted if possible for accurate trend analysis.

How checklist is scored: A lead person with knowledge of the topic being measured works with a team to score the checklist and to propose target scores for future years. Team members may be responsible for different elements on the checklist, depending on the nature of the element and their expertise; some elements may be jointly scored. Checklists include multiple types of elements. Some come from survey results or other instruments, which directly translate into rating scheme on the checklist. Checklist elements have been designed to be as objective as possible, e.g., specifying a number of sites in which a program should be implemented to attain a given score. For example, the person with knowledge of the number of sites implementing the program scores that element and communicates the score to the lead person. When an element has some degree of subjectivity to it (e.g. if a question is raised about what constitutes program implementation), the team members negotiate a joint score. The proposed current and projected scores are reviewed and approved by the Title V director before being finalized.

Due to a glitch in the EHB/TVIS software, we cannot directly enter our Annual Performance Objectives for future years. For Years 2007 - 2011, they are 11, 12, 15, 18, and 20 respectively.

Notes - 2005

As this measure was only adopted for FY06 and beyond, there is no scoring for the measure for FY2005.

Our projected annual performance objectives for 2006 - 2010 are as follows (out of the total possible score of 33):

2006 - 8
2007 - 14
2008 - 20
2009 - 25
2010 - 29

a. Last Year's Accomplishments

See also NPMs #17 and #18, as well as Priorities #1, #4 and #10 for information on additional activities.

See the Attachment to this section for a copy of the complete checklist being used and details on scoring of this measure for FY07 by component.

In collaboration with 19 statewide perinatal advocacy and support agencies, MDPH implemented the 18th annual "Partners in Perinatal Health Conference," which provided up-to-date training and multidisciplinary networking opportunities for over 500 perinatal care providers of all levels. Workshops focused on paradigms of healthcare, the history of birth, using data to inform community action, and a variety of other topics related to perinatal health.

The March of Dimes Massachusetts Chapter Annual Prematurity Summit, held in collaboration with the MDPH and other state partners, emphasized the impact of racial and ethnic disparities on birth outcomes, creating a forum for multidisciplinary discussions for addressing racial and ethnic barriers to access care.

The Massachusetts Community Health Worker (CHW) Network Project used CHWs to reduce health disparities by seeking opportunities for promoting MCH services in underserved populations, through culturally and linguistically competent outreach and collaboration building with rural health care organizations. The Massachusetts Community Health Worker Network

implemented trainings designed specifically to teach outreach educators strategies for increasing prenatal care utilization in culturally and geographically diverse target populations.

An expert group of clinicians reviews all pregnancy associated and pregnancy related maternal deaths in Massachusetts to establish recommendations for improving health systems and clinical care for women giving birth. MDPH worked closely with this group to write an article for MMWR on the risk and management of mid-trimester chorioamnionitis.

DPH began the CDC-funded Safe Families Project to address the link between perinatal disparities and domestic violence.

See Healthy Weight Learning Collaborative, SPM #6.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. With DPH Health Care Quality (hospital licensing), survey and educate MA Birth Hospitals to determine level of care and compliance with recent perinatal hospital regulations, and provide health and regulatory information to hospitals.				X
2. Annually analyze birth data at both the state and community level--including Perinatal Periods of Risk (PPOR), Population Attributable Risk (PAR) and risk statistics--and share results with state and community partners.				X
3. Continue to work with stakeholders and community partners to assess strengths, skills and capacity to collect and analyze data pertinent to disparities.				X
4. In collaboration with 18 statewide perinatal advocacy and support agencies, support annual "Partners in Perinatal Health Conference," reaching audiences of over 500 providers and including workshops focused on perinatal racial disparities.				X
5. The Perinatal Disparities Project actively collaborates with Fetal-Infant Mortality Review (FIMR) initiatives in Boston, Worcester and Springfield.				X
6. The Maternal Mortality Review Committee, convened by the MDPH, reviews all maternal deaths in Massachusetts and develops recommendations for clinical and systems improvement to ensure safe motherhood.				X
7. The Perinatal Advisory Committee, convened by Health Care Quality and BFHN, meets at least twice annually to review and advise DPH on perinatal services in birth hospitals.				X
8. The Perinatal Disparities Project is developing a tool kit to train communities in using state and local qualitative and quantitative data related to infant and maternal outcomes to identify priorities and inform policy and strategic planning.				X
9. Participate with Boston Public Health Commission and 7 other states in AMCHP/CityMatch Learning Collaborative to promote healthy weight in women of reproductive age in Boston, with emphasis on African-American & Hispanic communities.		X		X
10. Community Services for Women of Reproductive Age and Adolescents aims to improve perinatal outcomes through reducing health disparities and improving health status for		X		X

women and adolescents.				
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b. Current Activities

See Summary Sheet above, NPMs #17 and 18, as well as Priorities #1, #4 and #10.

DPH worked closely with Boston, Worcester and Springfield to implement community plans to address racial disparities in perinatal outcomes. In Springfield, presentation of a population-attributable risk (PAR) analysis of LBW/VLBW that highlighted the high risk attributable to Black race and Hispanic ethnicity helped move forward a DPH collaboration with local partners including the FIMR to conduct focus groups with black and Hispanic women to gather qualitative data on the perception of care they received while pregnant, giving birth or in the postpartum period, and impact of racism on it. The project presented the Springfield PAR results, SWOT analysis from the community discussion, and resulting action steps at the national FIMR conference in August.

The Perinatal Disparities Project training is being replicated in communities across the state and the project presented at 3 national conferences. AMCHP funded DPH to train high risk communities to use state and local quantitative and qualitative data to examine disparities and birth outcomes among teens.

The Safe Families Project will be completed.

Collaboration between AMCHP and the Family Violence Prevention Fund builds the knowledge and capacity of state-level MCH professionals and their community partners to integrate family violence prevention, assessment and intervention into community-based MCH programming.

c. Plan for the Coming Year

See also NPMs #17 and #18, as well as Priorities #1, #4 and #10 for information on additional activities.

Continue ongoing activities.

The Perinatal Disparities Project will complete its tool kit to assist communities to use state and local qualitative and quantitative data to inform policy and identify program priorities. This tool kit, having been piloted in two communities, will be offered to other communities experiencing racial disparities in perinatal outcomes. The MDPH will continue providing technical assistance in evaluating disparities at the community level. This project will also establish a formal communication network between Massachusetts communities to encourage information sharing, raise public awareness, and advocate for resources to eliminate institutional racism, or the differential access to goods, services, and opportunities of society by race. This project is also collaborating with NE regional efforts to train stakeholders in a lifecourse approach to women's health with an emphasis on preconception care.

The Perinatal Advisory Committee will continue to meet to review perinatal clinical care provided in Massachusetts Birth Hospitals, and establish or review QI in each institution.

The Massachusetts Community Health Worker Initiative will be collaborating with relevant MDPH staff to implement Section 110 of Massachusetts health care reform legislation (Chapter 58). Section 110 calls for the MDPH to: 1) Conduct an investigation to determine a) The current use and funding of community health workers (CHWs) in Massachusetts; b) The effectiveness and unique role of CHWs in increasing access to health care, particularly Medicaid-funded health and public health services; c) The effectiveness and unique role of CHWs in eliminating health disparities among vulnerable populations; 2) Convene a statewide advisory council to assist in developing recommendations for a sustainable community health worker program in

Massachusetts.; and 3) Make a report, including the results of the investigation and recommendations for a sustainable CHW program, to the general court.

State Performance Measure 10: *The percentage of adolescents reporting no current use (in past 30 days) of either alcohol or illicit drugs.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				59	59
Annual Indicator			59	59	66
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	66	67	67	68	68

Notes - 2007

This measure is based on information from the Massachusetts Youth Health Survey (MYHS). Because the MYHS results are reported as population-based estimates based on weighted survey data, only the percent will be reported, without numerators and denominators. The survey is conducted every other year and the data have been refreshed from the FY07 survey. Illicit drug use asked about includes those in the HP 2010 definition (with the exception that hashish is not asked), plus specific questions about "club drugs," over-the-counter drugs to get high; use without a prescription of steroids, Ritalin or Oxycontin; and drugs from prescriptions that weren't his/her own. In 2004 on MYHS, over half (59%) of Massachusetts middle and high school students reported no alcohol or drug use. This became the baseline for this new state measure.

Notes - 2006

This measure is based on information from the Massachusetts Youth Health Survey (MYHS). Because the MYHS results are reported as population-based estimates based on weighted survey data, only the percent will be reported, without numerators and denominators. Because the survey is conducted every other year, there are no new data to report for FY06. However, the FY07 survey has just been completed and initial analyses made available. Based on that preliminary information, we have modified future year objectives upward. Illicit drug use asked about includes those in the HP 2010 definition (with the exception that hashish is not asked), plus specific questions about "club drugs," over-the-counter drugs to get high; use without a prescription of steroids, Ritalin or Oxycontin; and drugs from prescriptions that weren't his/her own. In 2004 on MYHS, over half (59%) of Massachusetts middle and high school students reported no alcohol or drug use. This is the baseline for this new state measure.

Notes - 2005

This measure is based on information from the Massachusetts Youth Health Survey (MYHS). Because the MYHS results are reported as population-based estimates based on weighted survey data, only the percent will be reported, without numerators and denominators. Illicit drug use asked about includes those in the HP 2010 definition (with the exception that hashish is not asked), plus specific questions about "club drugs," over-the-counter drugs to get high; use without a prescription of steroids, Ritalin or Oxycontin; and drugs from prescriptions that weren't his/her own. In 2004 on MYHS, over half (59%) of Massachusetts middle and high school students reported no alcohol or drug use. This is the baseline for this new state measure.

a. Last Year's Accomplishments

Implementation of the state's Substance Abuse Strategic Plan strengthened responses to substance abuse (SA) issues regarding adolescents:

--Implementation plans began to standardize alcohol and drug screening, assessment & referral services within DPH Bureau of Substance Abuse Services (BSAS), BFCH, other EHS agencies & juvenile courts.

--28 BSAS-funded community coalitions in MA provided science/evidence-based substance abuse Prevention Programs to prevent SA (especially underage drinking), marijuana, and other drug abuse among children, pre-K to youth up to 18 years of age. Of the 28 programs, 12 implemented environmental approaches seeking to change the overall context within which substance abuse occur, focusing on substance availability, norms and regulations. The other 16 programs implemented other program/strategies from the Center for Substance Abuse and Mental Health Services Administration Center for Substance Abuse Prevention's (CSAP) science/evidence-based models list. Programs served 126,345 individuals.

--BSAS offered Prevention Programs training ranging from individual on-site orientations to a broad public health primary prevention conference. BSAS Prevention Programs also received technical assistance on MIS and CSAP Core Measures. Free social marketing oriented materials and other resources were highlighted on the BSAS web page.

--BSAS supported 6 Regional Centers for Healthy Communities (RCHCs) to train community residents, organizations and coalitions to become leaders to prevent alcohol, tobacco, and other drug (ATOD) abuse. Special emphasis was placed on science/evidence-based principles, strategies, models and environmental strategies. The RCHCs provided training and technical assistance to groups within their local communities and served 16,232 individuals. Representatives from the RCHCs served on the Gay, Lesbian, Bisexual and Transgender Task Force, the Media Production Committee and the Massachusetts Epidemiological Workgroup.

--BSAS involved youth in all stages of planning as it continued to develop and implement youth-oriented activities in ATOD-free settings. After-school programs included creative writing contests, photography, theater productions, community service, adventure and team-building activities.

--BSAS facilitated 49 Underage Drinking Prevention Town Hall meetings, an underage drinking campaign on the various state transportation systems and continued an OxyContin prevention campaign including youth-oriented messages.

--Contracts awarded for intensive early intervention case management programs targeting at-risk youth and families.

--BSAS Office of Youth and Young Adult Services (OYYAS) began to collect information on youth entering the state treatment system via the Youth Outcome Monitoring survey. The survey tracks adolescents' risk and progress during and after residential SA treatment and is the first initiative in MA to collect longitudinal data on this population.

--OYYAS sponsored a 2-day training on trauma-informed SA treatment for adolescent girls, conducted by Dr. Stephanie Covington.

--BSAS hosted trainings for clinicians on evidence-based practices, such as the GAIN biopsychosocial assessment tool, Motivational Interviewing, and CBT/MET.

--BSAS has continued to fund adolescent residential treatment programs that are gender-specific, trauma-informed, and able to address co-occurring mental health needs. The programs provide SA treatment as well as adolescents' other health needs, such as medical and dental visits.

--Three Recovery High Schools continue to operate with an average of 30 students enrolled per school and over 90% attendance.

--Grants continue with 7 school districts to implement an evidence-based early intervention program for elementary and middle school students (CASASTART). The program identifies youth exhibiting risk factors (individual risk, family risk, school-based risk) for substance use problems and provides intensive, family-centered case management for up to two years.

The School Health Institute offered a program on drugs and poisonings to 63 school nurses and, with DOE, on motivational interviewing for 114 school nurses.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. BFHN and BCHAP collaborate on a variety of youth programs and initiatives conducted by the Bureau of Substance Abuse Services (BSAS) to prevent alcohol and illicit drug use and support community-based programs that target known risk and protective fa				X
2. Support implementation of the state's Substance Abuse Strategic Plan including multiple policy and programmatic initiatives and an epidemiological work group conducting state and local needs/resource assessment and gap analysis.				X
3. Provide screening, assessment and treatment services for male and female pre-adolescents and adolescents, and continue to increase access to services, including specialized services for high risk youth (e.g., out of school, special health needs).	X	X	X	
4. Increase systematic screening and intervention for substance use and other adolescent risk behaviors, through a DPH-wide Youth and Young Adult Work Group.			X	X
5. Through BSAS, train MCH vendor clinicians (including SBHC) and, through The School Health Institute, train school nurses and other school personnel re substance abuse including (as relevant) prevention, screening, assessment and treatment.				X
6. Enhance collaboration with the Office for Healthy Communities and Tobacco Control Program to develop, maintain, and support BSAS Prevention Programs and the Regional Centers for Healthy Communities (formerly the Prevention Centers).		X		X
7. Promote and support increased youth involvement in the planning and implementing of youth-focused health initiatives.				X
8. Support local community coalitions, including BSAS funding for science/evidence-based prevention programs to address environmental & other sources of risk and protective factors (community-specific or statewide).			X	X
9. Implement public information campaigns using paid media and social marketing techniques to promote culturally competent primary prevention among youth.				X
10. Conduct substance abuse surveillance through the combined Youth Health Survey and Youth Risk Behavior Survey and collect/analyze service and/or outcome data from BSAS, BFHN				X

and BCHAP youth programs.				
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b. Current Activities

See "Summary Sheet" above, NPM #8, and PN #2.

BSAS opened the first state-funded youth stabilization/detoxification unit in Worcester in October.

OYYAS hosted a 2-day training on SA treatment for adolescent girls and a 1-day training on adolescent males in SA treatment.

Residential programs, recovery high schools, a juvenile drug court, and the DYS CASASTART now all use The Youth Outcome Monitoring survey.

OYYAS sponsored 1st statewide meeting of providers & state agencies serving youth & young adults in MA.

OYYAS hosted a job/internship fair for current students & recent graduates interested in working in the adolescent SA treatment field.

To open access to services, Central Intake and Care Coordination for the residential treatment programs was established and continues.

Distribute School Health Manual including chapter on addictions and the CRAFFT and other screening tools.

A workgroup of the Children's Mental Health Task Force, including DPH representatives, convened by MCAPP focused on early identification of substance use, integration of ongoing screening and linkage of evidence-based treatment programs with primary care. It endorsed CRAFFT, trained trainers, and is developing a tool kit for pediatric primary care settings.

c. Plan for the Coming Year

BSAS has procured and will fund a second youth stabilization and detoxification unit in Brockton. An expected start date for implementation is Fall 2008.

OYYAS will sponsor the second annual statewide meeting of providers and state agencies serving MA youth and young adults.

BSAS will continue to sponsor trainings on evidence-based practices for providers working with adolescents in substance abuse treatment settings. One specific initiative is to hold a training and begin ongoing coaching with Dr. Dave Mee-Lee on the ASAM Adolescent Patient Placement Criteria in FY09.

State Performance Measure 11: *The percentage of Massachusetts births that occur in a hospital that has an active Shaken Baby Syndrome Prevention Program.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective					
Annual Indicator					0.0
Numerator					0

Denominator					78000
Is the Data Provisional or Final?					Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	70	75	80	85	90

a. Last Year's Accomplishments

Not Applicable. This is a new State Performance Measure for FY09.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Convene and support the Shaken Baby Syndrome Prevention Advisory Group with representatives from key state agencies, parent and advocacy groups, to guide DPH in implementing the SBSP Initiative.				X
2. Administer state budget funding and maintain staff.				X
3. DPH collaborates with Children's Trust Fund (CTF) and DSS on the hospital-based education of new parents and works closely with a Hospital Program Subcommittee of the Advisory Board.		X		X
4. Issue guidelines and assist hospitals to comply with legislation and Advisory Group recommendations, including one-on-one education by nurse educators and written materials to all new parents.				X
5. Financially support Massachusetts parental support hotline.		X		X
6. Develop and provide hospitals with educational materials for parents in many languages, and with fact sheets for nurses on how to talk with parents about this topic.				X
7. Create fact sheets and a Talking Points brochure for DSS social workers to assist them in prevention education with their clients; DSS implement prevention education program.				X
8. Conduct surveillance of abusive head injuries in infants.				X
9. Support CTF training for community-based providers who serve infants and children and their caregivers and for "trained-trainers," who make a commitment to train other professionals in their agencies and communities, including at DSS Area Offices.				X
10. Through Child Care Resource and Referral agencies, in collaboration with DSS, train child care providers.				X

b. Current Activities

Received \$350,000 in the state budget to implement the Shaken Baby Syndrome Prevention (SBSP) Program in compliance with Chapter 356 of the Acts of 2006.

Appointed and convened the Advisory Group with representatives from the Department of Social Services (DSS), Children's Trust Fund (CTF), Massachusetts Citizens for Children, Parents Helping Parents, the Massachusetts Hospital Association, and other state agencies, nonprofits, and several hospitals. The MCH Director chairs.

Designated a SBSP Coordinator and hired a research analyst.

Began all key activities listed in the "Summary Chart."

Agreed upon 4 learning objectives for parents and that all hospitals must include both 1-on-1 education from a nurse educator and written materials to all new parents.

Developed and promulgated additional to state perinatal regulations related to SBS prevention, in accordance with the law.

Informed all hospitals with maternity care of the legislation and collected contact information for their SBSP liaison.

Trained nurse educators and began training hospital maternity nurses across the state.

Established an Interagency Service Agreement with CTF to support training. As of April 2008, CTF had directly trained more than 1000 people in multiple communities and 75 "trained-trainers" including in about ¾ of DSS Area Offices.

Developed SBS measure for the MCH Block Grant and the data collection methodology for it.

c. Plan for the Coming Year

Continue current activities as described above. State funding will remain at \$350,000 for FY09.

Complete first round of training to hospitals with maternity units to assure new parent education on SBS prevention in accordance with the law and regulations.

Continue to support the Children's Trust Fund to provide training of community-based providers on SBS prevention.

Implement the data collection system that will provide the results to monitor this new SPM. This will likely involve site visits, chart audits and QA assistance to assure that hospitals are implementing the law with fidelity.

Begin development of a parent education video on SBS prevention.

Develop training for emergency dept clinicians and other first responders related to SBS identification.

E. Health Status Indicators

The Health Status Indicators are all actively used by Massachusetts to track the health of the Commonwealth and to inform public health policy and practice.

The low birthweight and very low birthweight indicators (#1A, 1B, 2A, 2B) for both all births and singletons alone are of relevance to Massachusetts and are routinely reported in MDPH publications, as the state has a very high rate of multiple births. Thus analyzing these and other birth outcomes by plurality and fertility treatment is critical.

/2009/ As one example of how variances between singleton and other births are of concern, meetings between DPH, Boston University School of Public Health, CDC and members of the Society of Assisted Reproductive Technology (SART) have led to the establishment of the Massachusetts Outcomes Study of Assisted Reproductive Technology (MOSART) Collaborative. The purpose of this 4-way partnership is to investigate the association between assisted reproductive technologies, birth outcomes, and maternal and infant health, based on the linkage of core PELL data and SART's Clinical Outcomes Reporting Systems database. A memorandum of understanding has been drafted and is under legal review prior to final signing. A grant proposal to fund these innovative activities is under development. MOSART builds upon prior

departmental initiatives to examine the impact of ART on reproductive health in Massachusetts./2009//

These indicators, along with those related to chlamydia (#5A and 5B) are part of a much larger set of indicators that are routinely reviewed and that help shape efforts to reduce perinatal health disparities. Analysis by race, ethnicity, age, and other maternal characteristics -- at both the state and local levels -- is a key component of our SPM #9. A particular emphasis is working with communities at greatest risk to develop their own capacity to use data to create, implement, and monitor strategic plans. These indicators are also among the risk indicators that we use for tracking and early identification through such programs as EIPP. They and other indicators are also used in needs assessments for procuring community-based services.

/2009/ DPH continues to work closely with Boston, Worcester and Springfield to implement community plans to address racial disparities in perinatal outcomes. In Springfield, presentation this year of a population attributable risk (PAR) analysis of LBW/VLBW that highlighted the high risk attributable to Black race and Hispanic ethnicity helped move forward a DPH collaboration with local partners including the FIMR to conduct focus groups with black and Hispanic women to gather qualitative data on the perception of care they received while pregnant, giving birth or in the postpartum period, and impact of racism on it./2009//

The trend data displayed for the LBW/VLBW indicators show virtually no change over the last four years. These rates place Massachusetts close to the national average, while our infant mortality rate has continued to fall and is consistently among the lowest in the country. With the assistance of more complex analytic tools such as PELL and PRAMS, we hope to better understand the factors that keep the LBW rates higher than might be expected and what programmatic efforts targeted to which populations might improve overall perinatal outcomes.

These HSIs are closely related to a number of NPMs, SPMs, and Priority Needs. There is additional information in those sections of the narrative:

For HSIs 1A, 1B, 2A, 2B

NPMs # 8, 15, 17, and 18

SPM # 1, 2, 3, 9

Priority Need # 4

For HSIs 3A, 3B, 3C, 4A, 4B, 4C:

NPM # 10

SPM # 8, 10

Priority Needs #4 and 7

For HSIs 5A, 5B:

NPM # 8, 18

SPM # 1

Priority Need # 4

The six Health Status Indicators dealing with unintentional injuries to children and adolescents are also core indicators used on a regular basis for a number of purposes. Massachusetts has been a leader in the development of injury prevention and control programs based on data analysis. We have dedicated epidemiology resources and provide leadership using injury surveillance data, expanding data utilization and applying data to public health policy.

/2009/ Recent examples of using data to influence policy and practice are the recent passage of a revised state booster seat law, partnering with Injury Community Planning Group and the MA Coalition for Adolescent Road Safety to create educational and marketing campaign on risky teen occupant behaviors (which have already been affected by recently toughened junior operator regulations), and SBHC standards that call for screening questions on seatbelt use (with a follow up plan of risk reduction counseling and/or anticipatory guidance) and on being in a car (as driver or passenger) where

someone was high on alcohol or drugs, as a risk factor for vehicular homicide.

A plan based on recommendations from the Statewide Traumatic Brain Injury Prevention Task Force involving participants from DPH-MCH programs and external partners for primary and secondary prevention measures for traumatic brain injuries among children and youth is now being implemented.

The new Statewide Trauma Registry (IT) System will shortly begin transmitting data. In addition to providing more data on the circumstances of injuries treated in acute care hospitals, these databases will provide injury severity and outcome measures, which will be useful in evaluating the impact of disparities within the trauma system in Massachusetts.

Surveillance of unintentional injuries utilizing statewide death and hospital discharge data and dissemination of findings to DPH program staff as well as state and local audiences continues.

DVIP epidemiology staff, in conjunction with the Department's Bureau of Substance Abuse Services, will begin to collect real-time emergency department data on drug overdoses, in select emergency departments around Massachusetts.

Additional detailed information on several projects that demonstrate our use of data to influence policy and practice can be found in the Attachment to Part IV, Section F (Other Program Activities), particularly on pages 4, 6, 7-8, and 14. The attachment provides a discussion of work related to our Priority Needs that is not directly tied to one or more of the National and State Performance Measures. Briefly, these projects include the following:

Using the Pregnancy to Early Life Longitudinal (PELL) data system, Gene Declercq of Boston University continued to take the lead in collaboration with the BFCH, to study maternal outcomes (increased morbidities) for repeat cesareans with no indicated risk and published the study "Maternal outcomes associated with planned primary cesareans compared to planned vaginal births" in Obstetrics and Gynecology. The results from this study are informing new efforts of the DPH Medical Director to address Massachusetts rising c-section rate (currently over 30%). Data from a PELL manuscript still in review were presented to inform discussion at the at the Surgeon General's Conference on Preventing Preterm Birth in June.

Information from EI databases too recent to be linked with births and from PELL/EI linked files informed an extensive DPH review of EI programming and costs. The most up-to-date data were used to project costs, and the linked data provided additional understanding of how referrals had changed, which children were being referred (or not) compared with the birth population, and the cost of providing services to specific groups of children.

The School Health Unit has been collaborating with the University of Massachusetts, Department of Preventive and Behavioral Medicine, in conducting a randomized controlled trial (RCT) to determine if school-nurse interventions could help individual students stop using tobacco. A 71-school study demonstrated the feasibility and potential efficacy of this intervention in increasing self-reported short term (6 week and 3 month) quit rates among adolescent smokers who wished to quit. Based on these outcomes, the NIH has awarded the University of Massachusetts Medical School (UMMS) a 4-year grant to test this intervention in a randomized controlled trial and 36 public high schools with an enrollment of at least 350 students are currently participating in this NIH grant study.

Data from the most recent Youth Health Survey (YHS) and Youth Risk Behavior Surveillance System (YRBSS) surveys, conducted in coordination with one another by the DPH and state Department of Education, are being used by the SBHC program (along with

its own program data) to direct or modify its program model in the areas of nutrition and physical activity, sexual activity, clinical interventions for behavioral change, and continuum of care for chronic health conditions.//2009//

F. Other Program Activities

In addition to activities contributing to performance measures, a majority of Bureau programs conduct one-time and/or on-going activities directly focused on meeting one or more of the State's currently defined Priority Needs. A description of these activities is attached to this section of the application. Plans for FY06 are included for Priority Needs that will continue as a result of our Five-year Needs Assessment. Also in the attachment is a comprehensive list of MCH-related programs and service numbers for FY04, by MCH population categories. //2007// The 2007 attachments include updated information about Program Activities related to Priority Needs not otherwise covered by the NPM and SPM narratives and an updated listing of MCH-related programs and service numbers for FY05, by MCH population categories. //2007//
//2008// The 2008 attachments include updated information about Program Activities related to Priority Needs not otherwise covered by the NPM and SPM narratives and an updated listing of MCH-related programs and service numbers for FY06, by MCH population categories. //2008//

//2009// The 2009 attachments include updated information about Program Activities related to Priority Needs not otherwise covered by the NPM and SPM narratives and an updated listing of MCH-related programs and service numbers for FY07, by MCH population categories. //2009//

An attachment is included in this section.

G. Technical Assistance

Massachusetts is again making a specific request for Technical Assistance to assist in undertaking a CAST 5 Assessment. After significant changes in state resources and restructuring of the Department into larger Centers, CAST 5 would provide a better understanding of current resources and needed rebuilding or enhancements to assure strong MCH/CSHCN services. Although this was our original planned request for FY05, it was deferred as we joined the other Region I states in obtaining Technical Assistance support for a regional poison control symposium and meeting.

//2007// Massachusetts expects to make a request for assistance with planning a process for priority setting and team building. This will assist us in continued staff and program integration across previously separate bureaus in an era of shrinking federal funds and a changing health insurance and services system in the Commonwealth. In particular, we wish to identify and address the short and long-term impacts on Title V from the comprehensive Massachusetts health care reforms that are just getting underway. A formal request will be made through the web-based system at a later date.

The Commonwealth also is prepared to join other Region I states in a joint request for one or more regional technical assistance projects or events, as we have done in the last two years. No specific request has been determined at this time. //2007//

//2008// The Commonwealth has already submitted and been approved for one technical assistance request, to contribute funding to a New England Knowledge to Practice Project for Region I Title V Programs: Enhancing knowledge and capacity of Title V MCH leaders to identify program priorities and influence policy using evidence-based models for improving MCH health at the state level. The first meeting of the regional leadership/advisory group will take place in Boston, MA on October 2, 2007. Neal Halfron and Holly Grason will be presenting their research

and paradigm on a lifecourse and multiple determinant framework to improve maternal health. Because Massachusetts will not need to request TA funds for our participants to travel out of state, we are using our TA request to cover the travel and lodging expenses for the two presenters. //2008//

//2009/ As part of the NICHQ CSHCN leadership activity, MA would like to request funding to contract with National Initiative for Children's Healthcare Quality (NICHQ) staff to work directly with MA CYSHCN staff to begin the implementation of the Roadmap Action plan which is currently under development. A special focus will be on the expansion of the medical home model to additional pediatric primary care practices. //2009//

V. Budget Narrative

A. Expenditures

See the FY06 Expended columns in Form 3 (State MCH Funding Profile), Form 4 (Budget Details by Types of Individuals Served), and Form 5 (State Title V Programs Budget and Expenditures by Types of Services). The Form and Field Notes for the Forms provide additional details and explanations about the amounts shown, including differences between budgeted and expended amounts, changes in the levels of funding categories across years, and the sources of state Partnership funds and other Federal funds.

It is important to note that throughout these changes and variations from original budgets, the distribution of expenditures from the federal portion of the Title V Partnership remained much more stable. Due to the increasingly categorical nature of much of our state funding, we are not always able to shift it to moderate secular changes in funding levels or to target our highest MCH priorities. Because the ratio of total state funding is so much higher than our federal allocation (almost 5 to 1 in FY06), patterns in state funding drive the patterns seen in the total Partnership budget and expenditures.

Two aspects of the Expenditures warrant narrative discussion:

1. The difference between the FY06 Unobligated Balance originally budgeted and the amount expended.
2. Several differences between the amounts budgeted for FY05 and final expenditures by MCH Population Group (Form 4) and by Level of the Pyramid (Form 5)

The final Unobligated Balance Expended for FY06 is less than the original budget estimate by more than 10%. The reason for this apparent discrepancy is that the original unobligated balance estimate was too high, as it did not account for a portion of the MCH Block Grant which is transferred to CDC for direct assistance in the form of an MCH Epidemiologist assigned to Massachusetts. In fact, the two amounts are virtually identical.

Form 4 (Budget by MCH Population Groups). Final FY06 Expended totals are significantly different from FY06 Budgeted totals for Administration. The overall decrease in administrative expenditures in FY06, compared to budgeted amounts reflect the fact that the Bureau continued to be successful in both reducing overall administration costs and in shifting a number of them to other state and federal accounts that are not part of the Partnership budget.

Form 5 (Budgets by Level of the Pyramid). Final FY06 Expended totals are more than 10% higher than FY06 Budgeted totals for Infrastructure Building. In fact, final expenditures for FY06 were higher than budgeted amounts for Total Expenditures and for each level of the Pyramid except Enabling Services. Only the Infrastructure amount reached the 10% threshold for endnotes. The main reason for this is that there were substantial Supplemental state budgets in FY06 (particularly in the areas of Family Planning and Early Intervention). In addition, approximately \$400,000 was originally not budgeted because it was thought to be needed for state match for other accounts. However, that need did not arise, so the funds were added back into the Expended category. Spending from the MCH Block Grant itself was not higher than budgeted.

It may appear from Forms 4 and 5 that Massachusetts distributes our funding among MCH Population groups and service types in a variable manner from year to year. This picture is misleading, however, because these Forms present the entire MCH Federal-State Partnership budget, which in our case has been around 80% and is now about 86% state funds for FY08. We have flexibility in allocating federal Block Grant funds, while the populations to be served by state appropriations are usually closely controlled by the more categorical or earmarked nature of state budget language. A more accurate picture of our commitment to the MCH Populations and Types of Services may be seen in the tables attached to Part V, Section B, which presents data with federal funds and state funds separately over several years. These tables illustrate that virtually all of the year to year variation in the relative distribution of funds across population

groups is due to variations in state funding.

In addition, the target populations for the state funds, as well as the types of services specified by the Legislature, shape the overall percentage distribution of funds across the MCH Pyramid and MCH population groups.

//2009/ See the FY07 Expended columns in Form 3 (State MCH Funding Profile), Form 4 (Budget Details by Types of Individuals Served), and Form 5 (State Title V Programs Budget and Expenditures by Types of Services). The Form and Field Notes for the Forms provide additional details and explanations about the amounts shown, including differences between budgeted and expended amounts, changes in the levels of funding categories across years, and the sources of state Partnership funds and other Federal funds.

It is important to note that throughout these changes and variations from original budgets, the distribution of expenditures from the federal portion of the Title V Partnership remained much more stable. Due to the increasingly categorical nature of much of our state funding, we are not always able to shift it to moderate secular changes in funding levels or to target our highest MCH priorities. Because the ratio of total state funding is so much higher than our federal allocation (over 5 to 1 in FY07), patterns in state funding drive the patterns seen in the total Partnership budget and expenditures.

Total state expenditures in FY07 are higher than our original FY07 budget. This is due to a decision to include expenditures for the Catastrophic Illness in Children Relief Fund trust account in the final FY07 accounting, even though we had not included this account in our annual budgets for state match until our FY08 Application. This change will bring FY07 expenditures more in line with those for future years for trend analysis.

It may appear from Forms 4 and 5 that Massachusetts distributes our funding among MCH Population groups and service types in a variable manner from year to year. This picture is misleading, however, because these Forms present the entire MCH Federal-State Partnership budget, which in our case has been around 80% and is now approximately 87% for FY09. We have flexibility in allocating federal Block Grant funds, while the populations to be served by state appropriations are usually closely controlled by the more categorical or earmarked nature of state budget language. A more accurate picture of our commitment to the MCH Populations and Types of Services may be seen in the tables attached to Part V, Section B, which presents data with federal funds and state funds separately over several years. These tables illustrate that virtually all of the year to year variation in the relative distribution of funds across population groups is due to variations in state funding. In addition, the target populations for the state funds, as well as the types of services specified by the Legislature, shape the overall percentage distribution of funds across the MCH Pyramid and MCH population groups.

The year to year variation within state funds has leveled off in the last three years, so that even the total percentage shares have remained very consistent. This pattern remains susceptible to change each year due to changes in the state budget and relative budget priorities at the state level. //2009//

B. Budget

The budget proposed for FY08 in Forms 2, 3, 4, and 5 contains some differences with those of previous years. Overall, state funding, which had dropped for several years has now stabilized and is experiencing some gains, including some new areas of support from the state. The drop after FY04 had to do primarily with the transfer of two major and long-standing state health insurance programs for pregnant women and children -- Healthy Start and Children's Medical Security Program -- out of the Department of Public Health and the state Title V agency to the

state Medicaid program. Changes since then have occurred within accounts that have remained within the Title V agency's control.

The total Partnership budget of \$88,044,275 is made up of \$11,596,681 of MCH Block Grant funds (including carry-forward funds) and \$76,447,594 in state funds. Massachusetts continues to commit funds above our statutory maintenance of effort level from FY1989 of \$23.5M and the state funding represents a FY08 State Match (\$3 state for every \$4 federal) of \$8,697,511 and State Over Match of \$67,750,083. The total state funds represent all or portions of 10 state accounts (Family Health Services, Early Intervention (2 accounts), Teen Pregnancy Prevention, Universal Newborn Hearing, Domestic Violence and Sexual Assault Prevention and Treatment, Dental Health, School Health (including School-Based Health Centers), one Interagency account with Medicaid, and state administration). In addition, there is a new account in FY08 for Shaken Baby Syndrome Prevention, and funds from the state Suicide Prevention account are contributing to the Regional Poison Control Center. Within the Family Health Services account, there are new funds for the Regional Poison Control Center, the Massachusetts Birth Defects Monitoring System, and the Massachusetts SIDS Center; all of these are the first state funds for these MCH priorities in many years.

Details on the budgeted amount from each account are given in the Notes to Form 2.

Massachusetts continues to budget at least 30% of our federal MCH funds for Preventive and Primary Care for Children (30.17% in FY08) and for Children with Special Health Care Needs (31.09% in FY08). The proportion of federal funds used for Title V Administrative Costs is at the allowable 10% for FY08. As the amount of MCH Block Grant has decreased over the last several years, we have continued to be successful in sharing those costs with other state and federal sources in an equitable manner.

The state revenue picture is generally positive in FY08, continuing the restoration of several MCH-related accounts that began in FY05. A new state administration and the legislature have both provided increased support for public health, including some MCH priority areas. While state partnership funding continues to be below FY03 or earlier levels for some accounts, funding appears more stable. The impact of Health Care Reform -- both on our clients and programs and on our budgets (if costs exceed expectations) will be closely watched. In FY07 and FY08, substantial funding has been identified for health promotion and disease prevention across the lifespan as a complement to universal health insurance coverage. Cuts, changes, and restorations have not been uniform and certain types of services and population groups served have been affected more than others.

Our oldest and core MCH state account, Family Health Services, the one that most closely resembled the federal block grant and was created originally as the state match, was initially cut by almost 70% in FY04. This account had contained the only state funding for family planning services, rape crisis centers, the poison control center, MCH primary care wrap-around services, and prenatal/infancy home visiting. After the FY04 cuts and modified budget language, it only funded family planning services, rape crisis centers, and a small amount of MCH primary care wrap-around services in FY06. In FY07 budget, the rape crisis center funding was moved to a new domestic violence and sexual assault prevention and treatment account that consolidates funding from a number of accounts. While this new account is a very appropriate and exciting opportunity for better coordination of these critical services, the removal of the RCC funds made the Family Health account very narrow, with primarily categorical funding. New earmarking (without additional funding) and reductions to the funding allocated for Family Planning left us with even less funding than FY06 for core MCH programs supported in part by this account. Combined with the reductions in federal MCH funds, this was a very serious situation, which we had hoped may be remedied in the state FY08 budget.

The FY08 budget for the Family Health Services account is a very mixed bag, however. The entire account is now earmarked for specific programs -- or vendors. The good news is that the

Family Planning Program received a \$1M increase and the account includes new funds specified for the Regional Poison Control Center and the Massachusetts Birth Defects Monitoring System (both of these were priorities for the Department). It also includes \$100,000 for the Massachusetts SIDS Center, which currently receives only federal MCH funds. However, the total dollar amount of the earmarks (including these positive ones) completely subsumes the entire account, leaving no funds for MCH contracts for services for women of reproductive age and adolescents that were contributed from this account last year. It is expected that those programs will absorb cuts of about 11%.

Details on the budgeted amount from each account and the amount that it has changed (if relevant) are given in the Notes to Form 2.

The \$120,535,869 of other Federal funds shown on Forms 1, 2, and 3 comes from approximately 25 different grants, which cover all of the categories of the categories on Form 2 except federal Healthy Start and Abstinence Education. [Massachusetts has declined to reapply for ACF Abstinence Education funds for the coming year.] It is important to note that we include all of our WIC funds, state and federal, as they are budgeted in a seamless manner at the state level. Massachusetts funds WIC (both directly and with an infant formula retained revenue account) at over \$34M, which is included in the \$106.8M. The Bureau continues to have good success in obtaining a wide range of federal categorical grants. These grants are of great importance in maintaining the breadth of the Bureau's MCH efforts and in continuing our history of innovation and integrated service delivery model development.

Not included in the budget forms is a substantial amount of state funding administered by the Bureau for MCH programs, but which cannot be listed as match by us because the funds are used for match for other federal programs (e.g. TANF) or which originate in other state agencies that wish to maintain their options to use the funds for match. As we have a substantial amount of over-match, this is not a budget issue for the Bureau, but it does undercount the level of state support for key MCH services. The programmatic efforts supported by the funds continue to be fully described in our annual reports and plans. Some of the accounts involved are fully MCH-related; the largest of these have been the bulk of the Teen Pregnancy Prevention Challenge Fund and FOR Families; both of these accounts are funded with state TANF funds. In FY07, a new state account for Pediatric Palliative Care was funded, but is being used 100% for Medicaid-related match. Other accounts include both MCH-related and other activities that are difficult to identify precisely or that are needed for potential match for other purposes. These include several state-funded accounts that address sexual assault and domestic violence, batterer intervention, violence and injury prevention, and two that support community health center operations and initiatives.

It may appear from Forms 4 and 5 that Massachusetts distributes our funding among MCH Population groups and across types of services in a variable manner from year to year. This picture is misleading, however, because Forms 4 and 5 present the entire MCH Federal-State Partnership budget, which in our case is over 86% state funds in FY08. While we have flexibility in allocating federal Block Grant funds, the proportion of the total State Partnership budget that comes from "categorical" state accounts continues to increase and the total, as noted above, can fluctuate significantly from year to year. A more accurate picture of our commitment to the MCH Populations may be seen in the tables in the Excel file that is the attachment to this Part 5, Section B (Budget). These tables present budget data for the federal and state portions of the Partnership budget separately over several years. A comparison of Forms 4 and 5 with these tables illustrates that much of the year-to-year variation in the total and relative distribution of funds across population groups is due to changes (up and down) in state funding. Based on the categorical nature of our state funding stream (and the disproportionate cuts in some accounts), the impact of the state funding cuts is not always felt equally across all of MCH population groups.

These trends continue to place enormous pressure on the MCH Federal funds as the only source

of flexible funding for many key MCH activities. This strain has previously been felt primarily in the area of Infrastructure Building, as state accounts rarely include funds for systems development, data management, or evaluation. In addition, with caps (or complete prohibitions) on the number of personnel that can be hired on state accounts, a disproportionate number of our total MCH Partnership staff are funded from the Block Grant.

A noticeable change in FY07 that continues for FY08 is the level of federal funds budgeted and the portion of the Partnership budget from federal MCH funds. Only with the FY07 budget was the impact of federal cuts to the MCH Block Grant itself fully reflected in the annual budgets. Modest cuts -- and the lack of any increases to cover payroll costs rising annually due to union settlements, COLAs, and changes to fringe benefit and indirect cost rates -- for several years were managed by spending down some substantial carry-over savings.

However, with the substantial federal cut of over \$500,000 in FY06 that continues to the present, the federal share of the annual budget has been reduced significantly, and the annual total federal funding projected is much closer to the new annual award with little carry-over expected to be available. The reduction in federal MCH funding comes at the same time when inexorable increases in personnel costs have exhausted our previous carry-over cushion. Due to these factors and their particular impact on personnel costs, the number of FTE staff paid directly by the MCH Block Grant has been reduced, from approximately 107 in FY06 to 94 for FY08, and they now represent approximately 70% of all Partnership FTEs (down from 75% in FY06). A higher percentage of staff working in MCH-related areas is being funded from either state or other federal grant sources. With caps (or prohibitions) on state-funded positions and limitations on the types of staff that can be supported on our other categorical federal grants, our ability to hire and retain highly qualified professional staff is increasingly threatened.

In summary, the FY08 budget, although generally very good on the state side, continues to strain our ability to assure core direct, enabling, and population-based services and is altering the shape of many of our programs. These potential changes are discussed throughout our Narrative in the "Current Activities" and "Plans for the Coming Year" segments.

/2009/ The budget proposed for FY09 in Forms 2, 3, 4, and 5 continues to reflect several trends discussed in previous applications. Overall, state funding, which had dropped for several years has now stabilized and is experiencing some gains, including some new areas of support from the state. Of particular importance for maternal and child health services are state accounts supporting a Shaken Baby Syndrome program, pediatric palliative care, and youth violence prevention. In addition, state funding for Early Intervention services continues to keep pace with increased demand for these services.

The total Partnership budget of \$88,010,176 is made up of \$11,743,816 of MCH Block Grant funds (including carry-forward funds) and \$76,266,360 in state funds. Massachusetts continues to commit funds above our statutory maintenance of effort level from FY1989 of \$23.5M and the state funding represents a FY09 State Match (\$3 state for every \$4 federal) of \$8,807,862 and State Over Match of \$67,458,498. The total state funds represent all or portions of 13 state accounts. These include continuation of the first state funds in many years for poison control, birth defects surveillance, and SIDS, along with the continuation of a new account for shaken baby syndrome. Details on these accounts and the budgeted amount from each are given in the Notes to Form 2.

In addition, 3 state accounts that are considered part of the Partnership programmatically are not included, as their funds are used for other FFP matching purposes: Early Intervention Retained Revenue (\$6.5M), Pediatric Palliative Care (\$1M) and Youth Violence Prevention (3.5M). The latter two were new in FY08 and have been expanded for FY09. Removing these accounts from the state funds included in the official Partnership budget (and Forms 2, 3, 4, and 5) makes it appear that state support for the Partnership has decreased in FY09. In fact, total state support (including the \$11M that is no longer

included in the forms) has increased in FY09 and the Commonwealth continues its strong overall support for targeted MCH services.

Massachusetts continues to budget at least 30% of our federal MCH funds for Preventive and Primary Care for Children (30.05% in FY09) and for Children with Special Health Care Needs (31.85% in FY09). The proportion of federal funds used for Title V Administrative Costs is within the allowable 10% for FY09 (9.8%). As the amount of MCH Block Grant has decreased over the last several years, we have continued to be successful in sharing those costs with other state and federal sources in an equitable manner.

The state revenue picture has deteriorated since the initial submission of our FY09 application in July, although the restoration of several MCH-related accounts that began in FY05 is still in place. Emergency funding restrictions are being put into place in several areas and their full impact on Partnership activities is somewhat unclear. The new state administration and the legislature have both provided increased support for public health, including some MCH priority areas. The impact of Health Care Reform -- both on our clients and programs and on our budgets (if costs exceed expectations) continues to be watched closely.

Again in FY09, the entire Family Health Services account has been earmarked for specific programs -- or vendors. The good news is that the Family Planning Program has received a significant increase again (up to nearly \$6.0M in FY09) and the account continues to include funds specified for the Regional Poison Control Center, the Massachusetts Birth Defects Monitoring System, and the Massachusetts SIDS Center. However, the total dollar amount of the earmarks (including these positive ones and others targeting some other high-risk youth) completely subsumes the entire account, leaving no flexible funds for MCH services. It appears that this situation will continue on this account.

The \$132,462,710 of Other Federal funds for FY09 comes from approximately 20 different grants, which cover all of the categories on Form 2 except federal Healthy Start and Abstinence Education. [Massachusetts no longer applies for ACF Abstinence Education funds.] We continue to include all of our WIC funds, state and federal, as they are budgeted in a seamless manner at the state level. Massachusetts funds WIC (both directly and with an infant formula retained revenue account) at over \$35M. The Bureau continues to have good success in obtaining a wide range of federal categorical grants. We are hopeful that several pending grant applications will be added during FY09.

As noted previously, not included in the budget forms is a substantial amount of state funding for MCH programs that is used for match for other federal programs (TANF and Medicaid FFP). As we have a substantial amount of over-match, this is not a budget issue, but it does undercut the level of state support for key MCH services. The programmatic efforts supported by the funds continue to be fully described in our annual reports and plans.

For a more detailed picture of the different distribution of federal and state funds across the MCH Populations and the MCH Pyramid, see the updated tables in the Excel file that is the attachment to this Part 5, Section B (Budget). Historically, much of the year-to-year variation in the total and relative distribution of funds across population groups (or the pyramid) is due to changes (up and down) in state funding. Based on the categorical nature of our state funding stream (which is over 87% of the MCH Federal-State Partnership budget), the impact of the state funding cuts is not always felt equally across all of MCH population groups and while the patterns of funding have stabilized greatly for the last three years, they could begin to fluctuate again at any time.

State-level trends continue to place enormous pressure on the MCH Federal funds as the only source of flexible funding for many key MCH activities. This strain has previously

been felt primarily in the area of Infrastructure Building, as state accounts rarely include funds for systems development, data management, or evaluation. In addition, with caps (or complete prohibitions) on the number of personnel that can be hired on state accounts, a disproportionate number of our total MCH Partnership staff are funded from the Block Grant. But reductions in federal MCH funding have come at the same time when inexorable increases in personnel costs have exhausted our previous carry-over cushion. Due to these factors and their particular impact on personnel costs, the number of FTE staff paid directly by the MCH Block Grant has been reduced, from approximately 107 in FY06 to 92 for FY09, and they now represent approximately 70% of all Partnership FTEs (down from 75% in FY06). A higher percentage of staff working in MCH-related areas is being funded from either state or other federal grant sources. With reduced federal MCH funds, state position caps and limitations in our other categorical federal grants, our ability to hire and retain highly qualified professional staff is increasingly threatened.

In summary, the FY09 budget, although generally good on the state side, continues to strain our ability to assure core direct, enabling, and population-based services and is altering the shape of many of our programs. The worsening economic climate and state revenue picture are increasingly worrisome, affecting available funding at a time of increased demand for critical services. Restoration of federal funding levels and of flexible state funds, along with changes to personnel funding options are essential to the long-term richness and stability of the Title V Federal-State Partnership in Massachusetts. These potential changes are discussed throughout our Narrative in the "Current Activities" and "Plans for the Coming Year" segments.//2009// An attachment is included in this section.

VI. Reporting Forms-General Information

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

VII. Performance and Outcome Measure Detail Sheets

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

VIII. Glossary

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

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

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

C. Organizational Charts and All Other State Supporting Documents

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

D. Annual Report Data

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