Maternal and Child Health Services
Title V Block Grant

State Narrative for Idaho

Application for 2015
Annual Report for 2013

Document Generation Date: Friday, June 13, 2014

Table of Contents

I. General Requirements

A. Letter of Transmittal

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

B. Face Sheet

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

C. Assurances and Certifications

Assurances and certifications are on file with the MCH office - Bureau of Clinical and Preventive Services - and are available upon request.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

During the public comment period, the preliminary version of Idaho's Maternal and Child Health Block Grant Application and Annual Report is posted to the external website of the Idaho Department of Health and Welfare (IDHW), along with a request for input. The IDHW website is "searchable" by Google and other search engines, and the grant application is available for review and input by the general public. In addition, notification of the posting of the grant application and annual report is done via area newspapers throughout the state. Further, key partners/stakeholders are also informed.

* Idaho Parents Unlimited (IPUL) -- a grass roots advocacy organization who also are:
    - The Family to Family Health Information Center for Idaho
    - The Family Voices representatives in Idaho.

* St. Luke's Children's Hospital -- the only children's hospital in Idaho.

* Idaho Families of Adults with Disabilities (IFAD).

* The Idaho Council on Developmental Disabilities. This Council includes representatives from:
    - The Idaho Dept. of Education, Special Education Section
    - Vocational Rehabilitation
    - Idaho Commission on Aging
    - Idaho Medicaid
    - Partnerships for Inclusion
    - University of Idaho, Center on Disability and Human Development
    - Disability Rights Idaho
    - Idaho Self Advocate Leadership Network
    - University Centers for Excellence
    - McCall Memorial Hospital
    - Partners for Policy making
    - Community Partnerships of Idaho

- Panhandle Autism Society

* The Early Childhood Coordinating Council. This Council includes representatives from:
  - Parents of young children with disabilities
  - Providers of early intervention services, including Idaho Perinatal Project
  - Providers of early care and learning services
  - State legislators: one senator, one representative
  - University representation from child development programs
  - Developmental pediatrician
  - Idaho Chapter of American Academy of Pediatricians
  - Association for the Education of Young Children
  - Idaho Medicaid
  - Idaho Foster Care
  - Children's Mental Health
  - Idaho Department of Insurance
  - Office for the Coordination of Education of the Homeless
  - Idaho Migrant Council
  - Idaho Migrant Head Start
  - Idaho Child Care Program
  - Idaho Head Start Association
  - Head Start Collaboration Office
  - Idaho Infant Toddler Program
  - Idaho Bureau of Education Services for the Deaf and Blind
  - State Department of Education
  - Public Health Districts
  - Idaho Maternal and Child Health Director
  - Representation from Idaho Tribes

The grant was posted for one month. No comments were received.

II. Needs Assessment

In application year 2015, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Reduce premature births and low birth weight

In 2012, the Idaho Division of Public Health has joined the partnership between the March of Dimes and the Association for State and Territorial Health Officers (ASTHO) to reduce preterm births and ensure more healthy births in Idaho. As part of this partnership, Idaho has accepted the challenge to reduce the state's preterm birth rate by 8 percent by 2014. Although Idaho fairs better than the nation on preterm birth, there is still work to be done. In 2009, Idaho's preterm birth rate was 10.1 percent of live births compared with the national rate of 12.2 percent. An 8 percent reduction by 2014 would result in approximately 200 fewer preterm births statewide. The MCH Program began working with the local March of Dimes chapter on the Healthy Babies are Worth the Wait campaign to encourage pregnant women and healthcare providers to wait until labor occurs naturally or until 39 completed weeks of gestation before elective delivery. At the Idaho Perinatal Nurse Leadership Summit in October 2012, the March of Dimes provided awareness-building kits to all nurse managers for distribution at their hospitals and facilities, and a physician champion lectured on the topic. Kits were also sent to the Public Health Districts and approximately 40 OB/GYN clinics throughout the state.

In July 2014, the MCH Director and CYSHCN Director, along with stakeholders, will convene as a team for the Infant Mortality Collaborative Improvement and Innovation Network (CoIIN) summit in Arlington, Virginia. The launch of the Region X CoIIN summit, will build on the successes of other regional collaboratives. The Idaho team will glean best practices and lessons learned regarding drivers of infant mortality and morbidity.

Reduce the incidence of teen pregnancy

Idaho reported a steady decline in teen birth rates from 2007 to 2012. Overall, the teen birth rate declined 18.0 percent, from 41.4 births per 1,000 to 34.1 births per 1,000 women aged 15-19. The decrease in birth rates among non-Hispanic white teens and among Hispanic teens, especially in some of the most populated counties, is driving down the overall teen birth rates for Idaho.

Increase the percent of women incorporating effective preconception and prenatal health practices

The Idaho MIECHV program began delivering services through contracted local implementing agencies in north and south central Idaho in June 2012. The MIECHV program identified multivitamin use among enrolled women of childbearing age, alcohol used prior to and during pregnancy, and prenatal care utilization as preconception and prenatal health indicators as part of the program's benchmark and data collection plan. This alignment of indicators with the Title V block grant created another source of data to monitor these indicators. Home visitors also provide information to enrolled women about the benefits of regularly taking a multivitamin, abstinence from alcohol and other illicit substances before and during pregnancy, as well as information and referrals for prenatal care for pregnant women.

Through the Idaho Maternal, Infant, and Early Childhood (MIECHV) program's steering committee, the MCH program strengthened its relationship with the Idaho Substance Abuse program's Pregnant Women and Women with Dependent Children (PWWC) program. The

PWWC program has identified a network of providers to serve the specific needs of pregnant women and women with children who are facing substance use issues. This network will be used as a referral source for women enrolled in the MIECHV program.

In July 2014, in an effort to align programs according to the life course framework, the Title X Family Planning Program will be placed within the MCH Program structure. This restructuring allows for targeted preconception health messaging to Title X clinic consumers.

Reduce intentional injuries in children and youth

In 2012, Idaho established a state-specific, statewide Suicide Prevention Hotline. Idaho was the only state without a suicide prevention hotline for several years. Volunteers received training on the new Idaho Suicide Prevention Hotline. In October 2012, 33 clinicians received a training called "The Link Between Mental Illness and Stigma" which focused on the implications of stigma in mental health treatment.

Through executive order in 2012, Idaho established a child fatality review team to allow comprehensive and multidisciplinary review of the deaths of children younger than 18 years of age in order to identify what information and education may improve the health and safety of Idaho's children. This was a significant accomplishment for Idaho as we were the only state without such a review team.

Improve access to medical specialists for CSHCNs

In 2012, the MCH program began exploring options for implementing the patient-centered medical home model of care for children with special health care needs (CSHCN). In early 2013, the MCH program partnered with the Medicaid Children's Healthcare Improvement Collaboration (CHIC) project to implement medical home for CSHCN living in rural areas of Idaho.

In 2013, the MCH Program expanded contract funding with Eastern Idaho Public Health District to support provision of increased pediatric specialty clinics. By doing so, travel burden was reduced for families with CYSHCN, when previously out of state travel was necessary to receive care. Further, the MCH Program enhanced it's partnership wiht St. Luke's Children's Hospital by restructuring the genetic and metabolic services contract. The new contract leverages the hospital's expertise in pediatric specialty care.

III. State Overview

A. Overview

Geographical Information

The state of Idaho ranks 13th in total area in the United States and 11th in total dry land area. It is 490 miles in length from north to south and at its widest point, 305 miles east and west. Idaho has 44 counties and a land area of 84,033 square miles with agriculture, forestry, manufacturing, and tourism being the primary industries. The bulk of Idaho's landmass is uninhabited and unhabitable due to the natural deterrents of desert, volcanic wastelands and inaccessible mountainous terrain. Eighty percent (80%) of Idaho's land is either range or forest, and 70% is publicly owned. The state has seven major population centers. Five southern cities -- Idaho Falls, Pocatello, Twin Falls, Boise and Nampa/Caldwell -- follow the curve of the Snake River plain and are surrounded by irrigated farmland and high desert. Lewiston, in north central Idaho, is centered in rolling wheat and lentil fields, and deep river canyons. In north Idaho, Coeur d'Alene is located on a large forested mountain lake and is a major tourist destination. Much of the state's central interior is mountain wilderness and national forest. The isolation of many Idaho communities makes it difficult and more expensive to provide health services.

Population Information

In the 2010 census Idaho's population was 1,545,801. This ranks Idaho 39th in the United States in population. The population increase from 2000 to 2010 of 21.1%, more than doubles the national average of 9.7%. This population gives Idaho an average population density of 19.0 persons per square mile of land area. However, half of Idaho's 44 counties are considered "frontier," with averages of less than seven persons per square mile. In 2010, the national average for population density was 87.4 persons per square mile.

The physical barriers of terrain and distance have consolidated Idaho's population into seven natural regions with each region coalescing to form a population center. Approximately 66% of Idaho's population reside within one of the seven population centers. This tendency for the state's population to radiate from these urban concentrations is an asset for health planning, although it makes it more difficult to deliver adequate health services to the 34% of the population who reside in the rural areas of the state. To facilitate the availability of services, contiguous counties are aggregated into seven public health districts. Each district contains one of the seven urban counties plus a mixture of rural and frontier counties.

Population Estimate July 2010 for 2010
Source: Census Bureau Internet release April 2011

District	Population Count	%
Idaho	1,559,796	100.0
1	215,212	13.8
2	105,409	6.8
3	252,597	16.2
4	433,182	27.8
5	182,358	11.7
6	169,366	10.9
7	201,672	12.9

/2013/ Population Estimate April 2012 for 2011
Source: Census Bureau Internet release April 2012

District	Population Count	%
Idaho	1,584,985	100.0
1	214,625	13.5
2	106,217	6.7
3	256,653	16.2
4	443,851	28.0
5	187,012	11.8
6	170,147	10.7
7	206,480	13.0 //2012//

/2014/ Total Population 1,595,728 as of July, 2012 estimate; an increase of 1.8% since the 2010 census. [Source: Census Bureau Internet release April 2013] //2014//

/2015/ Total Population 1,612,136 as of April, 2013 estimate; an increase of 1.8% since the 2010 census. [Source: US Census Bureau] //2015//

Ethnic Groups

The estimated racial groups that comprised Idaho's population in 2009 were: (a) white, 89.1%; (b) black, 0.6%; (c) American Indian/Alaska Native, 1.4%; (d) Asian, 1.2% and (e) Pacific Islander, 0.1%. Hispanics make up 11.2% of the race categories. More than half of Idaho's Hispanic population resides in two health districts, with 32.5% residing in Health District 3 and 20.4% in Health District 5. Native Americans number 21,441with the majority residing on four reservations in Health Districts 1, 2, 3 and 6.

/2014/ The estimated racial groups that comprised Idaho's population in 2011 were: (a) white, 93.9%; (b) black, 0.8%; (c) American Indian/Alaska Native, 1.7%; (d) Asian, 1.3%; (e) Native Hawaiian/Other Pacific Islander, 0.2%. Persons of Hispanic or Latino origin comprised 11.5% of the total population. [Source: quickfacts.census.gov] //2014//

/2015/ The estimated racial groups that comprised Idaho's population in 2012 were: (a) white, 93.8%; (b) black, 0.8%; (c) American Indian/Alaska Native, 1.7%; (d) Asian, 1.4%; Native Hawaiian and Other Pacific Islander, 0.2%. Persons of Hispanic or Latino origin comprised 11.6% of the total population. [Source: US Census Bureau] //2015//

Migrant and seasonal farm workers are a significant part of Idaho's Hispanic population. A migrant farm worker is defined as a person who moves from outside or within the state to perform agricultural labor. A seasonal farm worker is defined as a person who has permanent housing in Idaho and lives and works in Idaho throughout the year. In 2009, the National Center for Farmworker Health, Inc. estimated that over 54,659 migrant and seasonal farm workers and their families resided in Idaho, at least temporarily. The majority of Idaho's Hispanic individuals live in southern Idaho along the agricultural Snake River Plain.

Economic Information

As a comparison to the nation as a whole, family median incomes in Idaho are below the national average, ranking 42nd out of 51. The average median income in Idaho (2009) was $44,644. The number of families living in poverty statewide average is 14.5% (placing Idaho 14th out of 51), and children under 18 living in poverty was 19.6% (18th out of 51). Idaho's unemployment rate in March of 2010 was 9.4%, nearly triple the 2004 rate of 3.2%.

/2014/ The Idaho average medium income for families was $43,341 (2011). This is down 0.3% from 2010; dropping median household income for the third straight year. [Source: labor.idaho.gov]. According to the 2010 Census, the percent of Idahoans living below poverty level was 12.6% statewide. This places Idaho 24th out of 51 in ranking. //2014//

/2015/ The Idaho average medium income for families was $43,341 (2011). This is down 0.3% from 2010; dropping median household income for the third straight year. [Source: labor.idaho.gov]. According to the 2010 Census, the percent of Idahoans living below poverty level was 12.6% statewide. This places Idaho 24th out of 51 in ranking. //2015//

Educational Information

Between 2005 and 2009, the percentage of Idahoans over the age of 24 who had graduated high school was 87.7%, compared to the national average of 84.6%. During the same time period, of Idahoans over the age of 24, 23.7% hold a bachelor's degree or higher, compared to a national average of 27.5%. New statistics from the 2010 census are still being compiled and should be available in future reporting years.

/2014/ Between 2007 and 2011, the percentage of Idahoans over the age of 25 who had graduated high school was 88.5%, compared to the national average of 85.4%. During this same time period, of Idahoans over the age of 24, 24.6% hold a bachelor's degree or higher, compared to a national average of 28.2%. [Source: U.S. Census Bureau, 2007-2011 American Community Survey] //2014

/2015/ Between 2008 and 2012, the percentage of Idahoans over the age of 25 who had graduated high school was 88.6%, compared to the national average of 85.7%. During this same time period, of Idahoans over the age of 25, 24.7% hold a bachelor's degree or higher, compared to a national average of 28.5%. {Source: U.S. Census Bureau, 2008-2012 American Community Survey] //2015//

Health Delivery System in Idaho

As a frontier state, Idaho is subject to a host of challenges not found in more highly populated, more urbanized states. Idaho's geography, to a large extent, dictates our population dispersal and our lifestyle. High mountain ranges and vast deserts separate the population into seven distinct population centers surrounded by smaller communities. Radiating out from these centers are numerous isolated rural and frontier communities, farms and ranches. Providing access to health care for this widely dispersed population is an issue of extreme importance for program implementation, planning health care systems and infrastructure. Serving distinct populations such as migrant/seasonal farm workers, children with special healthcare needs, and pregnant women and children can be problematic. Balancing the needs of these populations with the viability of providing services within their home communities requires a committed effort. Additionally, Idaho's residents and leadership tend to emphasize the importance of local control over matters affecting livelihood, health, education and welfare. The conservative nature and philosophy of Idahoans is manifested in offering programs and services through local control rather than a more centralized approach. This philosophy is also evident in political terms and has impacted state government both fiscally and programmatically, having important implications for all of Idaho's health care programs.

Health services in Idaho are delivered through both private and public sectors. The health delivery system is comprised of the following elements:

A. The Idaho Department of Health and Welfare, Division of Public Health, assures the provision of public health services through contracts, by formulating policies, by providing technical assistance, laboratory support, vaccines and logistical support for the delivery of programs and services, epidemiological assistance, disease surveillance, and implementation of health promotion activities. Additionally, the Division licenses all ambulances and certifies all emergency medical services personnel in the state. It also provides vital records and manages efforts to provide access to health care in rural areas. Public health preparedness activities for the state are also coordinated through the Division of Health.

MCH-funded clinics for PKU and other metabolic conditions are provided at the three major population centers around the state, several times per year. MCH-funded genetics clinics are offered in Boise every month. For both of these specialty clinics, Idaho uses MCH funds to bring in specialist physicians from Portland, Oregon since these specialties do not yet exist in Idaho.

B. Seven (7) autonomous district health departments provide a variety of services including, but not limited to: immunizations, family planning, WIC, STD clinics, and clinics for children with special health problems. The Children's Special Health Program (Idaho's CSHCN program) provides partial funding for specialty clinics in northern and eastern Idaho where specialty physicians are also brought in from neighboring states (Washington and Utah) to provide services not otherwise available in those areas.

C. In 2009, there were 48 licensed hospitals in the state with a total licensed bed capacity of 3,883.

D. Idaho has 12 Community Health Centers and one Federally Qualified Health Center "Look-Alike" that provide high quality health care to about 130,000 people each year. They are located in 37 communities throughout the state and in three communities across the border in eastern Oregon. Dental, mental health and behavioral services are also offered at many of these locations. Annually, Idaho's Community Health Centers serve just over 100,000 patients.

/2013/ In May 2012 Idaho community health centers were awarded $9.64 million from HRSA for construction and improvements. Long-term capital project awards to expand facilities, improve existing services and serve more patients went to Terry Reilly in Nampa, Family Health Services in Twin Falls, and Glenns Ferry Health Center. Awards for needed facility and equipment improvement went to Terry Reilly and Upper Valley Community Health Services in Saint Anthony. //2013//

/2014/ In 2012, the Idaho Hospital Association membership directory reports 44 member hospitals (includes 1 in Ontario, Oregon and 1 in Washington). The total number of acute beds is 3,226 (49 in Ontario and 25 in Washington). There are 14 skilled nursing facilities with a total of 482 skilled nursing facility beds.

Currently, 100% of Idaho is a federally-designated shortage area in mental health care, 96.7% of Idaho is a federally-designated shortage area in primary care, and 95.7% of Idaho is designated a shortage area in dental health care. Nationally, Idaho ranks 48th and 49th for the rate of physicians in primary care and overall rate of physicians in patient care practices located in remote locations. [Source: Idaho State Innovation Model Design Grant Abstract, January, 2013] //2014//

/2015/ In April 2013, the Centers for Medicare and Medicaid Services, Innovation Center (CMMI) awarded Idaho up to three million dollars to develop a Statewide Healthcare Innovation Plan (SHIP). This grant is administered within the Idaho Department of Health and Welfare, Division of Public Health. The primary goal of the SHIP is to transform the Idaho healthcare delivery system from a fee-for-service, volume-based system to a value-based model driven by improved health outcomes. Idaho contracted with Mercer to seek input from healthcare system participants throughout the state (healthcare professionals, other service providers and consumers). At least 56 focus groups and five 'Town hall' meetings were held across the state. Idaho is planning to apply for the Model Testing grant proposal (MTP). Through MTP, Idaho will request approximately 45 million dollars to implement the SHIP over a five-year period. [Source: State of Idaho Website] //2015//

E. As of the end of 2008, there were 3,063 licensed and practicing physicians within the state. The physician to patient ratio of care in Idaho was 201 physicians providing patient care per 100,000 population, as compared to the national average of 309. There were 1,020 primary care

practitioners licensed and practicing in Idaho. There were a total of 511 physician assistants in Idaho. There were 1,480 pharmacists, 840 physical therapists, 80 psychiatrists and 863 general dentists licensed in Idahoans. These numbers represent whole counts made available through State Licensure Boards and do not reflect the actual time (or fractions of time) that these practitioners avail themselves in health care services.
As of January 15, 2010 16.7% of Idahoans lacked access to primary care, as compared to the national average of 11.5%.

F. There are five Indian/Tribal Health Service Clinics operating in Idaho. These clinics provide a wide variety of preventive health services to Native Americans. There is a clinic serving each of the federally recognized tribes in Idaho -- Kootenai, Coeur d'Alene, Nez Perce, Shoshone Bannock and NW Shoshone. Each of these tribes is also a delegate to the Northwest Portland Area Indian Health Board.

Access to Health Care Needs of the Population in General

As previously indicated, the lack of health insurance is a significant barrier to health care in Idaho. In 2009 an estimated 19.1% of the state's population, over 295,000 individuals, had no health insurance. Of Idaho's Hispanic population, 34.9% reported having no insurance and 54% of Native Americans were uninsured. In 2008, there were approximately 440,023 children under the age of 18 living in Idaho. Of these, approximately 200,112 reside in households earning incomes at or below 200% of the federally designated poverty level. Approximately 12.4% (24,901), of children living in families with incomes at 200% of the poverty level or less did not have health insurance. For all income levels, there were an estimated 41,060 children under 18 who did not have health insurance in 2009. According to FY 2007 BRFSS survey data, 10.2% of Idaho households contained uninsured children.

Utilization of Medicaid in Idaho is average compared to the rest of the nation. In 2009 35% (147,049) of Idaho's children were Medicaid recipients, which is comparable to the average of the U.S. population enrolled in Medicaid. Additionally, in 2005 the AAP estimated that about 53% of children eligible for Medicaid in Idaho are actually enrolled in the program, which is on par with national averages.

According to the CQ Press, Health Care State Rankings 2010, Idaho ranked 49th for "rate of physicians in 2008" with 201 per 100,000 population. Idaho ranked 49th for "rate of physicians in primary care in 2008" with 67 per 100,000 population. Currently, 96.7% of the state's area has a federal designation as a Health Professional Shortage Area in the category of Primary Care, 93.9% in Dental Health, and 100% in Mental Health. The isolation of many Idaho communities makes it very difficult and expensive to provide health services, especially to low income individuals. The counties hardest to serve are the most isolated and those with the lowest populations such as Camas county, population 1,126, and Clark county, population 910. Providing services to frontier counties that do not have clinic sites is challenging.

According to the 2009 Idaho Kids Count Book, 13 percent of Idaho children under age 18 are without health insurance coverage, up from 11.4 percent in 2006. SCHIP enrollment for Idaho's children has an average annual growth rate of 24.5% (33,060 enrolled in 2007 and 19,054 in 2004), which is over 4 times the national growth rate of 5.69%.

/2013/ Between 2000 and 2009, the percent of children in Idaho without health insurance decreased from 16% to 9%. During this period, children receiving health insurance thr0ugh a parent's employer decreased from 54% to 46T. children with private insurance not associated with an employer increased from 7% to 12%. Children with public insurance increased from 15T to 24%. This trend has resulted in a decline of uninsured Idaho children from 16% in 2000 to 9%

in 2009. During this same time period, the combined enrollment of children in SHIP and Medicaid increased from 74,040 in 2000 to 164,999 in 2009, an increase of 122%.

/2014/ The percent of children in Idaho without health insurance increased from 11.6% in 2006, to 11.9% in 2012. [Source: Current Population Survey, U.S. Census Bureau]

In 2007, the number of children 'ever enrolled' for combined SCHIP programs was 33,060. In 2011, this number climbed to 42,604; a 28.9% increase over four years. [Source: Medicaid.gov-state enrollment data] //2014//

In 2009, 96.6% of mothers had access to health insurance (Medicaid or other) during pregnancy. This is up slightly from 95% in 2007. In 2009, as in 2007, approximately two out of five (38.6%) who gave birth in Idaho reported Medicaid as a payment source for prenatal care and/or delivery. //2013//

/2015/ In 2010, 43.9% of women utilized Medicaid during pregnancy, up slightly from the 2009 figure of 43.3%. The number of women reporting no health insurance during pregnancy was 36.0% in 2009 and has increased slightly to 37.4% in 2010. [Source: 2010 Pregnancy Risk Assessment Tracking System Annual Report] //2015//

/2015/ Idaho is operating as a "supported" State-based Marketplace. For the 2014 coverage year, eligibility and enrollment will be conducted by both the Federal-Facilitated Marketplace (FFM) and the state Medicaid/CHIP agency. Your Health Idaho is a resource that allows Idahoans to shop, compare and choose the insurance plan that best fits the individual, family or small business needs. Your Health Idaho is an independent entity overseen by an 18-member board of Idahoans which includes brokers and agents, physicians, business owners, legislators and non-profit representatives. The latest numbers released by the U.S. Department of Health and Human Services indicates that 76,061 Idahoans selected health insurance plans through Your Health Idaho. Idaho was third in the nation per capita for the number of residents who selected health insurance plans just behind Vermont and Florida. [Source: State of Idaho, Your Health Idaho] //2015//

Oral Health

In 2002 only 10% of Medicaid-enrolled received any form of dental treatment and only 6% received any preventive dental services. The 2001 Idaho Smile Survey results determined 64% of Idaho 2nd grade children had experienced dental caries and 28% had untreated dental caries. In Idaho there is a large disparity between Hispanic and Non-Hispanic individuals and also between lower and upper levels of income. Among Hispanic 2nd grade students, 79% had dental caries; and of those children 52% had unmet dental needs. Among students participating in the Free and Reduced Lunch Program, 66% had dental caries and 32% had unmet dental needs. Approximately 65% of the adults 18 and older in Idaho visited a dentist in 2006.

A 2006 Idaho Oral Health Needs Assessment identified the following oral health facts about the state. 67% of the population visited the dentist or dental clinic within the past year. 65% of the population had their teeth cleaned by a dentist or dental hygienist within the past year. 23% of the population age 65+ have lost all of their teeth. 44% of the population age 65+ have lost 6 or more teeth. 48% of the population on public water systems is receiving fluoridated water. 52% of 3rd grade students have one or more sealants on their permanent first molar teeth. 65% of 3rd grade students had caries experience (treated or untreated tooth decay). 26% of 3rd grade students had untreated tooth decay.

The Idaho Oral Health Needs Assessment also identified the following barriers to oral heath. The cost of dental treatment and services is one of the most common barriers. It does not matter if the patients are insured; it is still a major factor for not getting dental care. There are many rural

areas in Idaho and dental patients often have a difficult time traveling to a dental care provider. If a patient is in need of specialty care they often have to travel to the more metropolitan areas, adding costs to patients' treatment. Patients need to be educated about the importance of oral health in relationship to overall health. They also need to be educated about the new advancements in dentistry to help reduce their dental fear. There is a growing Hispanic population in Idaho and the language barrier continues to grow.

The Idaho Medicaid Program has not been able to fill the gap in providing dental care to low-income children. The Surgeon General's Report on Oral Health (2000) in America shows that for each child without medical insurance, there are at least 2.6 children without dental insurance. With Medicaid reform and an emphasis on preventive health, Medicaid recipients now receive preventive dental visits through the Idaho Smiles dental plan.

The Oral Health Program continues to fund the statewide School Fluoride Mouthrinse Program, serving 35,700 children grades 1-6 in 2009. The MCH Oral Health Program continues to fund early childhood caries (ECC) prevention and fluoride varnish projects for WIC clients, Head Start children, and children who are Medicaid/CHIP eligible. During 2009, 41,206 children received preventive dental services, including 3,999 who received fluoride varnish applications, and 10,230 parents, teachers, dental and medical health professionals served through education and community outreach efforts.

Idaho does not have enough dentists accepting Medicaid/CHIP patients to meet the demand from this population, much less the low-income, uninsured population. Thirty-nine of Idaho's 44 counties are either a geographic or population group Dental Health Professional Shortage Area. As of December 2009, there were 863 active licensed dentists statewide. During state fiscal year 2009, the toll-free Idaho CareLine averaged 175 calls per month from persons seeking a Medicaid dentist. From July 2008 through June 2009, the CareLine received 2,094 calls for a Medicaid dentist.

/2013/ In 2008, 49.6% of Idaho mothers did not go to a dentist during pregnancy for routine care. This is a significant drop from 2001 when 62.5% reported not receiving dental care during pregnancy. The most commonly cited reason for this was lack of money or insurance (50.9%). //2013//

/2014/ In 2009, 46.1% of Idaho mothers did not go to a dentist for routine care during pregnancy. The most commonly reported reason for not visiting the dentist was lack of money or insurance (50.5%). The percentage of pregnant women not receiving dental care has dropped significantly from the highest rate of 63.3% in 2002 to the lowest rate of 46.1% in 2009. [Source: 2009 Pregnancy Risk Assessment Tracking System Annual Report; Bureau of Vital Records and Health Statistics, 2012] //2014//

/2015/ In 2010, 48.9% of Idaho mothers did not go to a dentist for routine care during pregnancy. The most commonly reported reasons for not visiting the dentist were due to lack of access to oral health providers and lack of money or insurance. The percentage of women not receiving dental care dropped in 2009 (46.1%) and has increased slightly to 48.9% in 2010. As of 2008, 96.7% of the geographic area of Idaho was designated as a dental Health Professional Shortage Area (HPSA). In addition, Idaho has nine Federally Qualified Community Dental Centers providing treatment at reduced fees depending on income. Access to these centers is limited for those individuals who do not live near one of these centers. Furthermore, demand for care exceeds the resources of these centers leaving many without low cost options. Idaho has not expanded Medicaid at this time and cost/coverage seems to be the greatest contributing factor for not accessing dental services. [Source: Idaho Department of Health and Welfare website_Oral Health; 2010 Pregnancy Risk Assessment Tracking System Annual Report] //2015//

Impact on Health Outcomes

Although our linking of these factors to health outcomes may not be empirical, a number of them as described above including: the state's rural nature, long travel distances, shortage of health care providers, economics, and conservative philosophy, may contribute to health care outcomes characterized by a low percentage of immunization in the two year old population, low prenatal care utilization, a high percentage of uninsured children, and a low accessibility to pediatric specialists. Moreover, the conservative outlook has kept government involvement to a minimum. This limits the impact that government driven programs can have on many health outcomes. An example is the limitation on covered conditions in the Children's Special Health Program. Additionally, the rural and agricultural nature of the state has a strong association with high death rates due to motor vehicle accidents as well as other injuries and may also contribute to the high suicide rate, which is also seen in other western states.

Current MCH Initiatives

In Idaho, Title V programs exist within the broad continuum of health care delivery systems. The programs have responded to change based upon their relevance to the priority health concerns identified by the needs assessment process. In turn, programs have attempted to implement strategies and activities based upon their effectiveness in impacting outcomes as well as their acceptability within the targeted populations.

The Bureau of Clinical and Preventive Services, as the Title V agency, continues to play a major role in assuring the quality of and access to essential maternal and child health services in Idaho. We have worked to ensure that the expansion of Medicaid managed care enables women, infants and children to receive high-quality, comprehensive services.

In 2009, staff from Idaho's CSHCN program developed materials for a new Transition-to-Adulthood curriculum for distribution to Idaho's children with special healthcare needs. /2013/ The transition curriculum is available in a kit as well as online, and is available in both English and Spanish. As of January 2012, approximately 3,000 Transition-to-Adulthood kits had been distributed to families of CSHCN. //2013// In addition to the materials, CSHP staff travel to relevant meetings and conferences around the state presenting the information in workgroup and breakout sessions, as well as staffing a booth where materials are distributed.

Staff from the Newborn Blood-spot Screening program continue to work with existing and new Idaho birthing centers to improve compliance with the newborn screening methodologies. With this continued support, Idaho continues to enjoy high compliance rates and low unsatisfactory specimen numbers.

/2014/ The MCH Program has partnered with the March of Dimes as part of the ASTHO challenge to reduce premature births in Idaho by 8% by 2014. As part of this initiative, the group began work on the "Healthy Babies are Worth the Wait" campaign to encourage pregnant women and healthcare providers to wait until labor occurs naturally or until 39 completed weeks of gestation before elective delivery. At the Idaho Perinatal Nurse Leadership Summit in October 2012, the March of Dimes provided awareness-building kits to all nurse managers for distribution at their hospitals and facilities, and a physician champion lectured on the topic. Kits were also sent to the Public Health Districts and approximately 40 OB/GYN clinics throughout the state.//2014//

/2015/ The Bureau of Clinical and Preventive Services, as the Title V grantee, continues to play a major role in assuring the quality and access to essential maternal and child health services in Idaho.
The MCH Program continues to partner with the March of Dimes to reduce premature births in Idaho via the "Healthy Babies are Worth the Wait" campaign. The Newborn Blood-spot Screening program anticipates adding Severe Combined Immunodeficiency

(SCID) to the screening panel by 2015. The program will also be contracting with a courier service for blood spot specimen transport to facilitate expedited screen results.

The MCH Program is beginning year two of collaboration with Medicaid on a demonstration project that focuses on a patient-centered medical home model to providers of pediatric and family care for children and youth with special health care needs in rural Idaho. The program is also applying for funds through the State Implementation Grants for Enhancing the System of Services for CYSHCN through Systems Integration. If awarded, one area of funding would be directed toward strengthening (add parent partner to practices, refine the work plan and creating a formalized plan to transition the project from CHIC-supported to the MCH program) the patient-centered medical home demonstration project to prepare for future replication to all health districts in the future.

The CYSHCN and Title V directors have been involved in the statewide initiative to prevent child abuse in Idaho through increased awareness and dissemination of the "Crying Plan" aimed at preventing shaken baby syndrome. This initiative is directed by the Idaho Children's Trust Fund, and partners, such as MCH, Hospitals, Early Childhood Coordinating Council and Strengthening Families, Infant-Toddler program, to name a few, are instrumental in supporting this initiative.

Idaho will be sending a delegation to the Infant Mortality Collaborative Improvement and Innovation Network (CoIIN) sponsored by HRSA/MCHB for Region X. The delegation is comprised of the CYSHCN director, Title V director, a perinatologist, Deputy Division Administrator for Medicaid, Research Analyst for the Pregnancy Risk Assessment Tracking System and an RN/nurse mid-wife.

In 2006, Idaho ranked 45th among states in the percentage of population (31.3%) served by a community water system with optimal fluoride levels. Besides access to care and coverage for dental services, this too, is a contributing factor to dental carries in Idaho. To address the dental disparities, Idaho has focused efforts to aggressively educate the public on how to care for teeth and gums, educate community leaders and policy makers about the value of water fluoridation (as of 2010, 31% of Idaho community water systems provide fluoridation), develop and promote school-based programs that offer fluoride varnish and dental sealants to children and promote the importance of a dental home to the public and providers, with emphasis on children by one year of age and children and youth with special healthcare needs. [Source: Idaho Oral Health Action Plan 2010-2015] //2015//

As of May 2010, the Idaho State immunization registry, IRIS, has 1,001 active facilities which include VFC providers, private providers, health departments, schools, daycares and out-of-state clinics. 726,758 patients have enrolled in the system, with a total of 6,812,573 vaccinations delivered to them. Of those patients, 413,899 are under 18 years of age. Historically the IRIS system has been opt-in and about 94% of families chose to opt their children in at birth. During the 2010 legislative session, the Idaho Legislature approved new Administrative Rules that makes the IRIS system opt-out instead of opt-in, which should increase participation in the registry. IRIS providers can enter vaccination information through hand data entry, electronic data importing or send records to the Idaho Immunization Program for data entry. Routine monitoring of the data quality in the IRIS system is a high priority and the since 2008 the Idaho Immunization Program has performed regular data quality assessments of vaccination data.

/2013/ As of May 2012, the Idaho State immunization registry, IRIS, has ¬¬approximately 2,100 facilities which include Vaccine for Children (VFC) providers, private providers, health departments, schools, daycares and out-of-state clinics. The majority of these are child care providers of which 325 were actively using IRIS in May of 2012. Providers are primarily becoming active users as they receive their inspections and realize the value of the system to

their child care business. 991,350 patients have enrolled in the system, with a total of 10.2224.454 vaccinations delivered to them. Of those patients, 724,053 have received two or more immunizations. Several factors contributed to this increase including the change from an opt-in to an opt-out system, a strengthening of the laws governing immunizations required for school, increased capabilities for child care providers and the fact that Vital Records' birth records are exported into IRIS on a weekly basis. Additionally, IRIS moved to a new more agile and user friendly information system. The new information system was deployed on March 1, 2012, and was based on the Wisconsin Immunization Registry (the WIR System). The WIR System is currently deployed in nearly 20 states, and in Idaho it has been very well received by end users. //2013//

The Department of Health and Welfare 2007-2011 Strategic Plan is comprised of three goals: 1) Improve the health status of Idahoans; 2) Increase the safety and self-sufficiency of individuals and families; and 3) Enhance the delivery of health and human services. A separate, but integrated Department Customer Service Plan was put forth in October 2007. The customer service standards -- the 4 c's -- are caring, competence, communication, and convenience. /2013/ An up-dated plan is not available at this time. //2013//

/2014/ The Department of Health and Welfare FY2012-FY2016 Strategic Plan is comprised of five goals: 1) Improve the health status of Idahoans (improve the healthy behaviors of adults to 75.40% by 2016; increase the use of evidence-based clinical preventive services to 70.33% by 2016); 2) Increase the safety and self-sufficiency of individuals and families (increase the percent of Department clients living independently to 84.31% by 2016, increase the percent of individuals and families who no longer have to rely on benefit programs provided by the Department to meet their needs to 50.54% by 2016, the percent of children who are safe from maltreatment and preventable illness will reach 89.85% by 2016); 3) Enhance the delivery of health and human services (assure that in 2016, 100% of Idaho's geographic areas which meet Health Professional Shortage Area criteria will be submitted for designation as areas of health professional shortage, increase the percent of Idahoans with health care coverage to 78.67% by 2016, Department timeline standards will be met for 92.75T of participants needing eligibility determinations for , or enrollment in, identified programs); 4) The Department eligibility accuracy rates of key identified programs will reach 84.17% by 2016; 5) The Department will improve customer service in the areas of caring, competence, communication and convenience to 84.57% by 2016.//2014//

Last, though certainly not least, MCH staff are monitoring the impacts and opportunities arising from the national healthcare reform legislation, as we expect this new law to have sweeping effects on the MCH population and programs in Idaho.

Current MCH Priorities

/2015/ Idaho MCH Program has contracted with Boise State University (BSU), Center for Health Policy, to conduct the new five year needs assessment for Title V. The MCH and CYSHCN directors have regular meetings with the BSU team to inform on the needs assessment process and progress. The proposed process will include a general population survey of MCH identified needs/priorities along with planned family and provider surveys to further guide priorities. Key informant interviews are planned for quantitative data gathering as well. Surveys and interviews are planned for July-September, 2014. //2015//

A 5-year Needs Assessment was conducted during 2009 and 2010, with significant public input, to establish Idaho's MCH priorities for the coming five-year period. The survey garnered 189 completed responses within the following self-identified groups:
* Individual (parent, guardian, self) - 36.4%
* Representative of a government agency -- 34.5%
* Representative of a non-profit group -- 14.3%

* Representative of a for-profit company -- 2.3%
* Other -- 12.4%

The intent of the survey was to establish the MCH state priorities for the next five years, and the results of the survey were ranked by the various demographic groups (full rankings attached). The rankings that were selected to set the priorities for the next five years are the "All Idaho" rankings, and not those of the subset of the respondents. Below is a list of the seven Idaho state priorities for the next five years, arranged by target group.

Pregnant Women and Infants
* Reduce premature births and low birth weight
* Reduce the incidence of teen pregnancy
* Increase percent of women incorporating preconception planning and prenatal health practices

Children and Adolescents
* Improve immunization rates
* Decrease the prevalence of childhood overweight and obesity
* Reduce intentional injuries in children and youth

Children with Special Healthcare Needs
* Improve access to medical specialists for CSHCNs

An attachment is included in this section. IIIA - Overview

B. Agency Capacity

The State Title V agency in Idaho remains within the Division of Public Health, Idaho Department of Health and Welfare. Administrative oversight of the Maternal and Child Health Services Block Grant is vested with the Bureau of Clinical and Preventive Services (BOCAPS). The BOCAPS is responsible for the MCH Block Grant (Title V), family planning (Title X), STD/AIDS (including prevention and Ryan White CARE Act, Title II), WIC, programs for children with special health care needs (CSHCN), the newborn metabolic screening program, genetics and metabolic clinics, and Women's Health Check (WHC), Idaho's breast and cervical cancer screening program. The chief of BOCAPS provides additional fiscal support and/or program consultation for injury prevention including poison control, oral health, adolescent pregnancy prevention grant, perinatal data analysis (Pregnancy Risk Assessment and Tracking System -- PRATS), and toll-free hotline activities. Organizational charts for the Idaho Department of Health and Welfare, Division of Public Health, Bureau of Clinical and Preventive Services, Bureau of Community and Environmental Health, Bureau of Vital Records and Health Policy, and Division of Family and Community Services are attached in the TVIS System.

/2014/ The Division of Public Health went through a major reorganization during the summer of 2012. The Division Administrator, Jane S. Smith, retired and Elke Shaw-Tulloch, promoted from Chief, Bureau of Community and Environmental Health to Division of Public Health Administrator. Traci Berreth promoted to Chief, Public Health Business Operations. //2014//

/2011/ The Home Visiting Program funded through the Patient Protection and Affordable Care Act was placed within BOCAPS under the Children's Special Health Program. //2011//

/2013/ The Children's Special Health Program has been renamed to the Maternal and Child Health Program (MCHP) //2013//

/2011/ During State fiscal year 2011, the Women's Health Check program received $150,000 in Millennium funding from the state legislature to provide diagnostic services for breast and cervical cancer to young women aged 18 through 29. This is an age group for whom there are very few resources in Idaho. This funding will not be available in state fiscal year 2012. As of June 10,

2011 this program had enrolled 107 young women for symptoms/tests suspicious for cancer. Of these, 16 have received breast cancer work-ups, and 91 have received cervical cancer work-ups. Of these, 35 have been diagnosed with cancer or dysplasia and referred to Breast / Cervical Cancer (BCC) Medicaid for treatment of pre-cervical cancer. Thirty four of these were cervical related, and one was for breast cancer. //2011//

/2013/ During state fiscal year 2012, WHC did not receive any Millennium funds. However, during the 2012 legislative session, the Millennium Committee granted $250,000 in Millennium funds to the program for use during state fiscal year 2013. Unlike the previous award, these funds are not targeted at a younger population, but rather are to provide clinical services to women in the program's defined population of women 40 to 60 years of age. This funding is critical as Idaho continues to rank 50th for mammography screening. //2013//

The Idaho Department of Health and Welfare was formed in 1974 pursuant to Idaho Code 39-101 to "promote and protect the life, health, mental health, and environment of the people of the state." The Director is appointed by the Governor and serves "at will." S/he serves as Secretary to the state's Health and Welfare Board with seven other appointed representatives from each region of the state. The Board is charged with formulating the overall rules and regulations for the Department and "to advise its directors." Programmatic goals and objectives are developed to meet the specific health needs of the residents of Idaho and to achieve the Healthy People 2020 (HP) objectives for the nation.

Bureau of Clinical and Preventive Services (BOCAPS)

As a derivative agency of the Department of Health and Welfare, BOCAPS functions under the statutory authority described above. The Bureau is within the Division of Public Health. That portion of the Bureau's mission, related to maternal and child health, fulfills the responsibility of Code 39-101. There is no specific state statutory authority to provide guidance or limit the Bureau's capacity to fulfill the purposes of Title V.

Newborn Screening Program

In 1965, state legislation (Idaho Code Sections 39-909, 39-910, 39-911, and 39-912) was passed mandating testing for "phenylketonuria and preventable diseases in newborn infants." The current newborn test battery includes screening for all 29 conditions recommended by the March of Dimes, and several other conditions for a total of 45 conditions.

Children's Special Health Program (CSHP)
/2013/ Renamed Maternal and Child Health Program (MCHP) //2013//

The Children's Special Health Program (CSHP) is administratively located in BOCAPS. CSHP is governed by IDAPA 16, Title 02, Chapter 26 "Rules Governing the Idaho Children's Special Health Program." The Program is statutorily limited to serving individuals in eight major diagnostic categories: Cardiac, Cleft Lip and Palate, Craniofacial, Cystic Fibrosis, Neurological, Orthopedic, Phenylketonuria (PKU), and Plastic/Burn. Services are limited to children under 18 years of age, and -- except for PKU and cystic fibrosis -- to children without creditable health insurance using the SCHIP definition of "creditable."

/2011/ During the 2010 legislative session, the state appropriation to serve adults with cystic fibrosis was not made. The Children's Special Health Program continues to serve children under the age of 18 with cystic fibrosis. //2011//

/2013/ The Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program is managed under the MCHP. //2013//

The individuals providing program management and their qualifications are listed as follows:

Bureau of Clinical and Preventive Services

Dieuwke A. Dizney-Spencer, RN, MHS, is Idaho's MCH Director. Ms. Dizney-Spencer joined the MCH program in December of 2005 and holds the title of Chief of the Bureau of Clinical and Preventive Services.

/2014/ Dieuwke Dizney-Spencer promoted from Chief, Bureau of Clinical and Preventive Services, to Deputy Administrator -- Public Health Integration within the Division of Public Health. //2014//

Kathy Cohen, RD, MS, has been the Manager of the Family Planning, STD and HIV Programs since December 2006, and has many other years of experience with the Division of Public Health as manager of the WIC program, and in the Epidemiology program. Ms. Cohen manages the Title X family planning grant, the STD program, the HIV/AIDS care program, and the HIV prevention program.

/2014/ Kathy Cohen retired August, 2012. Aimee Shipman, PhD was hired as the new Program Manager over Title X family planning, STD and HIV/AIDS care, and HIV/Viral Hepatitis prevention programs. Ms. Shipman worked previously in the department as a PRATS Project Director. //2014//

Mitchell Scoggins, MPH, has been the director of Idaho's CSHCN program since May 2007. Mr. Scoggins comes to Idaho with several years of experience implementing public health and other programs in developing countries. Some of these projects have included: family planning, child survival, micro-enterprise, HIV/AIDS prevention, food security, agricultural development, and disaster relief.

/2011/ Mitch Scoggins resigned in December of 2010 to assume the position of Immunization Program Manager for the state of Idaho. //2011//

/2011/ Jacquie Daniel was hired as the manager of the Children's Special Health Program on March 7, 2011. Ms. Daniel has been with the Department for approximately six years. She was first hired as an analyst in Vital Records and Health Statistics and spent the past four years as the Principal Analyst for Idaho's Pregnancy Risk Assessment Tracking Survey. //2011//

Carol Christiansen, BSN, RN, joined CSHP on the 21st of April 2008, in the role of Nurse, Registered Senior. Ms. Christiansen coordinates the newborn screening activities and provides care coordination for CSHP's clients. Ms. Christiansen comes to Idaho with 14 years of experience in Florida's Children's Medical Services program and is well qualified to bring clinical and programmatic expertise to CSHP.

/2011/ Laura DeBoer, MPH, joined the CSHP staff in October of 2010 as manager of the home visiting program. Laura came to the program with experience in Early childhood Comprehensive Systems in Iowa, Rhode Island, and Louisiana. //2011//

//2014// Laura (DeBoer) Alfani resigned as manager of the home visiting program in April, 2013. The position is currently vacant and in process of being filled. Lachelle Smith's volunteer commitment ended December, 2012. The MCH program is in the process of hiring a state temporary position to sustain the duties that the Lachelle assisted with. //2014//

/2013/ Lachelle Smith, a VISTA Volunteer, has been hired to assist with the development and implementation of the home visiting program. //2013//

Kris Spain, MS, RD, LD, is the manager of the WIC program having accepted the position in March of 2010. Prior to accepting the manager position, Ms. Spain served with the Idaho state

WIC office for 6 years, and 3 years in a local WIC clinic.

/2014/ Kris Spain, MS, RD, LD promoted to Chief, Bureau of Clinical and Preventive Services October, 2012. Ms. Spain is Idaho's MCH Director. //2014//Cristi Litzsinger was promoted to WIC Program Manager in November, 2012. Previously, Cristi worked in WIC as the Vendor Manager. //2014//

Emily Geary MS, RD, LD, has worked as the Nutrition Education Coordinator for the Idaho WIC Program since 1998.

/2013/ Emily Geary resigned in March 2012. The position was reclassified to a Program Systems Specialist-Automated. BJ Bjork was hired in May 2012 to fill this position. The change was made due to the development and implementation of a web-based WIC information system. Training needs for staff in the field have evolved to where they require more technical emphasis. Ms. Bjork will work closely with WIC nutritionists on technical and training needs. //2013//

Marie Collier, RD, LD, provides assistance to the MCH block grant regarding promoting reducing the percentage of children ages 2 to 5 years receiving WIC services with a Body Mass Index at or above the 85th percentile.

Cristi Litzsinger, RD, LD, IBCLC, has served as the State Breastfeeding Promotion and Outreach Coordinator for the Idaho WIC Program since 2004. Cristi Litzsinger is an International Board Certified Lactation Consultant and Registered/Licensed dietitian. She provides technical assistance to the MCH block grant regarding breastfeeding promotion and support systems in Idaho. Prior to joining the Idaho program, Ms. Litzsinger worked with WIC in Alaska.

/2013/ In April of 2011 Cristi Litzsinger was promoted to the WIC Vendor Manager position. In July of 2011, MarLee Harris, RD, LD, was hired as the Breastfeeding Promotion and Outreach Coordinator for the Idaho WIC Program. In this capacity, she also manages the WIC Peer Counseling Program. //2013//

/2015/ Minnie Munez-Inzer, who managed the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) retired in September, 2013. Susan Bordeaux, clinical RN for the program, promoted to Program Manager in October, 2014. //2015//

Office of Epidemiology, Food Protection and Immunization

Christine Hahn, MD, has been the State Epidemiologist since February 1997. Dr. Hahn provides epidemiological support and consultation to all Title V programs.
/2014/ In October, 2012, Dr. Christine Hahn was promoted as the Public Health Medical Director and continues as the state's chief epidemiologist. //2014//

Leslie Tengelsen, PhD., DVM, has been the Deputy State Epidemiologist since 1998. Dr. Tengelsen, in her role as deputy state epidemiologist and designated state public health veterinarian, provides epidemiologic support and consultation on public health aspects of zoonotic, vectorborne, and foodborne diseases.

/2011/ Mitchell Scoggins, MPH, assumed the position of Immunization Program Manager in December 2010. Prior to that time Mr. Scoggins had been the director of Idaho's CSHCN program since May 2007. //2011//

Bureau of Community and Environmental Health

Elke Shaw-Tulloch, MHS, has been the chief of the Bureau of Community and Environmental Health since 2002.

/2014/ Elke Shaw-Tulloch, MHS, was promoted to the Administrator over the Division of Public Health in October, 2012. Sonja Schriever, was promoted from program manager over Health Preparedness to Bureau Chief, Community and Environmental Health in October, 2012. //2014//

Steve Manning is the Manager of the Injury Prevention and Surveillance Program located within the Bureau of Community and Environmental Health.

Mimi Hartman-Cunningham, MA, RD, CDE, has managed the Diabetes Program since 1997 and the Oral Health Program since 2008. Both of these programs are located in the Bureau of Community and Environmental Health.

Mercedes Munoz, MPA, supervises the Adolescent Pregnancy Prevention program and Sexual Violence Prevention program since 2008.

Jamie Harding, MHS, ATC, CHES, manages the Idaho Physical Activity and Nutrition program. Ms. Harding has managed this program since 2008. /2013/ Jamie Harding resigned in March 2012. The position is vacant as of May 2012. //2013//

/2014/ Angie Gribble currently manages the Idaho Physical Activity and Nutrition program. Ms. Harding started with the Department May 27, 2012. //2014//

/2011/ Rebecca Lemmons, MHS, manages the Coordinated School Health Grant in partnership with Pat Stewart at the State Department of Education. //2011// /2013/ Rebecca Lemmons resigned in May of 2012. The position is vacant as of June 2012. //2013//

/2011/ Jack Miller, MHE, has managed the Tobacco Prevention and Control Program since 2004. //2011//

/2014/ Jack Miller has been promoted to Program Manager, Chronic Disease Section overseeing Diabetes, Oral Health, Heart Disease and Stroke, and Comprehensive Cancer. He began his new assignment November 2012. //2014//

/2011/ Ivie Smart, MHE, has been the Health Education Specialist with the Tobacco Prevention and Control Program since 2005. //2011//

/2014/ With Jack Miller's promotion, the Health Program Manager position became available. Ivie Smart, MHE, also received a promotion filling the Health Program Manager spot. Ivie began her new role in December 2012.
Casey Suter has been with the Tobacco Prevention Control Program replacing Ivie as the Health Education Specialist since February 2013. Casey has been with the Department since August 2010 working in the Bureau of Health Planning and Resource Development. //2014//

Bureau of Health Planning and Resource Development

Angela Wickham, MPA, an employee of the Department of Health and Welfare since 2001, is the Chief of the Bureau of Health Planning and Resource Development.

/2014/ Angela Wickham resigned as Chief of Bureau of Health Planning and Resource Development in October, 2012. //2014//

Mary Sheridan, RN, MBA, is the Manager of the Rural Health and Primary Care program. As the manager, she coordinates state programs to improve health care delivery systems for rural areas of the state. Ms. Sheridan has held this position since 2003.

Laura Rowen, MPH, manages the Primary Care program. Her role is to assess the state for areas of medical under service, barriers in access to health care, and identification of health disparities.

/2014/ Laura Rowen resigned in March, 2013. Andrew Noble was hired in April, 2013 to manage the Primary Care program. //2014//

/2015/ In March of 2014, the Office of Rural Health and Primary Care was re-organized to become a bureau within the Division of Public Health. Mary Sheridan, who has overseen this area as a program manager, was promoted to bureau Chief. Because of the SHIP grant and emphasis placed on the creation of a planning implementation grant, along with strategies to bring medical professionals to rural Idaho, it was deemed essential to align the activities in this area with a separate bureau. //2015//

Bureau of Vital Records and Health Statistics

James Aydelotte has been the Chief of the Bureau of Vital Records and Health Statistics since February 2007. Mr. Aydelotte has been with the Bureau since 2000.

Jacqueline Daniel has been a Principle Research Analyst August of 2005. She is responsible for computing and analyzing health statistics regarding prenatal care, maternal risk factors, and birth outcomes. She manages the yearly Pregnancy Risk Assessment Tracking System (PRATS). Ms. Daniel is the current SSDI Program Manager for Idaho and serves on the Advisory Board for the Idaho Perinatal Project.

/2011/ Ms. Daniel resigned in February 2010 to accept the Children's Special Health Program Manager position in the Bureau of Clinical and Preventive Services. This position had not yet been filled at the time of submission of the Block Grant. //2011//

Edward (Ward) Ballard, Principal Research Analyst, has served as the dedicated analyst for MCH since 2007. He spent the two years prior to that as a BRFSS analyst. Prior to joining the Department, Mr. Ballard had experience with health survey data collection and reporting as a contractor.

/2013/ Aimee Shipman was hired as the new PRATS Project Director/Perinatal Assessment Analyst by the Bureau of Vital Records and Health Statistics on September 6, 2011. Dr. Shipman received her Ph.D. in geography from the University of Idaho in 2008 where she engaged in epidemiological research on the socioeconomic determinants of HIV prevalence in southern Africa. Dr. Shipman has a Master's degree in Public Administration from the University of Washington and has experience in budget, program planning and policy analysis with federal agencies. Prior to assuming per position with the Idaho Department of Health and Welfare, Dr. Shipman was employed as a land use planner for Latah County, Idaho where she analyzed the environmental, socioeconomic, transportation, and health related impacts of land use proposals. //2013//

/2014/ Aimee Shipman resigned her position as PRATS Project Director to assume the position as Program Manager for Title X family planning, STD and HIV/AIDS care, and HIV/Viral Hepatitis prevention programs. //2014//

Division of Family and Community Services unsure if any changes here?

Alberto Gonzalez is the 2-1-1 Idaho CareLine supervisor for our toll-free referral service.
Alex Zamora
/2011/ Courtney Keith has replaced Alberto Gonzalez as the supervisor for the 2-1-1 CareLine. //2011//

/2013/ Gretchan Heller has replaced Courtney Keith as the supervisor for the 2-1-1 CareLine. //2013//

/2014/ Alex Zamora is the Program Specialist over the 2-1-1 CareLine. He began his duties in January 2013. //2014//

/2011/ Larraine Clayton, MEd, manages Idaho's Early Childhood Comprehensive Systems (ECCS) Grant and staffs the Early Childhood Coordinating Council (EC3). The Title V, MCH Director is a required member of this Council. //2011//

/2011/ Cynthia Carlin manages the newborn hearing screening program. //2011//

Public Health Districts

District health departments, who carry out implementation of many state strategies through contracts, are staffed by public health professionals from nursing, medicine, nutrition, dental hygiene, health education, public administration, computer systems, environmental health, accounting, epidemiology, office management, and clerical support services. A number of key staff have public health training at the master's level. MCH needs are addressed at the seven districts through activities of personnel in 44 county offices. Title V resources support these efforts through technical assistance, training, and selected materials/supplies. The main funding streams that complement Title V are county funds, fees, the State General Fund, Title X, Preventive Health and Health Services Block Grant, CDC's Immunization grant, HIV/AIDS Programs and the WIC Program.

C. Organizational Structure

C. Organizational Structure
Much of the statewide service delivery for MCH is carried out by the public health districts and other non-profit and community based organizations through written contracts. The contracts are written with time-framed and measurable objectives and are monitored with required progress reports. Site visits are made to programs as part of monitoring both performance and adherence to standards. A description of the MCH programs and their capacity to provide services for each population group follows.

Pregnant Women, Mothers and Infants

The Family Planning, STD and HIV Programs provide reproductive health exams, counseling and preventive health education to women of childbearing age. Clinical services and community education are also targeted for adolescents. The WIC Program provides pregnant and postpartum women and infants and children through age four with supplemental foods, nutrition counseling and education.

The Immunization Program purchases and distributes vaccines to public and private health care providers in Idaho with the bulk being used to immunize the 0-2 year old population. Additionally, the program maintains a surveillance effort to record childhood immunization levels among two-year old and school age children. They also assist in the investigation of outbreaks of vaccine-preventable diseases and the promotion of immunizations through statewide media campaigns. The Immunization Program fills a key role in promoting and implementing a statewide immunization registry called IRIS, the Idaho Immunization Reminder Information System. During the 2010 legislative session, the Idaho legislature created the Immunizations Advisory Committee to advise and set policy for immunizations in Idaho.

The Newborn Screening program provides newborn metabolic screening through a contract with the Oregon Public Health Laboratory. As of July 2007, the Idaho NBS program screens for all 29 conditions recommended by the March of Dimes, and for several others. Medical information relative to conditions screened for is provided through contractors at the Oregon Health and

Science University to Idaho physicians and other health care professionals involved with the follow-up of abnormal newborn screens. /2011/ Current screening in Idaho can detect more than 40 serious conditions. //2011//

Idaho's Genetics and Metabolic Services Program provides clinical services through contracts with St. Luke's Children's Hospital in Boise and through outlying health districts, for genetic evaluation, diagnostic testing and counseling services for infants, children, and adolescents. Due to increased demand, MCH-funded genetic clinical service days have been increased by 50% in the last two years. As a result of the MCH program's funding a genetic specialist to provide services in Boise, St. Luke's hospital has contracted additional services from the geneticist, resulting in improved genetic services infrastructure in Idaho.

/2014/ In May 2013, the Idaho MCH Program restructured the contract with St. Luke's Children's Hospital for the provision of Genetic and Metabolic Services for pediatric patients within the south central and central regions of the state to allow for direct clinic oversight. It is expected that this change to the contract and clinical direction will result in improved care coordination and health outcomes for Idaho's most vulnerable children. //2014//

/2013/ Idaho's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program provides evidence-based home visiting services to pregnant women, children, and their families through contract with various community-based organizations and public health districts in at-risk communities. The MIECHV program was new to Idaho as of July 2010 and has been in the planning and implementation stages since that time. As identified by a needs assessment, Idaho's at-risk communities are Kootenai and Shoshone counties in North Idaho and Twin Falls and Jerome counties in South Central Idaho. These communities are being treated as two, two-county contiguous service areas. The MIECHV program identified three evidence-based home visiting models to meet the needs of Idaho's at-risk communities: Parents as Teachers, Early Head Start-Home Based, and Nurse-Family Partnership. Contracts to provide these services were executed with organization in early 2012, and service delivery is expected to begin following a contractor readiness assessment in June 2012. Of highlight, the Idaho MIECHV Program established a contract with the north Idaho public health district to implement Nurse-Family Partnership through an innovative cross-state collaboration with Spokane Regional Health District--the first cross-state home visiting collaboration in the country. //2013//

/2013/ The MIECHV Program is staffed by .25 FTE Program Manager, 1.0 FTE Health Program Manager, .5 FTE Administrative Assistant 1 and .5 FTE Administrative Assistant 2, as well as a full-time Americorps VISTA. //2013//

/2014/ The MIECHV Program is undergoing some staffing changes. The Program is staffed by .25 FTE Program Manager. With the resignation of the former Health Program Manager, the position has been reclassified to a 1.0 FTE Health Program Specialist; the duties align more with this job classification. There continues to be 1.0 FTE Administrative support. The Americorps VISTA volunteer period expired this year and the program has hired a .5 FTE state temporary Health Program Specialist to assume some of those duties, along with oversight for the MIECHV data. //2014//

/2015/ The MIECHV Program hired Deborah Drain, MPA, in August 2013 to oversee the program in Idaho. Ms. Drain brought a wealth of experience from her work in Early Head Start and home visiting. The state temporary Health Program Specialist position was filled by Kristen Bergeson. Kristin is a Registered Dietitian and has extensive background in WIC. //2015//

Children

The Bureau of Community and Environmental Health (BCEH) administers the Title V programs of Oral Health, Adolescent Pregnancy Prevention, and Injury Prevention. The other programs

include several preventive health education programs such as diabetes and tobacco use prevention. This bureau provides consultation to assist local district health departments, industries, schools, hospitals and nonprofit organizations in providing preventive health education.

The Oral Health Program contracts with the district health departments to perform surveys of oral health status, as well as to conduct the school fluoride mouth rinse program, preventive dental health education, early childhood caries prevention fluoride varnish projects, and school sealant projects.

The Injury Prevention Program manages and coordinates the Department contract with Rocky Mountain Poison and Drug Center, and coordinates activities associated with National Poison Prevention Week. The program also provides community-based prevention education for child safety seat, seatbelt and bicycle safety programs through the work of unintentional injury prevention coalitions.

Children with Special Health Care Needs

The Children's Special Health Program (CSHP) provides and promotes direct health care services in the form of family centered, community-based, coordinated care for uninsured children with special health care needs, including phenylketonuria (PKU) and nutrition services for high-risk children and social, dental, and medical services for a number of diagnostic eligibility categories, including neurologic, cleft lip/palate, cardiac, orthopedic, burn/plastic, craniofacial and cystic fibrosis.

CSHP is administered from the central office of the Department of Health and Welfare, where a senior RN does care coordination and prior-authorization for services. A .75 FTE Program Manager, a 1.0 FTE Senior Registered Nurse, and 1.0 FTE Medical Claims Examiner, and .5 FTE Administrative Assistant staff the CSHP program. In addition, services for children with special healthcare needs not covered by other insurance are coordinated through CSHP. (Note: Even insured children with PKU and cystic fibrosis are covered.) A registered and licensed dietitian provides technical support through a contract with CSHP to assure PKU and special nutritional needs are met. An additional out-of-state RD/LD is employed by CSHP to improve the metabolic-dietitian capacity of Idaho's RDs. A metabolic and a genetic physician are also employed part-time by CSHP to provide services in Idaho. The two physicians live and work in Portland but travel to Idaho periodically to provide services not otherwise available in this state.

/2013/ CSHP underwent a name change at the beginning of 2012 and is now known as the Maternal and child Health (MCH) Program. Although the program itself has not changed, the new name better reflects the activities conducted and services offered by the program including Newborn Screening and Genetics, Children's Special Health, Maternal, Infant, and Early Childhood Home Visiting (MIECHV), as well as special projects like the Text4Baby initiative and Transition-to-Adulthood materials. //2013//

All MCH Populations

The Office of Epidemiology, Food Protection and Immunization provides health status surveillance and guidance for infectious and chronic disease activities and disease cluster investigation directed to all segments of the maternal and child health population. This office is also responsible for the implementation of Idaho's immunization activities.

The Family Planning, STD and HIV Program provides HIV prevention education activities as well as counseling and testing. It also distributes HIV/AIDS therapeutic drugs to eligible clients. This program also manages the Title X Family Planning grant.

The toll-free telephone referral service, Idaho CareLine, provides information and referral service

on a variety of MCH, CSHCNs, Infant Toddler, and Medicaid issues to callers, thus serving all segments of the MCH population. The Idaho CareLine has been expanded to play the central role of the clearinghouse on services available for young children in Idaho and is under the administration of the Division of Family and Community Services.

The Bureau of Health Policy and Vital Statistics administers programs that provide for a statewide system of vital records and health statistics. The bureau employs a Perinatal Data Analyst who is currently reviewing a variety of perinatal health status indicators and has conducts the annual Pregnancy Risk Assessment Tracking System survey (PRATS) of women who have recently delivered. Additionally, the bureau conducts population-based surveys, i.e., the BRFSS.

The Bureau of Health Planning and Resource Development manages activities focused on improving services in rural and underserved areas. They work closely with hospitals, federally qualified health centers, emergency medical service providers, local district health departments, associations, universities and other key players in the Idaho health system.

An attachment is included in this section. IIIC -- Organizational Structure

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

All state level MCH funded personnel are located within the Department of Health and Welfare's central office building. Other Division of Public Health programs offering collaboration and support services to Title V staff, such as the Immunization Program, the Bureau of Community and Environmental Health, the Family Planning, STD and HIV Program, the WIC Program, Bureau of Laboratories, the Bureau of Health Planning and Resource Development and the Bureau of Vital Records and Health Statistics are also housed within this same building. The Division of Medicaid is housed outside the Department's central offices. Genetics and metabolic clinical services, coordinated by the Bureau of Clinical and Preventive Services, are offered at the St. Luke's Children's Hospital in Boise, which is only five blocks away from the Health and Welfare offices. Metabolic clinics are also held in northern and eastern Idaho. Distance does not deter joint collaboration, which occurs via periodic meetings, telephone, electronic mail, a web-enabled database system, and FAX communication.

A program coordinator and an administrative assistant staff the Oral Health Program.

The MCH Systems Coordinator (funded partly through the State Systems Development Initiative and partly MCH block grant), is housed in the Bureau of Vital Records and Health Statistics.

The toll-free telephone referral line is supported by a Community Services Coordinator and several Public Service Representatives jointly funded through Title V and Part H of the Individuals with Disabilities Education Act (IDEA), Medicaid and other programs using the service.

Most of the programs receiving MCH Block Grant funding are housed with the Bureau of Clinical and Preventive Services, which is designated as the Title V State Agency. These programs include: Children's Special Health; Family Planning, STD and HIV Program; the Newborn Screening Program; WIC; Women's Health Check; and Genetics/Metabolic Services. Within the Bureau of Community and Environmental Health programs receiving MCH Block Grant funds are: Injury Prevention and Environmental Health Programs, Oral Health and Diabetes, and Physical Activity and Nutrition. The Bureau of Vital Records and Health Statistics also receives MCH block grant funding. Finally, within the Division of Family and Community Services, the Idaho CareLine receives direct MCH block grant funding.

/2011/ MCH Block Grant funds are no longer supporting a Principal Research Analyst in the

Bureau of Vital Records and Health Statistics, though an analyst remains dedicated to MCH programming. //2011//

/2014/ With the Division of Public Health re-organization, there is no longer a Bureau of Health Planning and Resource Development. The programs within that bureau were moved to the Bureau of Emergency Medical Services and Preparedness and the State Office of Rural Health and Primary Care. Looking forward, Idaho's MCH planning budget does fund a Principal Research Analyst position within the Bureau of Vital Records and Health Statistics.

Idaho has two infrastructure opportunities to support with MCH funds. One is the development of a system that will allow medical providers to send birth records electronically to Vital Records and the other is to assist in the upgrade to the Women's Health Check data system, which captures breast and cervical screening and referral information. //2014//

/2015/ Idaho MCH funds supported the enhanced data system update to allow medical providers to send birth records electronically to Vital Records. The anticipated project completion date is September, 2014. Idaho did not use MCH funds to support the Women's Health Check data system, for the screening and early detection of breast and cervical cancer, as planned. Exploration of the data system uncovered complications stability and data migration in the original plan. Because this infrastructure project will require further investigation of identified issues, funds were utilized to support a Division of Public Health Continuous Quality Improvement position that will be utilized heavily by the MCH programs. //2015//

There are a number of other programs within the Department of Health and Welfare that are tied in varying degrees with the overall operation of MCH activities within Idaho. Several of these receive MCH funds from other sources than the block grant. For instance, the Adolescent Pregnancy Prevention Program within the Bureau of Community and Environmental Health receives MCH funds via the Adolescent Pregnancy Prevention Grant. The Bureau of Vital Records and Health Statistics is responsible for the SSDI grant.

There are a number of other programs under the umbrella of the Department of Health and Welfare that provide data for assessing program progress and also provide services within the MCH pyramid model to various MCH targeted populations. They include within the Bureau of Clinical and Preventive Services: the WIC Program and the Family Planning, STD and HIV Program; within the Bureau of Community and Environmental Health: the Tobacco Prevention and Control program and the Adolescent Pregnancy Prevention program; within the Bureau of Vital Records and Health Statistics: Health Statistics and Surveillance; and within the Division of Family and Community Services: Idaho Children's Trust Fund, Council on Domestic Violence, Council on Developmental Disabilities, the Early Childhood Coordinating Council and the Infant Toddler program.

Finally, most of the MCH programs have a strong working relationship with the Division of Medicaid. This division provides much of the important data used in program assessment including providing data on Medicaid coverage as well as access to care issues. Also, each of the seven District Health Departments has very strong ties to many MCH programs through a contracting process to provide direct, population-based, enabling, or infrastructure services as defined by that MCH program.

/2014/ In May, 2013, the Idaho MCH Program collaborated with Medicaid Children's Healthcare Improvement Collaboration (CHIC) to introduce the patient-centered medical home model to providers of pediatric and family care to families with children with special health care needs (CSHCN) in rural parts of Idaho, utilizing the Public Health Districts. The demonstration project will pilot in Southeastern and Eastern Idaho. This area of the state has the highest birth rate and identified children with special healthcare needs. MCH will fund a Medical Home Coordinator

(MHC) in each health district who will serve as a member of the provider practice team. The MHC will assist the practice in identifying patient populations (CSHCN) who could benefit from care coordination, along with helping the practice learn to track evidence-based care through formal quality improvement techniques. Medicaid is providing some funding for the project, in addition to in-kind contributions for MHC training and on-going coaching, web-based quality improvement team site for data entry, an evaluation component and assistance with overall project oversight.

"The patient-centered medical home is a model of primary care in which patients receive well-coordinated services and enhanced access to a clinical team, and clinicians use decision support tools, measure their performance, and conduct quality improvement activities to meet patients' needs. The model holds promise not only for improving clinical quality and patients' experiences, but also for reducing health system costs". [Source: Idaho Primary Care Association-www.idahopca.org] //2014//

/2015/ The Idaho patient-centered medical home demonstration project is entering year two of two. In 2013, the Idaho Division of Public Health (Title V MCH Program), Division of Medicaid (CHIC Project), Eastern Idaho Public Health District, and Southeastern Idaho Public Health District partnered to address persistent health disparities among children with special health care needs residing in rural Idaho communities. The goal of this multidistrict collaboration is to introduce a PCMH model to providers of pediatric and family care serving CYSHCN in rural parts of Idaho through the public health districts. A shared medical home coordinator operates from the health district and travels weekly to multiple participating practices to assist with quality improvement, patient education and referral coordination, PCMH transformation, and patient registry and workflow management. This collaboration is evaluating the model of a shared Medical Home Coordinator as an effective method to engage rural practices in comprehensive care coordination through PCMH.

Although Idaho seeks to evaluate models of care to provide CYSHCN improved outcomes, primarily through PCMH, there is much emphasis on sustainability. This partnership has experienced successes with the shared PCMH model of care in our rural communities. While the inter-Department partnership is quite noteworthy, that alone would not sustain this systems change. Realizing the gap in a trusted community resource for this project, Title V and Medicaid invited the community to the table at the front of this project. Two local public health districts serving primarily rural communities were asked to join the team. Through this partnership, including community health nurses, Medical Home Coordinators were staffed and recruiting clinics began. Many lessons have been learned and documented through this demonstration. Overall, after one year of implementation the local public health districts believe the community is stronger, providers have attested to improved outcomes borne from quality improvement implementations in practice workflows, and the partnership created between agencies has introduced new strategies for additional programs. This demonstration will undergo a formal independent evaluation. The evaluation will include both qualitative and quantitative data. //2015//

E. State Agency Coordination

The Bureau of Clinical and Preventive Services, the Title V designated agency, collaborates formally and informally with a number of entities within and outside of the Department of Health and Welfare.

A formal agreement exists between the Divisions of Public Health and Medicaid. This agreement refers to the relationship of the two divisions concerning the Title XIX (Medical Assistance) Program, EPSDT Services for Children, EPSDT Child Welfare Services under Title IV of the Social Security Act, the Title V (Maternal and Child Health Block Grant) Program, the Title X

(Family Planning) Program, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Collaborative efforts with the Division of Medicaid have allowed the Title V agency to provide input regarding Medicaid policy as it impacts the Title V population, specifically focusing on the implementation of the Family Opportunity Act -- Buy In, and the CHIPRA grant, which is a coordinated effort between Medicaid, the State of Utah, the 2-1-1 Idaho CareLine, CSHP and the Immunization Program.

/2014/ The Title V MCH Program and the Medicaid Children's Healthcare Improvement Collaboration (CHIC) are collaborating together on a patient-centered medical home model demonstration project. The project is a two-year project. Medicaid and MCH will work with two Public Health departments in Idaho to fund a Medical Home Coordinator (MHC) position within Public Health. The MHC will work with identified medical practices to assist those clinics in providing transformational services to Children with Special Healthcare Needs. The MHC will evaluate clinic processes, collaborate across practices to introduce the medical home concepts to rural communities, introduce evidence-based quality improvement strategies and provide prevention, education and data evaluation. //2014//

/2015/ The Title V MCH Program and Medicaid Children's Healthcare Improvement Collaboration (CHIC) is in year two of the patient-centered medical home model demonstration project. The MCH program funded two medical home coordinator positions and partial project activities within two public health departments to carry out the activities of the collaborative project. Medicaid provides training for the medical home coordinators as well as oversight for the medical home portal for data entry. The MCH program will work with Medicaid to develop a contract for a third party to evaluate the project, identify strengths, areas for improvement and replication for expansion. It is anticipated that contract will be ready summer 2014. //2015//

A formal agreement between Title V and the Title X Family Planning, STD and HIV Programs is unnecessary. All aspects of family planning services and clinics are supported through the Bureau of Clinical and Preventive Services.

The Bureau of Clinical and Preventive Services and the Bureau of Community and Environmental Health (BCEH) have a strong collaborative relationship. The BCEH provides health promotion activities for injury prevention, adolescent pregnancy prevention, tobacco use prevention, oral health promotion, diabetes control, arthritis, rape prevention, comprehensive cancer, physical activity and nutrition, heart disease and stroke, environmental health and indoor air quality. The Bureau of Community and Environmental Health collaborates with the MCH Director to impact those performance measures dealing with suicide, adolescent pregnancy prevention, protective tooth sealants, the comprehensive cancer control program, and the Idaho Physical Activity and Nutrition Program.

/2015/ The State agency has strengthened coordination in many ways this past year that benefits the Maternal and Child Health programs. The Division of Public Health created a Collaborative Bureau Integration Team (CBIT) that is comprised of various bureau and program representatives, led by the Deputy Division Administrator. Both the Title V MCH Director and CYSHCN Director are part of CBIT. The CBIT team meets every other month to update partners on funding opportunities, shared business practices and to ensure no duplication of services is occurring and programs are aligning with the Division strategic priorities. In addition, the Division of Public Health has a Public Health Integration Team (PHIT) that meets twice monthly to focus on division- and department-wide objectives that will lead to enhanced public health integration. The primary focus of PHIT has been to assist the Division in the Public Health Accreditation process. The Division has created a plan and timeline to address the PHAB standards with an accreditation decision to submit in July, 2016. The MCH Title V Director is a member of PHIT and is working collaboratively

with another bureau on PHAB domains 1, 5, and 9.

Within the past year, the Division of Public Health has representation on the Idaho Health and Wellness Collaborative for Children (IHAWCC). The Division representative is the Deputy Division Administrator, Dieuwke A. Dizney-Spencer who was the former Title V MCH Director prior to her promotion into her current position. IHAWCC aims to create a meaningful, long term collaboration of stakeholders invested in child health care quality, with the common purpose of improving the health of the children and youth of Idaho. IHAWCC works with state government, private companies, professional groups and other state and regional entities to facilitate progress in the areas of focus. IHAWCC is instrumental in the provision of learning collaborative for providers of care for children and youth in Idaho. Most recently, there has been learning collaborative on adolescent depression screening, immunization, pediatric patient-centered medical home demonstration and childhood obesity.

In past years, the Bureau of Community and Environmental Health (BCEH) has retained a contract with the Nebraska Regional Poison Center for the Poison Prevention hotline. During 2011, the most recent year for which poison fatality data is available, poisoning was the third leading cause of unintentional injury deaths among Idahoans, subsequent only to motor vehicle crashes and falls. In 2012, the Nebraska Regional Poison Center received over 17,000 calls from Idaho residents; the majority of these calls (58.8%) were received from parents of children age 5 years and younger [Source: Idaho Dept. of Health and Welfare website]. Beginning in July, 2014, this contract will be moved under the Maternal and Child Health Program area. The decision to move the contract was made based on a pending staff retirement in BCEH and funding support for this critical need from the block grant. //2015//

The Title V designated agency also fulfills its role, mandated by the OBRA legislation, of informing parents and others of available providers. This is accomplished through the funding of a toll-free telephone referral service designated Idaho 2-1-1 CareLine. This service is administered through the Division of Family and Community Services.

Councils, Coalitions, and Committees (State and Non-State Agencies)

There are many councils, coalitions, etc., which address MCH issues in Idaho. MCH staff formally serve on many of the bodies, and collaborate, as needed, with all of them.

a) The Pediatric Pulmonary Center Advisory Committee at Children's Hospital in Seattle provides advice concerning funding issues, program planning and data.
b) The MCH Director serves on the Early Childhood Coordinating Council (supported by the State Early childhood Comprehensive Systems -- SECCS grant.)
c) The Idaho Perinatal Project.
d) Emergency Medical Services for Children Taskforce.
e) Perinatal Substance Abuse Prevention Project, funded by the Division of Family and Community Services, Bureau of Substance Abuse. This project is to develop statewide guidance for health care and other human service providers in identifying substance use among potentially pregnant women with the intent of intervening early for the prevention of substance affected newborns.
f) Disability Determinations Services (DDS) addresses the needs of children with special needs and their families.
g) Idaho's Rural Health Program (RHP), established to create a focal point for health care issues that affect the state's rural communities.
h) Idaho Sound Beginnings -- the state's Early Hearing Detection and Intervention (EHDI) program -- provides public awareness, and collects statewide data.
i) Sexual Assault Prevention Advisory Committee.
j) The Idaho Oral Health Alliance, a group dedicated to improving the general health of Idahoans

by promoting oral health and increasing access to preventive and restorative dental services.
k) Idaho Kids Count Editorial Board, a group whose expertise helps guide development of the Idaho KIDS COUNT book and related efforts to track and promote the well-being of children in Idaho through research, education, and mobilization strategies.
l) Association of State and Territorial Dental Directors Data Surveillance Committee.
m) The CSHCN Director serves on the Developmental Disabilities Council.
n) Idaho Immunization Coalition.
o) Comprehensive Cancer Alliance for Idaho (CCAI) -- a partnership between many individuals and organizations to address issues relating to the impact of cancer in Idaho. The CCAI is working to reduce the number of preventable cancers and decrease late stage diagnosis of treatable and survivable forms of cancer by improving screening rates in Idaho and to improve the quality of life of Idahoans impacted by cancer.
p) Operation Pink B.A.G. (Bridging the Access Gap) -- a coalition of agencies and hospitals in Southwestern Idaho funded through the Boise Affiliate of Susan G. Komen Race for the Cure.
q) Breast and Cervical Cancer Medicaid Team -- brings together three divisions of IDHW to address unique issues relating to Women's Health Check clients who are diagnosed with breast or cervical cancer and transferred into the Medicaid system for the duration of cancer treatment.
r) Coordinated School Health Committee, an effort through the Division of Public Health and the Department of Education.
s) The Covering Idaho's Kids Coalition -- insurance coverage for children.
t) The CSHCN Director serves on the advisory board for Idaho Parents Unlimited (IPUL), which is Idaho's Family Voices State Affiliate organization.
u) Canyon County Area Immunization Coalition.
v) Idaho Safe Routes to School Advisory Committee - enable and encourage children to walk and bicycle to school; improve the safety of children walking and bicycling to school; and facilitate projects and activities that will reduce traffic, fuel consumption, and air pollution near schools.
w) Idaho Highway Safety Coalition - reduce traffic deaths, injuries, and economic losses through outreach programs and activities that promote safe travel on Idaho's transportation systems.
x) Idaho Partnership for Hispanic Health - the main objective is to decrease health disparities experienced by Hispanics in Idaho.
y) The Tobacco Free Idaho Alliance (TFIA) - meets quarterly and is a statewide coalition.
z) Idaho Voices for children.
aa) Idaho Chapter of American Academy of Pediatrics.
bb) Northwest Bulletin editorial board.
cc) Healthy Eating, Active Living (HEAL) Idaho.
dd) Idaho Families of Adults with Disabilities (IFAD).
ee) BYU-Idaho EC/EC Special Education Program.
ff) Idaho State Department of Education.
gg) Coeur d'Alene Tribe Early Childhood Learning Center.
hh) Idaho Head Start Association.
ii) Idaho State child Welfare Programs.
jj) St. Luke's children's Specialty Center.
kk) Idaho Infant Toddler Program (IDEA, Part C).
ll) Head Start Collaboration Office.
mm) Idaho Department of Insurance.
nn) Idaho Services for the Deaf and Blind.
oo) Local Public Health Districts.
pp) Coordinator for the Homeless, State Department of Education.
qq) Child Care Administration, Idaho Department of Health and Welfare.
rr) University of Idaho Center on Disabilities and Human Development.
ss) Idaho Primary Care Association.
tt) Medicaid, Idaho Department of Health and Welfare.
uu) Substance Abuse Program, Idaho Department of Health and Welfare.
vv) Child Protection Services, Idaho Department of Health and Welfare.
ww) Idaho Hunger Task Force.
xx) Idaho Chapter of American Academy of Family Practice Physicians.

Local Health Departments

The seven public health districts, representing all 44 counties, are not part of state government but are rather governmental entities whose creation has been authorized by the state as a single purpose district. They are required to administer and enforce all state and district health laws, regulations and standards. These entities provide the basic health services of public health education, physical health, environmental health, and public health administration. Some of the specific activities include: immunizations, family planning services, STD and HIV services, health promotion activities, communicable disease services, child health screenings, WIC, CSHP, and a variety of environmental health services including inspection of child care facilities.

The Title V agency implements program strategies through contracts with the public health districts. The core functions of public health - assessment, policy development, and assurance - are provided to the entire state through the collaboration of state and district health departments. Division of Public Health administration and staff meet monthly with the Directors of the district health departments.

Federally Qualified Health Centers/Community Health Centers

Idaho is served by 11 Community Health Centers with 70 sites that offer primary and preventive care. Dental and mental health behavioral services are also offered at many of these locations. The FQHCs and CHCs often represent the only health care available in rural areas; past partnerships have resulted in projects involving the migrant and seasonal farm workers population for initiatives targeting tuberculosis, family planning, STD/AIDS, diabetes, and breast and cervical cancer.

/2014/ Idaho has 12 Community Health Centers (CHC) and one Federally Qualified Health Center (FQHC) "Look-Alike" that provide high quality health care to about 130,000 people each year. These centers are located in 37 communities throughout the State. MCH interface with CHC/FQHC involve a partnership for the dissemination of health education and services. Specifically, these activities support family planning and reproductive health, breast and cervical cancer screening, STD/HIV/AIDS, diabetes, and prenatal care. [Source: Idaho Primary Care Association-www.idahopca.org] //2014//

Universities

The Division maintains a relationship with all three of Idaho's universities. Past projects have included a needs assessment for high-risk populations for the HIV/AIDS Program by the University of Idaho and formal agreements to provide: faculty/staff collaboration, opportunities for graduate and undergrad students to work with the Division, joint research and data projects, curriculum development for graduate and undergrad programs, and strategic planning.

/2011/ Over the past two years, the interactions with the Center on Disabilities and Human Development at the University of Idaho has developed into a viable and mutually beneficial relationship. //2011//

//2013// The MIECHV Program contracted with Boise State University's Center for Health Policy to conduct evaluation activities and provide data collection technical assistance to the State and local contractors. //2013//

/2014/ The Division of Public Health, MCH Title V Director and CYSHCN Director in Idaho continue to collaborate with partners from the University of Idaho (UI), Boise State University (BSU), Idaho State University (ISU) and Brigham Young University-Idaho (BYU-ID).

The MIECHV program partners with BSU to conduct a formal evaluation of program activities and

technical assistance to both the State and local contractors.

The MCH Program has partnered with the University of Idaho's Center for Disability and Human Development to support the operation of the annual Tools for Life Assistive Technology Conference. The target audience for the event is Idaho educators, therapists, counselors, service providers, job developers, rehabilitation specialists, and especially secondary students with disabilities, youth with special health care needs (CYSHCN), and their families. CSHP nurse care coordinator hosted a vendor table during the 2-day event to present information about the MCH Program's Transition-to-Adulthood kits. The kits are targeted toward three different age groups which provide information to empower youth with special health care needs to take control of their health care and be active in the coordination of their care.

The MCH Director is a member of the Early Childhood Coordinating Council (EC3) which has a rotating member comprised of one of the universities mentioned above. The mission of the EC3 council is to provide leadership and education and coordinate resources for Idaho's young children and families.

The Idaho Department of Health and Welfare's Child Care Program commissioned with the UI to conduct a survey of child care providers in the state. The purpose of the study was to identify characteristics of child care providers and facilities in Idaho, economic status of child care providers, number of providers who participate in Idaho's Child Care State Training and Registry System (IdahoSTARS) professional development and the number of facilities where children with disabilities and special medical needs receive care. Findings of the study (not all inclusive): Over 50% of children in Idaho are in child care, the majority 70% of children in child care live in two-parent households, 76,070 of all Idaho children in child care are under the age of six, average distance families traveled for child care was 13.5 miles, 39% of Idaho child care facilities have one or more children with special health care needs, 9% of facilities had to ask a family to remove a child in the past year due to behavioral challenges or special needs that could not be met. The study results were shared back to EC3 council members and will assist members in comprehensive system plan evaluation and future development. [Source: Child Care in Idaho: A Summary Report of the Idaho Child Care Study Conducted by the University of Idaho and IdahoSTARS] //2014//

F. Health Systems Capacity Indicators

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2012	payment source from birth certificate	7.7	5.6	6.5

Narrative:
/2015/ HSCI 05: Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State. Title V in Idaho uses data from vital statistics which publishes prenatal care based on the 2003 U.S. Standard Certificate. Percent of low birth weight (<2500 grams) births in Idaho has increased slightly to 6.5% in 2012 compared to the 2011 level of 6.1%. Specific to Medicaid populations, there is a

similar increase, 7.7% in 2012 to 7.2% in 2011 [IDHW Vital Statistics Annual Report, 2012]. //2015//

/2015/ From 2011 to 2012, Idaho there was a slight decrease in the percent of pregnant women with adequate prenatal care, 77.2% and 76.1% respectively. Overall, Idaho has seen an improvement since 2007 (65.9%) to 2012. In 2011, 72.6% of pregnant women who received adequate prenatal care were on Medicaid. In 2012, there was a slight decrease noted, 70.8%. It is difficult to pinpoint the reason(s) behind the slight decrease in pregnant women seeking adequate prenatal care. As noted previously, a possible contributing factor may be the Adequacy of Prenatal Care Utilization (APNCU) Index which classifies care as intensive, adequate, intermediate, inadequate, or no care by comparing the number of actual prenatal care visits to the number of visits that a woman was expected to receive, given the onset of prenatal care and the length of gestation. //2015//

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

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	1	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	1	No
Annual birth defects surveillance system	1	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2015

Narrative:
/2015/ Beginning in 2014, Idaho began collecting two sub-categories of data under pregnancy related to infertility7 treatment on births to women with "assisted reproductive technology" and/or "infertility medications utilized". Additionally, eclampsia became a category of hypertension along with pre-pregnancy hypertension and gestational hypertension. //2015//

IV. Priorities, Performance and Program Activities

A. Background and Overview

Being the beginning of a new 5-year cycle, the Idaho Title V programs embarked upon a process to establish the state priorities for the next five years. In mid-2009 the MCH Director formed a Needs Assessment Committee composed of the following Department of Health and Welfare staff:

* The Administrator for the Division of Public Health,
* The Special Assistant to the Administrator, DoPH,
* The Chief of the Bureau of Vital Records and Health Statistics,
* The MCH Director and Chief of the Bureau of Clinical and Preventive Services,
* The CSHCN Director and Manager of the Children's Special Health, Newborn Screening, and Genetics Services Programs,
* The MCH Data Analyst, and
* A Principal Research Analyst from Health Statistics who is in charge of the Pregnancy Risk Tracking System and is the Manager of the SSDI Project.

This committee has met several times over the past year to set methodologies, gather data, and process information as it came in. Secondary data was gathered from a host of sources including, though not limited to;
National Resources-
*Women's Health USA, 2009
*Child Health USA 2008-2009
*America's Children: Key National Indicators of Well-Being, 2009
*Catalyst Center State-at-a-Glance Chartbook, 2007
*Reaching Kids: Partnering with Preschools and Schools to Improve Children's Health, 2009
* The Health and Well-Being of Children: A Portrait of States and the Nation, 2007
*Healthy People 2020
*The National Survey of CSHCNs Chartbook 2005-2006

Idaho Resources-
* Idaho Behavioral Risk Factors, 2009
* 2007 Annual Report from the Pregnancy Risk Assessment Tracking System,
* 2007 Idaho Vital Statistics Report,
* The Burden of Cardiovascular Disease in Idaho, 2009

In addition to secondary sources, the committee gathered primary Needs Assessment-specific data through two surveys. The main survey was requesting state-wide input about which MCH priorities the state should set for the next 5-year period. There were a total of 191 valid responses to this survey with more than one-third (36.4%) of the respondents being individuals, as opposed to government or non-profit representatives. A secondary survey was targeted directly at the families of Children with Special Healthcare Needs and sought to quantify the issue of geographic lack of access to medical specialists in Idaho.

After the survey results were analyzed, the top seven priorities - as selected by all respondents to the survey - were selected as Idaho's state priorities for the next five years.

B. State Priorities

Based on the results of the 2010 needs assessment, these priorities were identified. Following each priority is the measures that will feed into monitoring it.

NPM -- National Performance Measures SPM -- State Performance Measures

NOM -- National Outcome Measures
HSCM -- Health Systems Capacity Measure
HSCI -- Health System Capacity Indicator
HSI -- Health Status Indicator

PREGNANT WOMEN AND INFANTS

- Reduce premature births and low birth weight.
  - NPM 15 Percentage of women who smoke in the last 3 months of pregnancy.
  - NPM 18 Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.
  - NOM 1 The infant mortality rate per 1,000 live births.
  - NOM 3 The neonatal mortality rate per 1,000 live births.
  - HSCI 5 Comparison of health system capacity indicator for Medicaid, non- Medicaid and all MCH populations in the State.
  - HSI 01A Percent of live births weighing less than 2,500 grams
  - HSI 01B Percent of singleton births weighing less than 2,500 grams
  - HSI 02A Percent of live births weighing less than 1,500 grams
  - HSI 02B Percent of live singleton births weighing less than 1,500 grams

- Reduce the incidence of teen pregnancy.
  - NPM 8 The rate of birth (per 1,000) for teenagers aged 15-17 years.
  - SPM 1 Percent of 9th -- 12th grade students that report having engaged in sexual intercourse.
  - HSI 07A Live births to women of all ages enumerated by maternal age and race.

- Increase the percent of women incorporating effective preconception and prenatal health practices.
  - NPM 15 Percentage of women who smoke in the last 3 months of pregnancy.
  - NPM 18 Percentage of infants born to pregnant women receiving prenatal care beginning in the first trimester.
  - SPM 2 Percent of pregnant women 18 and older who received dental care during pregnancy.
  - SPM 4 Percent of women 18 and older who fell into the "normal" weight category according to the Body Mass Index (BMI=18.5 to24.9) prior to pregnancy.
  - SPM 5 Percent of women 18 and older who regularly (4 or more times per week) took a multivitamin in the month prior to getting pregnant.
  - SPM 6 Percent of women 18 and older who gave birth and drank alcohol in the 3 months prior to pregnancy.
  - HSCM 4 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.

CHILDREN AND ADOLESCENTS

- Improve immunization rates.
  - NPM 7 Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.
  - SPM 7 Percent of children at kindergarten enrollment who meet state immunization requirements.
  - SPM 8 Percent of children at seventh grade enrollment who meet state immunization requirements.

- Decrease childhood overweight and obesity prevalence.
  - NPM 11 Percentage of mothers who breastfeed their infants at 6 months of age.
  - NPM 14 Percent of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

- SPM 3 Percent of 9th -- 12th grade students that are overweight.

- Reduce intentional injuries in children and youth.
  - NPM 16 The rate (per 100,000) of suicide deaths among youths aged 15 -- 19.
  - NOM 1 The infant mortality rate per 1,000 live births.
  - NOM 4 The post-neonatal mortality rate per 1,000 live births.
  - NOM 6 The child death rate per 100,000 children aged 1 through 14.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

- Improve access to medical specialists for CSHCNs.
  - NPM 3 The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.
  - NPM 4 The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	19	29	18	19	19
Denominator	19	29	18	19	19
Data Source	Idaho Newborn Screening Program	Idaho Newborn Screening Program	Idaho Newborn Screening Program	Idaho Newborn Screening Program	Idaho Newborn Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments
As the state's lead Text4Baby partner, the Maternal and Child Health Program's (MCHP) and Newborn Screening (NBS) program's care coordinator promoted information about Text4Baby and Newborn Screening at meetings and conferences around the state. Other activities included coordinating efforts with other state partners to promote Text4Baby, marketing Text4Baby via mailings and social media, and tracking enrollment for the state. The MCH Program reaches approximately 9,000 women annually through the Text4Baby mailing to Medicaid enrolled women.

In response to a series of articles published in the Milwaukee Journal-Sentinel about improvements needed in NBS programs across the nation, the NBS coordinator reached out to all birthing facilities to provide training and guidance on improving specimen transit times. The Idaho NBS continued to explore methods to improve transit time and reduce errors.

For 2013, the number of NBS specimens submitted without error was not below 90% all year and achieved the highest compliance rate in the past five years. The NBS coordinator's consistent communication with providers and face-to-face provider educational and compliance visits supported this effort.

The NBS program launched a new electronic payment system for providers to order and pay for NBS kits online.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Newborn Screening (NBS) follow-up staff continue to provide in-service trainings to NBS providers (birthing facilities, midwives, and family practice offices) around Idaho to improve compliance with NBS protocols.			X	X
2. NBS staff provide short-term follow-up from the point of an abnormal NBS screen through confirmatory testing to treatment (if necessary).		X	X	X
3. Administrative rules governing the Idaho NBS program were passed in 2010 that mandate a second newborn screen for all Idaho-born babies.				X
4. Contract with out-of-state specialty doctors to provide consultation and follow-up for genetic and metabolic conditions identified through NBS.				X
5. Promote the Text4Baby campaign to disseminate messages to pregnant women and new mothers about how to keep themselves and their baby healthy during and after pregnancy.			X	
6. Launched an online electronic payment system for providers to purchase NBS kits				X
7.				
8.				
9.				
10.				

b. Current Activities
The NBS coordinator has hosted a vendor table for the NBS program at a number of conferences related to maternal and child health around the state. The NBS coordinator is planning a number of in-service visits to hospitals and birthing facilities in northern and eastern Idaho this summer to

discuss any issues and answer questions related to NBS collection and submission performance.

The NBS is planning on offering free overnight courier services to first specimen providers beginning in fall 2014. This strategy is used by other states as a way to decrease transit times and expedite screening, diagnostics, and follow-up. The courier service will be paid for by the MCH Block Grant.

The Idaho NBS program experienced its highest percentage of newborn screening specimens submitted without error at 96.15% for the month of March 2014. This is the highest error-free rate recorded since the program began graphing and tracking results in 2008.

The NBS coordinator now has access to the new Oregon State Public Health Laboratory (OSPHL) Case Management System which will allow her to enter reports of patient and provider follow-up directly and view actions taken by OSPHL on any newborn screen.

As of May 2014, enrollment in Text4Baby has reached nearly 3,846 pregnant women and new mothers.

c. Plan for the Coming Year

The Idaho NBS program will continue to monitor the roll-out of the free overnight courier services offered to first specimen providers and the impact on transit times. Further, the NBS Program will likely be adding (severe combined immunodeficiencies) SCID to Idaho's NBS panel in early 2015.

With the addition of SCID screening, the NBS coordinator will work regional partners to develop algorithms for screening and treatment, locating and obtaining services from consultants and treatment centers, and offer provider education.

Idaho will continue to collaborate with state partners to promote the Text4Baby campaign.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**22010**					
Reporting Year:	**2013**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	21769	98.9	4	1	1	100.0
Congenital Hypothyroidism (Classical)	21769	98.9	389	6	6	100.0
Galactosemia	21769	98.9	19	1	1	100.0

(Classical)						
Sickle Cell Disease	21769	98.9	241	2	2	100.0

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	53	53	53	73	75
Annual Indicator	52.7	52.7	72.4	72.4	72.4
Numerator					
Denominator					
Data Source	National Survey of CSHCNs 2005-2006	National Survey of CSHCNs 2005-2006	National Survey of CSHCNs 2010	National Survey of CSHCNs 2010	National Survey of CSHCNs 2010
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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	75	75	75	75	75

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first

conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
The role of coordinating and communicating with PKU clients and registered dieticians was transferred from the program manager to the CSHP nurse care coordinator in 2013. The nurse care coordinator continued to document programmatic policies and procedures related to the PKU program in order to provide consistent services and information to our clients.

In March 2013, the contract for nutritional and dietary support for Children's Special Health Program (CSHP) clients with PKU and other metabolic conditions was transitioned to the St. Luke's Children's Hospital's Registered Dietitian (RD) staff. St. Luke's has the only children's hospital in the state and are the experts on care provision to pediatric patients with genetic and metabolic disorders. Letters were sent to families notifying them of the change in nutritional support. Family responses to the change have mostly been favorable.

The Title V Children and Youth with Special Health Care Needs (CYSHCN) Rural Medical Home demonstration was launched in June 2013 as a collaboration between the MCH Program, Medicaid's Children's Healthcare Improvement Collaborative (CHIC) project, and two local public health districts in eastern Idaho to implement a patient-centered medical home demonstration for children with special health care needs in rural areas of the state. The CHIC project is part of a CHIPRA grant that Idaho and Utah received to look for ways to improve healthcare for kids. A focus of the CHIC project is transforming pediatric practices to a medical home in order to increase access to care for patients, support a Medical Home Coordinator to lead and facilitate the transformation to a patient-centered medical home, and provide support to parents and feedback to clinics to improve patient and family involvement and satisfaction. An innovative approach to support the transformation of rural pediatric practices was used by providing funding and establishing contracts with the Public Health Districts to hire and support a Medical Home Coordinator in each district to partner with pediatric and family practices in the rural areas to facilitate the medical home model of care for children with special health care needs.

The Medical Home Coordinator serves as a member of the practice team(s) that helps guide patients and their families through barriers in the complex health care system and helps guide clinical teams in their mission to and improve quality of continuous care. While the primary work station for the MHC is at the public health district, the MHC travels between multiple independent pediatric and family practice clinics educating and coaching practice teams. On the patient and family side, the Medical Home Coordinator (MHC) assists CYSHCN and their families by

developing care plans, connecting to community resources, referrals, care conferences, and family centered care to help properly manage the condition in a patient-centered way. The demonstration is planned for at least two years and will include an evaluation component. The goal of the collaboration between CHIC, Title V MCH Program, and Public Health is to introduce the patient-centered medical home model in rural settings where it may not be feasible for a single practice to support a MHC. This collaboration will present a complete patient care model goal that includes health education, prevention and quality improvement. At the end of the demonstration period a local infrastructure (personnel, best processes, best procedures, and materials) will be accomplished. Benefits of this partnership and infrastructure building may include:

- Introduction of available tools related to health education
- Prevention strategies and tools for public health
- Reduce duplication of services and tests,
- Reduce utilization of emergency room and inpatient facilities,
- Improve patients'/families' understanding of their health care needs,
- Connect patients/families with appropriate resources and support services,
- Improve quality outcomes,
- Develop care plans specific for children with special health care needs,
- Identify patient populations, starting with the top three chronic conditions the clinic sees
- Increase patient/family, provider, and staff satisfaction

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Idaho Children's Special Health Program (CSHP) continues to partner with Idaho Parents Unlimited (IPUL) and Idaho Families of Adults with Disabilities (IFAD).		X		X
2. MCH staff continue to serve on the Developmental Disabilities Council and the Early Childhood Coordinating Council providing these bodies with information about MCH programs and using information from participation to direct MCH programming.		X		X
3. After input from families and dietary and medical consultants, CSHP made revisions to calculations for PKU formula provisions to account for cases of increased need.	X			X
4. The role of coordinating and communicating with PKU clients and registered dieticians was transferred from the program manager to the CSHP care coordinator.		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Title V CYSHCN Rural Medical Home Demonstration will start its second year as of June 2014. The MCH Program and the CHIC project are currently working with the University of Utah to develop a contract for an independent evaluation of the demonstration, including measurement of parent/family satisfaction. Data are expected to be collected and reported next year.

Due to one of the medical home coordinator's resignation, the local public health district will be hiring to fill the position this summer.

The CSHP staff continue to serve on various councils and advisory boards such as: Idaho Parents Unlimited, Idaho Council on Developmental Disabilities, the Idaho Perinatal Project, and Idaho Sound Beginnings. In addition, CSHP continues to support the organization, Idaho Families of Adults with Disabilities (IFAD).

c. Plan for the Coming Year

Through the independent evaluation, satisfaction data and other data will be collected from the Title V CYSHCN Rural Medical Home Demonstration. The CHIC project is compiling an implementation manual and medical home coordinator handbook as means to transfer the demonstration solely to Title V once the CHIC project ends in 2016. Transition planning of the project will occur over the coming year.

The nurse care coordinator will continue to improve upon the PKU program's activities and document program procedures and work with the Children's Hospital RD staff to coordinate care for families.

CSHP will continue to be active in in-state commitments, working groups, etc. and will continue to develop new relationships with community-based organizations. As part of the Transition-to-Adulthood activities, CSHP will be presenting the materials and staffing tables at conferences around the state.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	52	52	52	43	45
Annual Indicator	47.7	47.7	42.9	42.9	42.9
Numerator					
Denominator					
Data Source	National Survey of CSHCNs 2005-2006	National Survey of CSHCNs 2005-2006	National Survey of CSHCNs 2010	National Survey of CSHCNs 2010	National Survey of CSHCNs 2010
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

	2014	2015	2016	2017	2018
Annual Performance Objective	45	50	50	50	50

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
The Title V Children and Youth with Special Health Care Needs (CYSHCN) Rural Medical Home demonstration was launched in June 2013 as a collaboration between the MCH Program, Medicaid's Children's Healthcare Improvement Collaborative (CHIC) project, and two local public health districts in eastern Idaho to implement a patient-centered medical home demonstration for children with special health care needs in rural areas of the state.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. CSHP staff continue to work with uninsured CSHCNs to apply for Medicaid if they are eligible.		X		
2. CSHP's Transition-to-Adulthood materials include a section on how to find a medical home.		X		
3. MCH staff serve on the IPUL advisory board which provides input into the Children's Healthcare Improvement Collaboration (CHIC) project's three newly implemented pediatric practice demonstrations of patient-centered medical homes.		X		X
4. Launched the new Title V CYSHCN Rural Medical Home Demonstration in collaboration with CHIC and local public health.		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

There are 6 clinics participating in the Title V CYSHCN Rural Medical Home Demonstration. These 6 clinics were part of a statewide learning collaborative facilitated by the CHIC project which focused on increasing early detection and initiation of treatment for adolescent depression through a universal screening process using a validated tool during clinic visits for all youth aged 12 and older. As of March 2014, more than half of adolescents had been screened for depression and substance use during a clinic visit with nearly 90% of positive screenings having a documented follow-up plan in place.

In March 2014, the Title V medical home coordinators attended the National Medical Home Summit and training in Philadelphia, PA. The Title V CYSHCN Director, Jacquie Watson, attended the web-based version of the summit.

c. Plan for the Coming Year

The CHIC project is compiling an implementation manual and medical home coordinator handbook as means to transfer the demonstration solely to Title V once the CHIC project ends in 2016. Transition planning of the project will occur over the coming year.

In the coming year, the MCH Program will work closely with the CHIC Project and the Southeastern Idaho Public Health and Eastern Idaho Public Health Districts to support the pediatric patient-centered medical home demonstration in the rural areas, provide training to the districts and Medical Home Coordinators, and document successes and challenges. The goal is to use the evaluation data, successes, challenges, and lessons learned to implement similar demonstrations in all regions of the state.

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	2009	2010	2011	2012	2013

Annual Performance Objective	60	60	60	60	60
Annual Indicator	56.9	56.9	55.2	55.2	55.2
Numerator					
Denominator					
Data Source	National Survey of CSHCNs 2005-2006	National Survey of CSHCNs 2005-2006	National Survey of CSHCNs 2010	National Survey of CSHCNs 2010	National Survey of CSHCNs 2010
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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	60	60	60	60	60

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
CSHP continues to provide condition-specific coverage for Idaho's uninsured children within certain diagnostic categories, which has a slight positive impact on this indicator. Since there are no insurance restrictions for clients diagnosed with PKU or cystic fibrosis, CSHP does provide additional coverage for condition-specific services and prescriptions on top of the client's existing private insurance or Medicaid.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHP provides condition-specific coverage for CSHCNs with qualifying conditions and have no other health insurance.		X		
2. The CSHP care coordinator offers advice for other resources to applicants who do not qualify for CSHP coverage.		X		
3. Idaho's Transition-to-Adulthood materials offer information and advice on obtaining and keeping health insurance.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
As applicants apply to receive services through CSHP, CSHP staff and contractors continue to work with each family to complete the Medicaid application process. This process is undertaken whether or not the child is found to be eligible for CSHP. In an effort to better serve our clients and individuals who contact our program but may not be eligible, the CSHP nurse care coordinator is developing one-page resource sheets that provide information about different conditions as well as any resources such as support groups, meetings/conferences, or agencies located throughout Idaho. The goal of the resource sheets is to provide relevant information to CSHP clients, as well as to link individuals or families who are not CSHP-eligible with community resources that may help them.

c. Plan for the Coming Year
CSHP will continue to assist families with navigating and completing Medicaid applications when applying for CSHP. CSHP will continue to look for opportunities with the Idaho Developmental Disabilities Council to support legislation that will provide increased health care coverage to CSHCN.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	86	86	86	65	65
Annual Indicator	86	86	64.6	64.6	64.6
Numerator					
Denominator					
Data Source	National Survey of CSHCNs 2005-2006	National Survey of CSHCNs 2005-2006	National Survey of CSHCNs 2010	National Survey of CSHCNs 2010	National Survey of CSHCNs 2010
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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	67	67	70	70	70

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
The Children's Special Health Program (CSHP) continued to fund the only cystic fibrosis, genetics, and metabolic medical services available in Idaho. These clinics continue to be held at St. Luke's Children's Hospital in Boise, and the relationship between CSHP and St. Luke's continues to be strong (metabolic clinics are held in other parts of the state as well). With all of CSHP's specialty clinics housed within medical facilities at St. Luke's, CSHP has been conducting "maintenance of effort".

In March 2013, the contract for nutritional and dietary support for Children's Special Health Program (CSHP) clients with PKU and other metabolic conditions was transitioned from the previous contractor to the St. Luke's Children's Hospital's Registered Dietitian (RD) staff. St. Luke's has the only children's hospital in the state and are the experts on care provision to pediatric patients with genetic and metabolic disorders. As part of the new contract, the previous solely-state funded genetic and metabolic clinics that were house at the children's hospital will now be partially funded by the hospital to align clinics with their standards of care and best-practices. The new partnership with the children's hospital to provide care to local families is expected to increase the quality of care and access to resources for families.

The CSHP also renewed the contract with the company that provides low-protein medical foods to Idaho's pediatric PKU clients.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHP funds and staffs metabolic clinics around Idaho using MCH Block Grant funds. Since Idaho has no metabolic physicians, CSHP imports one from Oregon to provide services to Idaho's children who would otherwise have to travel out-of-state for care.	X			
2. CSHP funds and staffs monthly genetics clinics in Boise using MCH Block Grant funds. Since Idaho has no genetic physicians, CSHP works with St. Luke's Children's Hospital to import one from out of state.	X			
3. CSHP partially funds Idaho's Cystic Fibrosis center, providing no-cost clinical services to Idahoans under the age of 18 with cystic fibrosis.	X			
4. CSHP funds ongoing PKU services around the state by supplying dieticians to advise PKU clients and by providing medical foods and formula to manage their PHE levels.	X			
5. CSHP funds several specialty clinics in eastern Idaho that	X			

provide no-cost care for uninsured children with cardiac and orthopedic conditions.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The medical home coordinators have compiled a list of community resources for practices participating in the Title V CYSHCN Rural Medical Home Demonstration. The medical home coordinators provide information and make referrals for families to a variety of resources based upon the needs of the families.

c. Plan for the Coming Year
The Title V CYSHCN Rural Medical Home Demonstration will continue for the second year of implementation. The CHIC Project and MCH Program will continue to monitor implementation and launch the independent evaluation of the project.

CSHP will continue to serve on the advisory councils of the Idaho Council on Developmental Disabilities and Idaho Parent Unlimited which focus on increasing statewide systems, resources, and supports to those with special health care needs.

CSHP is also exploring methods for expanding, without MCH funding, available specialty services to improve Idaho's medical infrastructure and to increase access for CSHCNs.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	46	46	46	47	47
Annual Indicator	45.8	45.8	46.6	46.6	46.6
Numerator					
Denominator					
Data Source	National Survey of CSHCNs 2005-2006	National Survey of CSHCNs 2005-2006	National Survey of CSHCNs 2010	National Survey of CSHCNs 2010	National Survey of CSHCNs 2010
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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	49	49	51	51	51

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
CSHP printed and distributed the Transition-to-Adulthood kits for CSHCN. There are three different kits, each targeted at a specific age group: junior high or middle school-aged youth, high school-aged youth, and young adults transitioning to college and/or the workforce. All kits are

available electronically on the CSHP website, as well as in hard-copy. The second round of kits were printed, hole-punched, and bound in plastic in order to be binder-ready rather than printed and assembled in a binder. The elimination of the binder resulted in a large cost savings for the program which allowed for more kits to be printed.

The CSHP nurse care coordinator visited various community partners and agencies, including colleges and universities, Head Start, and physician's offices, to promote the use of Transition-to-Adulthood kits for their students, patients, or clients with special needs.

Transition-to-Adulthood kits for all age groups are available in Spanish and will be available on the CSHP website in both English and Spanish.

CSHP promoted the Transition-to-Adulthood kits at a conference for special education teachers and at the Tools for Life Conference for special needs youth transitioning from high school. CSHP also sponsored the Tools for Life Conference by providing transportation via bus to the Tools for Life Conference for students, family member, and teachers from around the state. The CSHP nurse care coordinator spoke with young adults at the conference to promote use of transition kits.

Transition-to-Adulthood kits are provided to all children participating in the CSHP as they reached the milestone ages.

The CSHP established a sub-grant with the University of Idaho's Center on Disabilities and Human Development to support the annual Tools for Life Conference which focuses on supporting and empowering high school students with disabilities to transition to college or work. The conference offers presentations about assistive technology and transitioning from high school to college or the work force. The target audience for the event is Idaho educators, therapists, counselors, service providers, job developers, rehabilitation specialists, and especially secondary students with disabilities, youth with special health care needs (CYSHCN), and their families. The CSHP care coordinator hosted a vendor table during the 2-day event to present information about the MCH Program's Transition-to-Adulthood kits. Approximately 400 kits were requested by and mailed to families after the event.

The CSHP redesigned the Transition-to-Adulthood website in order to make the Transition Kits interactive online. The redesign was completed in winter 2013.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Idaho's Transition-to-Adulthood materials for CSHCN were redesigned and mass-produced in order to be available to all CSHCNs in Idaho.		X	X	
2. Transition-to-Adulthood training sessions are being offered to families of CSHCNs and to providers by CSHP staff in coordination with staff from IPUL. These sessions are offered at meetings and conferences around the state.		X		
3. CSHP's care coordinator has been promoting the use of the Transition-to-Adulthood kits to various community partners and agencies including colleges and universities, Head Start, and physician's offices.		X		
4. The Transition-to-Adulthood materials are being used in the Title V CYSHCN Rural Medical Home Demonstration and Learning Collabortive		X		X
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Title V Rural Medical Home Demonstration clinic sites will be participating in a learning collaborative regarding transition of care for CYSHCN led by the CHIC project beginning in the summer of 2014. The medical home coordinators are distributing the CSHP transition kits to families and CYSHCN identified on the registries of participating clinics as part of the learning collaborative.

c. Plan for the Coming Year
The data and results from the transition learning collaborative will be reported by 2015. The MCH program intends to use these results to enhance the Title V CYSHCN Rural Medical Home Demonstration and the program's transition kits for families.

CSHP will be researching the development of transition kits targeted at elementary age children and their families. CSHP is also exploring a partnership with the Special Ed section of the Idaho Department of Education to try to get promotional brochures distributed through Idaho's Special Ed teachers.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	83	75	75	75	75
Annual Indicator	65.8	65.1	68.8	64.5	64.5
Numerator					
Denominator					
Data Source	NIS	NIS	NIS	NIS	NIS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	75	75	75	75	75

Notes - 2013
NIS data for CY2013 is not available until August, 2014. 2012 value used as estimate for 2013, The value entered is 4:3:1 plus >2or >3 doses of Hib vaccine depending on brand type (primary series only), 3 or more doses of HepB, and 1 or more doses of varicella vaccine.

The percentages come from the National Immunization Survey. No numbers are given as to appropriate population numerator or denominator.

Notes - 2012
The value entered is 4:3:1 plus >2or >3 doses of Hib vaccine depending on brand type (primary series only), 3 or more doses of HepB, and 1 or more doses of varicella vaccine.

The percentages come from the National Immunization Survey. No numbers are given as to appropriate population numerator or denominator.

Comparable data point in 2011 was 59.3.

Notes - 2011
NIS data for CY2011 is not available until August, 2012. 2010 value used as estimate for 2011, The value entered is 4:3:1 plus >2or >3 doses of Hib vaccine depending on brand type (primary series only), 3 or more doses of HepB, and 1 or more doses of varicella vaccine.

The percentages come from the National Immunization Survey. No numbers are given as to appropriate population numerator or denominator.

Rate is depressed because of shortage of Hib vaccine for birth cohort. Excluding Hib rate raises 70.1

a. Last Year's Accomplishments
The 2013 legislative session was a difficult one for the Idaho Immunization Program (IIP). There were three pieces of legislation of interest to the IIP. The first two were proposing to change the statute governing Idaho's immunization registry to allow for bi-directional data exchange (between the registry and Electronic Medical/Health Records), to allow for connections to Health Data Exchanges, to change the requirements for people opting-out of participation in the registry, and to clarify that the registry also includes adults. Due to strong opposition from a very small yet very vocal minority, these bills were held in committee and did not advance during the 2013 session.

The other bill of interest was the one which extended the sunset date on Idaho's vaccine assessment program, the one which keeps vaccines free for insured children. The assessment system was created in statute during the 2010 legislative session, but a 3-year timer was put on it to force a legislative review of the program after it had run for a while. Insurance carriers asked for a 2-year extension on the sunset clause to give them a little more time to gather data on program savings. This bill was successful and changed the sunset date to July 1, 2015.

During 2013 the IIP also completed a year-long program reorganization effort which streamlined processes to meet new CDC requirements for vaccine management.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide free vaccine to all children 0 through 18 years of age by consistently supplying all Vaccine for Children (VFC) providers in the state of Idaho.			X	
2. Perform annual site visits to VFC providers and conduct provider education.			X	
3. Provide parent, school and daycare education, media and training.			X	
4. Maintain an immunization registry, which includes data quality monitoring.				X

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The IIP continues to receive funding from the CDC and from the State to operate the state immunization program, one of the primary foci of which is the improvement of childhood immunization rates. Immunization promotion activities continue similar to previous years. A few highlights of current activities:

The 2014 legislative session was considered "ok" by the IIP. While the changes to our immunization registry statute proposed unsuccessfully in 2013 we not re-proposed in 2014, there was a successful effort to remove the sunset clause from the 2010 law that created Idaho's Childhood Immunization Policy Commission, making it a permanent body. This commission is composed of various immunization stakeholders such as physicians, public health practitioners, legislators, and medical society representatives, and is tasked with making recommendations to the IDHW and the Legislature to improve immunization rates in Idaho.

There was an attempt by an anti-vaccine organization during the 2014 legislative session, to make changes to Idaho law that would have made the administration of immunizations by medical providers more cumbersome by significantly increasing paperwork requirements. Fortunately this proposed bill did not receive a committee hearing, so failed to move forward during the session.

The IIP continues to support the Idaho Immunization Coalition through a combination of financial and in-kind contributions, and through participation on their Executive Board and working groups.

c. Plan for the Coming Year

The big plans for the coming year once again revolve around legislation. Idaho's Vaccine Assessment Program, which keeps vaccines free for insured children and maintains the state's status as a "universal vaccine purchase state" is scheduled to sunset on July 1, 2015 unless renewed by the legislature. We believe a bill will be proposed during the 2015 legislative session which will eliminate the sunset clause from the Assessment Program and make Idaho's universal purchase system permanent. We do expect some resistance to the bill, though how much is unknown.

It is also possible that a bill will be proposed to the 2015 legislature that will try to make some of the change to our immunization registry statute that were attempted during the 2013 session. If this proposal is made, we expect to meet with similar opposition as we saw in 2013.

As always, we cannot know what anti-vaccine bills may be proposed during the next session, we can only be reactive to those.

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	2009	2010	2011	2012	2013

Annual Performance Objective	17.7	16	16	15	15
Annual Indicator	16.8	15.1	11.5	11.7	11.7
Numerator	548	505	385	391	391
Denominator	32573	33362	33425	33513	33513
Data Source	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate
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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	13.7	13.3	13	12.8	12.6

Notes - 2013
Due to out-of-state birth certificates not received as of date of entry 2012 values are used as estimate.

a. Last Year's Accomplishments
During CY2013, family planning clinics around the state served a total of 2,134 (unduplicated) teens aged 15-17 years of age compared with 2,165 teens aged 15-17 years of age who received services in CY2012 -- a decrease of 1.4% (31/2165, or 31 fewer clients, served in CY2013 (Ahlers table AL-12). Idaho's 2011 teen pregnancy rate for 15-17 year olds is 14.6%. The 2010 teen pregnancy rate was 15.1 percent. The data shows a slight decrease in teen pregnancy rates between 2010 and 2011.

The 15-17 year old teen clients received a physical assessment, education, and counseling services. All clinics continued to emphasize adolescent education which focuses on abstinence, parental involvement, relationship safety including screening for human trafficking, contraception and STI/STD prevention.

All health districts provide family planning services to teen clients aged 13-19 years of age. Many districts provide extended clinic hours in the evening to accommodate teen client's schedules.

Funding was received for the Title X Family Planning Program for year 3 of a three-year special project, "Family Planning HIV Integration Project which ended June 29, 2013. Title X clinics have continued to offer and perform HIV Rapid Test screening from June 30, 2013 -- June 29, 2014. January 2011 noted one reactive (+) HIV Rapid test screening, which the client was referred for medical management following the positive confirmatory test. All other HIV Rapid Test screenings performed since that time have been non-reactive (negative).

During CY2012, the Ada County (Boise) Juvenile Detention Center project provided access to reproductive health care services for 96 high-risk adolescents. Residents were provided with the opportunity to receive services through weekly preventive reproductive health clinics. Pre- and post-test evaluations were given to measure the level of intention to change risky sexual behaviors.

During SFY 2014 a Title X sub-recipient established a look-alike school based reproductive health clinical services presence in an alternative high school for high risk youth. In addition similar services have been established on a local college campus.

During CY2013, the Adolescent Pregnancy Prevention (APP) Manager, the Family Planning Coordinator, the STD Prevention Coordinator, and the HIV Prevention Coordinator met to discuss collaboration and coordination efforts between their programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide family planning services to teens through the public health districts.	X		X	
2. Develop comprehensive educational messages targeted to teens.		X	X	X
3. Continue to conduct Teen Education Afternoon (TEA) local district clinic project.		X	X	
4. Continue program collaboration and coordination activities with the Adolescent Pregnancy Prevention Program.				X
5. Continue to conduct HIV Rapid Screening tests on all Title X family planning clients.	X		X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

All health districts provide family planning services to teen clients. Districts provide extended clinic hours in the evening to accommodate teen clients' schedules. Districts have active advisory boards which guide the content of educational materials and provide direction for outreach activities. Advisory boards have committee members with various backgrounds representing communities from within each agency's service areas. Members include, but are not limited to, faith-based members and teen representatives. These relationships have allowed the boards to develop more trusting relationships with local groups.

Funding was received for the Title X Family Planning Program, "Family Planning HIV Integration Project." Clinics began implementing HIV Rapid Test screening on January 3, 2011, making it available to all low risk by history Title X family planning clients and will continue to provide HIV Rapid Test screening through CY 2013 and CY 2014

During CYs 2013-2014, the Ada County Juvenile Detention Center project continues to provide access to reproductive health care services for high-risk adolescents. Residents are provided with the opportunity to receive services through weekly preventive reproductive health clinics. Pre- and post-test evaluations are given to measure the level of intention to change risky sexual behaviors.

c. Plan for the Coming Year

All health districts provide family planning services to teen clients. Districts provide extended clinic hours in the evening to accommodate teen clients' schedules. Districts have active advisory

boards which guide the content of educational materials, provide direction for outreach activities but also share with sub-recipient staff their community updates. Advisory boards have committee members with various backgrounds representing communities from within each agency's service areas. Members include, but are not limited to, faith-based members and teen representatives. These relationships have allowed the boards to develop more trusting relationships with local groups.

Funding was received for the Title X Family Planning Program, "Family Planning HIV Integration Project." Clinics began implementing HIV Rapid Test screening on January 3, 2011, making it available to all Title X family planning clients and will continue to provide HIV Rapid Test screening through CYs 2013 - 2014.

During CYs2013-2014, the Ada County Juvenile Detention Center project continues to provide access to reproductive health care services for high-risk adolescents. Residents are provided with the opportunity to receive services through weekly preventive reproductive health clinics. Pre- and post-test evaluations are given to measure the level of intention to change risky sexual behaviors.

The Adolescent Pregnancy Prevention Manager, Family Planning Coordinator, STD Prevention Coordinator, and HIV Prevention Coordinator meet together periodically to discuss collaboration efforts.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60.6	60.6	60.6	60.7	60
Annual Indicator	57.1	57.1	57.1	62.7	62.7
Numerator					
Denominator					
Data Source	Smile Survey 2009	Smile Survey 2009	Smile Survey 2009	Smile Survey 2012	Smile Survey 2012
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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	62.7	62.8	62.8	62.8	62.9

Notes - 2013
The Idaho Smile Survey is conducted every four years conducted through out the school year. Data was collected during the 2012/2013 school year.

Numerator and denominator not provided as the results would be from weighted survey data and imply artificial precision.

Notes - 2012
The Idaho Smile Survey is conducted every four years conducted through out the school year. Data was collected during the 2008/2009 school year. Data collection for the 2012/2013 period will not be completed before June 2013.

Numerator and denominator not provided as the results would be from weighted survey data and imply artificial precision.

Notes - 2011
The Idaho Smile Survey is conducted every four years conducted through out the school year. Data was collected during the 2008/2009 school year.

Numerator and denominator not provided as the results would be from weighted survey data and imply artificial precision.

a. Last Year's Accomplishments
Last year all of the Public Health Districts in Idaho provided dental sealants to elementary and middle school children through either School-Based Dental Sealant Clinics, Give Kids a Smile Day, Teen Dental Parties, or other clinics such as Idaho State University's Dental Hygiene Department. As in previous years, this was supplemented by Delta Dental of Idaho's School-Based Dental Sealant Program. With the increase in Public Health Districts now providing dental sealants, especially through School-Based Dental Sealant Clinics, it is estimated that over 60% of children in Idaho have received a dental sealant on at least one permanent molar tooth. In Idaho, Registered Dental Hygienists with Extended Access Endorsements are able to work in Public Health Districts and provide dental sealants without the direct supervision of a dentist. Along with providing dental sealants, the Registered Dental Hygienists with Extended Access Endorsements also provide oral health screenings or assessments, fluoride varnish applications, oral health education, and dental home referrals if needed. All of the Public Health Districts were able to purchase needed equipment to successfully run mobile dental sealant clinics, establish protocols with their supervising dentists to deliver the clinics, identify and work with schools to plan and deliver the clinics, and establish a billing process. Last year the Public Health Districts continued to provide Fluoride Varnish Programs in Women, Infants, and Children (WIC) Clinics, Early Head Start and Head Start, and in some healthcare facilities as well. Similar to the sealant clinics, the oral health preventive services provided during fluoride varnish clinics include oral health screenings or assessments, fluoride varnish applications, oral health education, and dental home referrals if needed. The Public Health Districts continued to provide oral health education and dental home referrals if needed to pregnant women presenting in WIC Clinics. In addition, the 2013 Idaho Smile Survey was completed. The data has been analyzed and was developed into a final report.
Key findings of the report include:
? More than one in five (21 percent) of all third-grade students had untreated tooth decay, significantly lower than surveys conducted in 2001 and 2005. This finding represents a 7 percent reduction since 2001. The Healthy People 2020 (HP2020) goal for children aged six to nine years is a rate of untreated decay of 25.9 percent or less.
? More than two thirds of third-graders had some caries experience, primary or permanent teeth with decay or filled caries, or were missing permanent teeth. The HP2020 goal for children aged six to nine is a rate of caries experience of 49 percent or less.
? More than half (58 percent) of third-grade students had dental sealants on all teeth recommended for sealants, similar to the previous surveys. Sixty-three percent had sealants on at least one tooth recommended for sealants, a statistically larger rate than in any of the previous surveys. The HP2020 goal for children aged six to nine is a rate of 28.1 percent or better on one or more of their permanent first molar teeth.
Lastly, the Public Health Districts discontinued the fluoride mouth rinse program in June 2013 to focus more on planning and delivering School-Based Dental Sealant Clinics, and to be able to measure solid outcomes.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title V support for oral health programs will be maintained at current levels.			X	
2. Oral health preventive services delivered to children and adolescents (oral health screenings or assessments, fluoride varnish applications, dental sealants, oral health education, and dental home referral if needed)			X	
3. Idaho Oral Health Action Plan 2010-2015: Plan and implement goals and objectives.				X
4. Idaho Oral Health Action Plan 2015-2020: Plan Update				X
5. Release 2013 Idaho Smile Survey Report to Stakeholders & Partners				X
6. Finalize Oral Health Burden Report				X
7.				
8.				
9.				
10.				

b. Current Activities

As in previous years the Idaho Oral Health Program (IOHP) continues to support Idaho Medicaid's goal to increase the number of enrolled children with dental sealants by 10%. Currently, all of the Public Health Districts are concluding their School-Based Dental Sealants Clinics for the 2013-2014 school year. These clinics will continue into the 2014-2015 school year, and some of the Public Health Districts will add more clinics as well. The Public Health Districts continue to provide Fluoride Varnish Programs in WIC Clinics, Early Head Start and Head Start, and other settings. The 2013 Idaho Smile Survey Report will be printed and released to IOHP partners and stakeholders. The IOHP continues to receive funding from the DentaQuest Foundation to provide oral health preventive services to children, adolescents, and pregnant women. Lastly, funding from the DentaQuest Foundation has allowed healthcare providers at three Community Health Centers, family medicine residents at the Family Medicine Residency of Idaho, and physician assistant students at Idaho State University to complete the Smiles for Life: A National Oral Health Curriculum, which includes a specific module on oral health and children.

c. Plan for the Coming Year

The IOHP will continue to work with the Public Health Districts to deliver School-Based Dental Sealant Clinics and report data back to the program. They will also continue to provide oral health screenings or assessments, fluoride varnish applications, oral health education, and dental home referrals if needed to all children and adolescents encountered through either School-Based Dental Sealant Clinics, Fluoride Varnish Programs, or other clinics. Several of the Public Health Districts will continue to work with healthcare providers and provide oral health educational materials for their patients and to help increase the healthcare provider's knowledge of oral health in general. The IOHP will update the Idaho Oral Health Action Plan 2010-2015 to develop the new 2015-2020 plan. The program will continue to expand the oral health network in Idaho as well as advocate to improve the oral health status of children. The program will work with the Idaho Oral Health Alliance and other community partners to identify opportunities for new oral health programs and policies focused on improving the oral health of children.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	5.5	5.5	4.3	4	3.9
Annual Indicator	4.8	3.9	2.2	2.2	2.8
Numerator	17	14	8	8	10
Denominator	351924	359922	359046	357402	357402
Data Source	Death Certificates	Death Certificates	Death Certificate	Death Certificate	Dept of Transportation
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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	3	2.9	2.8	2.7	2.6

Notes - 2013
Death count preliminary total from Idaho Dept of Transportatio for 2013. IDT records usually reflect deaths at the scene of an accident and therefore will be lower than subsequent death certificate data.

2013 population data by age not available at time of entry, 2012 used as best estimate for denominator.

The death rate is also subject to significant fluctuation from year to year as a single multi-death crash can move the rate significantly. Also crashes in rural areas are likely to have delays in medical treatment.

a. Last Year's Accomplishments
The Division of Public Health Injury Prevention & Surveillance Program continues to use a strong public-access world-wide web presence on the Internet to share injury prevention information with the Idaho public. Those who visit the webpage will find a description of the goals, objectives, and services provided through the Injury Prevention & Surveillance Program.

(see: http://www.healthandwelfare.idaho.gov/Health/InjuryPrevention/tabid/1388/Default.aspx)

The Idaho public may now access a variety of internal and external information resources on injury prevention and control to better protect their families and communities. Special emphasis

is provided on the unintentional causes of injury including: Motor Vehicle Crashes, Poisoning, Drowning, Pedestrian & Cyclist Safety, and Fall Prevention for seniors. During 2013, there were 248 visits to our webpage to gain information about injury prevention.

Poisoning prevention public education continues to be a primary injury prevention intervention of the program. The Nebraska Regional Poison Center (NRPC) serves as the provider of poisoning prevention consultation services to Idaho residents, healthcare professionals, emergency management services and law enforcement. Evaluation and analysis of the call volume to NRPC continues to serve as a valuable source poisoning exposure information to the program. Lesson plans were developed and distributed throughout Idaho in 2013 to assist teachers and caregivers of pre-school age children in educating children and their parents about poison prevention and recognition in the home.

National Poison Prevention Week activities were again successful this year with the assistance of pharmacists and pharmacy students throughout Idaho. Almost 100 elementary school teachers, WIC clinic providers, and Idaho Head Start educators were reached to help share poison prevention information with K-8 students throughout Idaho.

The Injury Prevention & Surveillance Program, in cooperation with the Idaho Department of Parks and Recreation, continues to expand the Kids Don't Float Program. This is a national drowning prevention program sponsored by the U.S. Coast Guard, provides personal-floatation devices (lifejackets) on a loan basis at water recreation facilities throughout Idaho State Parks. This evidence-based drowning prevention intervention has been shown to save several lives in states where a program has been adopted. The Injury Prevention & Surveillance Program has cooperated with the Idaho Department of Parks and Recreation to build Kids Don't Float loaner station and drowning prevention education kiosks in Idaho state parks.

The Injury Prevention & Surveillance Program manager continues to serve on the Idaho Highway Safety Coalition and helps provide guidance in developing Idaho Strategic Highway Safety Plan.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Reduce mortality rates for children 14 years of age and younger caused by motor vehicle crashes, including pedestrian and cyclists-related traffic crashes.			X	X
2. Coordinate efforts with Idaho Transportation Department through the Idaho Highway Safety Coalition and Safe Routes to School Program.			X	X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Manage and coordinate state Idaho Poison Control contract between the Department of Health and Welfare and Nebraska Regional Poison Center (NRPC).

i. Facilitate communications between NRPC and the Department to enhance rapid

exchange of poison control and emergency health information.
ii. Maintain the Idaho Poison Control information database to collect, analyze and retrieve poison exposure data received from NRPC on a quarterly basis.
iii. Assist the Division of Health Administration in evaluating alternative funding sources for the continued support of Idaho Poison Control Services.
iv. Coordinate activities associated with the National Poison Prevention Week during March 2014.
2. Provide State Advisory Committee with technical assistance on pedestrian and bicycle prevention and control interventions from a public health perspective.
3. Serve as Department liaison to the Idaho Highway Safety Coalition.
4. Maintain and advance the Department's Injury Prevention and Control website.

c. Plan for the Coming Year
Injury Prevention & Surveillance Program emphasis areas for 2014 will continue to focus on reducing traffic crash fatalities, especially among vulnerable drivers (including teens); poison prevention activities directed toward parents of children 5 and younger and the reduction of prescription drug poisonings; drowning prevention; and a general expansion of public awareness associated with the burden of injury and its prevention.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	52	52.1	52.2	53	53
Annual Indicator	55.2	55.4	53	57.1	57.1
Numerator					
Denominator					
Data Source	PRATS	PRATS	PRATS	PRATS	PRATS
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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	55.1	55.2	55.3	55.4	55.5

Notes - 2013
Data source is the 2011 Idaho PRATS survey. Data for 2013 births is not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision. Rate reported has approximately +/- 2 percent confidence limits from survey methodology.

Due to the nature of the survey data variability the target goals are not adjusted based on a single year's values.

Notes - 2012
Data source is the 2011 Idaho PRATS survey. Data for 2012 births is not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision.

Due to the nature of the survey data variability the target goals are not adjusted based on a single year's values.

Notes - 2011
Data source is the 2010 Idaho PRATS survey. Data for 2011 births is not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision.

Due to the nature of the survey data variability the target goals are not adjusted based on a single year's values.

a. Last Year's Accomplishments
The State WIC Program provided technical assistance to Local WIC Agencies regarding breastfeeding education and support.

The State WIC Program hosted a breastfeeding training session for all Local WIC Agency staff and a networking/brainstorming session for Breastfeeding Peer Counselors. The State WIC Breastfeeding Coordinator compiled a report for Local WIC Agencies of the current practices, challenges, ideas and possible next steps shared by Peer Counselors during the session.

The State WIC Program developed and enhanced MIS tools for improved breastfeeding communication and documentation.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance to Local Agency WIC Programs to enhance breastfeeding Peer Counseling Programs.		X		X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The State WIC Program provides Local WIC Agencies with technical assistance regarding breastfeeding education and support.

The State WIC Program develops and enhances MIS tools for improved breastfeeding

documentation and support.

WIC staff support the Idaho Physical Activity and Nutrition Program (IPAN) in providing technical assistance for building worksite breastfeeding programs.

The State WIC Program works with Maternal and Child Health and Information Technology staff to revise the Department of Health and Welfare breastfeeding website.

c. Plan for the Coming Year
The State WIC Program will work with the State Breastfeeding Workgroup to maintain and enhance Peer Counseling Programs, provide breastfeeding training for all WIC staff, and improve breastfeeding materials for participants and community partners.

The State WIC Program will train on and support implementation of breastfeeding MIS tools.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	98.8	98.8	98.8	99.6	99.6
Annual Indicator	99.3	99.5	99.4	99.3	99.1
Numerator	22179	21632	20273	20500	20152
Denominator	22341	21751	20397	20650	20337
Data Source	HiTrack	HiTrack	HiTrack	HiTrack	HiTrack
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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	99.3	99.3	99.3	99.4	99.4

Notes - 2013
Data Source is State NHS program tracking and surveillance program –HiTrack.

Rate reflects births in hospitals. Not all Idaho births occur in hospitals so use of hearing screening by time of hospital discharge misses roughly 8 percent of births. Final birth rates for Idaho not available at time of entry.

Notes - 2012
Data Source is State NHS program tracking and surveillance program –HiTrack.

Rate reflects birthsin hospitals. Not all Idaho births occur in hospitals so use of hearing screening by time of hospital discharge misses roughly 8 percent of births. If using all births in state with hearing checked in hospitals the rate is 91.6.

Notes - 2011

Data Source is State NHS program tracking and surveillance program –HiTrack.

If births in hospitals are used the rate is approximately 99.4. Not all Idaho births occur in hospitals so use of hearing screening by time of hospital discharge misses roughly 8 percent of births.

a. Last Year's Accomplishments
99% of newborns born in hospitals received screenings in 2013; 96% of those passing. A major focus of Idaho Sound Beginnings (ISB) last year was to move the screening programs from the windows based version of HiTrack (ISB's tracking software) to the web based version enabling more timely reporting. At the beginning of 2013 there were 10 of 31 hospitals connected to HiTrack Web. ISB has successfully connected an additional 17 hospitals and 2 midwife clinics. The number of infants early diagnosed with hearing loss in 2013 was 49; 67% of which enrolled in Idaho's early intervention program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Planning and collaboration for improved surveillance and tracking system.				X
2. Match or exceed the national benchmarks set by the JCIF 2007 Guidelines.			X	
3. Increase family to family support and access to information for families.		X		
4. Expand newborn hearing screening to other community-based sites.			X	X
5. Increase and improve the participation of physicians in EHDI and the provision of a medical home.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
ISB is currently working on creating an interface with both the Infant Toddler Program (ITP) (Idaho's Part C program) and Idaho Vital Statistics. The connection with Vital records will increase the accuracy of ISB's occurent birth count. The connection with ITP will aid ISB in identifying missing screening information, as well as infants that are diagnosed with hearing loss but have not been reported to ISB. The creation of a central, standardized physician list is underway. This will aid ISB in communicating with infant's primary care physicians and encourage parents to take their infants in for follow-up, diagnostic audiology testing.

c. Plan for the Coming Year
Future PDSA's include identifying the causes that children in Idaho are lost to follow-up (LTF), allowing ISB to make specific targeted decisions regarding what causes LTF, to develop further initiatives which will continue to decrease LTF, to reduce LTF by establishing a Medical Home Model that engages all spokes in the process of identifying and managing infants with hearing loss, to decrease LTF by improving communication of Newborn Hearing Screening (NHS) results to physicians by the NHS program via physician letters automatically generated within the HiTrack system, to decrease LTF by enhancing outreach to community partners and stakeholders through better, targeted communication; resulting in the improvement of seamless data sharing, to reduce LTF by utilizing the ISB monitoring team to provide technical support and outreach to

screeners and screening locations, and to decrease LTF by implementing the NCHAM training module for screeners in hospitals onboarding and annual training curricula.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	12.4	8.8	10	9	9
Annual Indicator	8.9	10.2	9.0	11.3	10.0
Numerator	37161	42845	37721	48315	45859
Denominator	418764	421894	417962	427360	456430
Data Source	Current Population Survey	Current Population	Current Population Survey	Current Population Survey	Current Population Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	9	8.9	8.9	8.9	8.9

Notes - 2013
Source: U.S. Census Bureau
Current Population Survey, Annual Social and Economic Supplement,

http://www.census.gov/cps/data/cpstablecreator.html

The Current Population Survey Annual Social and Economic Supplement is an annual survey of approximately 78,000 households nationwide. Therefore, use extreme caution when making inferences when the cell sizes are small.

Objectives in future years may be notablely higher or lower than current performance. The data source tends to have swings from year to year due to nature of the survey.

Notes - 2012
Source: U.S. Census Bureau
Current Population Survey, Annual Social and Economic Supplement,

http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

The Current Population Survey Annual Social and Economic Supplement is an annual survey of

approximately 78,000 households nationwide. Therefore, use extreme caution when making inferences when the cell sizes are small.

Objectives in future years may be higher than current performance. The data source tends to have swings from year to year due to nature of the survey.

Notes - 2011
Source: U.S. Census Bureau
Current Population Survey, Annual Social and Economic Supplement,

http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

The Current Population Survey Annual Social and Economic Supplement is an annual survey of approximately 78,000 households nationwide. Therefore, use extreme caution when making inferences when the cell sizes are small.

Objectives in future years may be higher than current performance. The data source tends to have swings from year to year due to nature of the survey.

a. Last Year's Accomplishments
The State reported a 4% increase in FFY2013 over FFY 2012 in the number of children enrolled in Medicaid (as per our CHIP annual report).

Idaho Medicaid received a CHIPRA Bonus payment for FFY2012 and FFY2013 for increasing CHIP enrollment and streamlining eligibility processes.

Idaho Medicaid reported on thirteen clinical quality measures in its CHIPRA Annual Report, which included our first CAHPS survey ever.

The eligibility income limit for Idaho SCHIP is 185% of the FPG. This is about $44 thousand annually for a family of four. Idaho is one of only four states that currently have income limits set below 200% of FPG. Idaho's program did not use any income disregards during FFY2013. This means that gross income is used as the measure against the income limit. Over one third of the children in Idaho are enrolled in either Medicaid or SCHIP at the current eligibility levels.

The State submitted 13 State Plan Amendments for Medicaid and CHIP to comply with changes in the Affordable Care Act during the Fall of 2013. These amendments included changes to income limits which shifted some CHIP participants to Medicaid and added a 5% disregard to income limits. These changes were effective January 1, 2014.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to implement, expand and monitor CHIP coverage through the child-only health coverage applications.				X
2. Monitor the impact of the Children's Redesign and work with Medicaid as appropriate.				X
3. MCH staff serve on the Covering Kids Coalition which is managed by Idaho Voices for Children to address health coverage for Idaho children.				X
4. Work with the Department of Insurance to address child specific issues as insurance exchanges and health care reform are implemented.				X
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
Idaho Medicaid currently partners with a CHIP outreach grantee whose goal is to target populations accessing care through our rural health clinics.

Recently contracted with a vendor to administer our second CAHPS survey to CHIP beneficiaries. The survey will provide us with an opportunity for comparison against FFY2012's baseline data and assist us in developing targeted quality improvement activities with our providers.

Distributing updated CHIP informing materials to stakeholders and preparing for our statewide outreach to school districts.

c. Plan for the Coming Year
Increase the number of CHIPRA quality measures we are reporting to CMS. Developing operational policy that supports our increased enrollment numbers.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	30.9	30.8	29.5	29.4	28.9
Annual Indicator	30.1	29.5	29.4	28.9	28.1
Numerator	7314	7259	7012	6555	5639
Denominator	24316	24629	23828	22716	20060
Data Source	State WIC Data	State WIC Data	State WIC Data	State WIC Data	State WIC Database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	28.8	28.8	28.7	28.7	28.6

Notes - 2013
As of last certification visit per child within age group with valid height and weight measurment.

Notes - 2012
As of last certification visit per child.

a. Last Year's Accomplishments
WIC participated in the ID Hunger Relief Taskforce. A statewide childhood hunger coalition was convened as a result of the Oct. 2012 ID Hunger Relief Taskforce Summit. The coalition is focused on strategic plan work. The mission of the Task Force is "To put public and private resources into action statewide in order to eliminate hunger and provide food security for all Idahoans."

WIC participated in Healthy Eating Active Living (HEAL) ID. The primary focus of HEAL ID is to develop and maintain an active engaged network of partners working together; investing resources and expertise to create/support an active living, healthy eating population in Idaho. Networking includes collaborating/planning with ID Physical Activity and Nutrition Program (IPAN) and other agency/community partners.

WIC had a 3 day all staff state training meeting focused on strengthening staff skills related to Participant Centered Services/Education (PCS/PCE), motivational interviewing OARS counseling aimed at facilitating change towards desired health outcomes, customer service, breastfeeding support, and documentation of participant services.

WIC promoted WIC food packages which align with the Dietary Guidelines for Americans (DGA). Food packages included fresh fruits, fresh vegetables, juice, whole grain foods, low fat/fat free dairy products and protein sources. Infant food packages included baby food fruits, vegetables, meats and cereal (along with breastfeeding resources/support). Formula fed infants received supplemental amounts of formula.

WIC utilized United States Department of Agriculture (USDA)/Food & Nutrition Service (FNS) and state developed materials to reinforce tailored nutrition education messages designed to promote healthy eating, breastfeeding and a physically active lifestyle.

WIC offered participants a variety of nutrition/breastfeeding/physical activity education opportunities including individual counseling, group classes and Quick WIC (WIC nutrition education fairs including items like interactive learning displays, cooking demonstrations, etc.).

WIC promoted/referred participants to other relevant Title V funded programs.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. WIC participated in the ID Hunger Taskforce, ID Hunger Summit.				X
2. WIC participated in HEAL ID.				X
3. WIC developed/implemented staff training to strengthen nutrition services towards achieving a desired health outcome.				X
4. WIC provided tailored nutrition services/education aligned with DGA, promotion of WIC foods and breastfeeding, and an active lifestyle.			X	
5. WIC promoted/referred participants to other Title V funded programs.		X		
6.				

7.				
8.				
9.				
10.				

b. Current Activities
WIC continues to participate in the Idaho Hunger Relief Taskforce and the statewide childhood hunger coalition. Currently the Taskforce is planning the Oct. 2014 summit meeting. The childhood hunger coalition is working on a coalition strategic plan Nourishing Idaho's Children. WIC is involved in Gap #3 where the goal: The food insecure families of ID with children from ages 0 to 5 are educated about and have access to available resources to assist them in feeding (including breast feeding) their children nutritious meals resulting in increased participation in services and programs, and better health outcomes.

WIC continues to participate in HEAL ID including collaborating with IPAN and other agency/community partners. Future collaboration planning occurred at the April 2014 Creating Healthy Communities Summit with a focus on reducing/preventing childhood obesity.

WIC's attending the Preventing Childhood Obesity Learning Collaborative May meeting to explore future collaboration possibilities between WIC and the Children's Healthcare Improvement Collaboration (CHIC) members focused on working towards childhood obesity prevention in ID.

WIC's developing staff training resources focused on improving participant care plan formation/documentation to improve the continuity of services targeting desired health outcomes.

WIC continues to offer participants a variety of nutrition/breastfeeding/physical activity education opportunities including counseling, group classes and Quick WIC

c. Plan for the Coming Year
WIC will participate in the Idaho Hunger Relief Taskforce, the ID Hunger Summit and the childhood hunger coalition.

WIC will participate in HEAL ID and continue collaborating with IPAN and other agency/community partners.

WIC will implement regional LMS online training modules to strengthen staff skills related to PCS, motivational interviewing OARS counseling techniques and the Value Enhanced Nutrition Assessment (VENA) process.

WIC will promote WIC food packages which align with the Dietary Guidelines for Americans (DGA).

WIC will utilize USDA/FNS and state developed materials to reinforce tailored nutrition education messages designed to promote healthy eating, breastfeeding and a physically active lifestyle.

WIC will offer participants a variety of nutrition/breastfeeding/activity education opportunities including individual counseling, group classes, Quick WIC and any other feasible method.

WIC will promote/refer participants to other relevant Title V funded programs.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	8.5	8.4	8.4	8.3	8.3
Annual Indicator	9.1	8.8	8.1	8.0	8.0
Numerator	2158	2033	1804	1838	1838
Denominator	23713	23173	22277	22916	22916
Data Source	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate
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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	8	8	8	7.9	7.9

Notes - 2013
Due to out-of-state birth certificates not received as of date of entry 2012 values are used as estimate.

a. Last Year's Accomplishments
Approximately 2.2% of women who called the Idaho QuitLine or registered on www.quitnow.net/Idaho in 2013 reported being pregnant at the time of the call. 1.2% of women reported planning pregnancy in the next 3 months.
Outreach activities are not specific to pregnant women. Rather, efforts are for the general population, of which pregant women are included in efforts. Television and radio spots ran throughout the year for smoking cessation and referral to the QuitLine. In addition, Project Filter sponsored information-related activities at rodeos, racetracks, fairs, baseball games, LGBT Pride events, Native American powwows and other community events. QuitLine and quitnow.net/Idaho was promoted through the Idaho Academy of Family Physicians, dentists and other healthcare professionals throughout the state.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide Family Planning services to educate pregnant women on the risk of tobacco use.			X	
2. Provide WIC services to pregnant women.			X	
3. Provide Idaho QuitLine services.			X	
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

The 1-800 Quit Now and the www.quitnow.net/Idaho cessation resources remain the same. All of the quit coaches for the Idaho QuitLine and online cessation program, as well as the instructors for the local cessation services, are trained to work with pregnant women and follow a specific protocol. Project Filter is not currently targeting pregnant women in our media efforts, but the local public health districts have been promoting their classes to pregnant women.

c. Plan for the Coming Year

Project Filter received $2.0 million for FY14 to provide telephone and online services, including 4-weeks of free Nicotine Replacement Therapy (NRT) to qualified participants (must be over the age of 18 and meet certain health requirements). This funding is also used to provide media and counter-marketing throughout the state. Project Filter will receive $2.5 million for FY15 and will offer the same services. The increase in funding will be used to sponsor additional events throughout the state and to provide up to 8 weeks of nicotine replacement therapy through the quitline and quitnow.net/Idaho starting July 1, 2014.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	10.9	9.8	9.8	9.8	16.5
Annual Indicator	8.7	16.5	23.3	20.2	20.2
Numerator	10	19	27	23	23
Denominator	114944	115359	116117	113782	113782
Data Source	Death Certificates	Death Certificates	Death Certificates	Death Certificate	Death Certificate
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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	16.5	16.5	16.4	16.4	16.4

Notes - 2013
2013 death records have not been finalized, 2012deaths have been used as best estimate.

2013 population data by age not available at time of entry, 2012used as best estimate.

a. Last Year's Accomplishments
The School Communities Program consists of four elements: Sources of Strength, Sources of Strength train the trainer, gatekeeper training and connectedness and capability strategies.

At the core of the Idaho Lives Project (ILP) and its School Communities Program is Sources of Strength. Sources of Strength is an ongoing, strength-based, comprehensive wellness program that focuses on suicide prevention, but also impacts other issues such as substance abuse and violence. This evidence-based program, centered on hope, help and strength, is based on a relational connections model that uses teams of peer leaders mentored by adult advisors to change peer social norms about help seeking and encourages students to individually assess and develop strengths in their lives.

Schools are selected based on demonstrated need, readiness to benefit, level of interest and commitment, needs of special populations and geographic location.
Schools trained in Cohort 1 training were:

•Priest River Lamanna High School, Priest River
•Lapwai Middle High School, Lapwai
•Parma High School, Parma
•Parma Middle School, Parma
•Nampa High School, Nampa
•Silver Creek Alternative High School, Hailey
•Salmon Middle-High School, Salmon
•Teton High School, Driggs

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Statewide suicide prevention referral sources will be available through the 2-1-1 Idaho CareLine.		X		
2. Idaho has established a statewide, state-specific Suicide Hotline.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Juvenile Justice Program contains two elements: Shield of Care training and technical assistance.

Juvenile Justice facilities serve youth populations with far higher numbers of those at risk for suicide than the general population. Such facilities have procedures in place to help these young

people. However, unique training developed specifically for juvenile justice facilities is now available. Shield of Care is a best-practice suicide prevention program tailored to the juvenile justice environment. This program utilizes a systems-level model to prevent suicide. The model focuses on connectedness to youth and communication among staff and teaches staff at all levels specific, effective intervention strategies.

In partnership with the Idaho Department of Juvenile Corrections and the Tennessee Department of Mental Health and Substance Abuse Services (the creators of Shield of Care), ILP is assisting to train Idaho trainers within the juvenile justice system who will, in turn, train the staff members of all 13 Idaho juvenile justice facilities. The Shield of Care program is available online for free. However, these Idaho trainers will be trained first by those who developed the Shield of Care program, and then may get additional help and materials online.

ILP reaches out to colleges and universities in or near participating school communities to offer and provide suicide prevention gatekeeper training for Resident Assistants, college staff and students.

c. Plan for the Coming Year
Schools selected for Cohort 2 training are:

•Emmett High School, Emmett
•Homedale High School, Homedale
•Frank Church High School, Boise
•Rimrock Jr/Sr High School, Bruneau
•Pocatello High School, Pocatello
•Preston Jr. High School, Preston
•Preston High School, Preston
Applications for Cohort 3 will be available November 2014. Check our Forms and Fliers page for the application at that time.

Three aspects comprise ILP's Health Professionals Program: Suicide assessment training, behavioral health mentors and trained professionals referral.

Mental and primary health providers receive a high degree of training in many areas pertinent to their professions. However, specialized training in suicide assessment is not often included unless sought out by individual providers or their employer.

In 2014 and 2015, expert suicide assessment training will be provided in nine locations throughout Idaho for behavioral health, substance abuse and primary health professionals. These trainings will be conducted by David Rudd, PhD, an expert in clinical suicidology. Dr. Rudd's research focuses on clinical suicidology, cognitive therapy, as well as ethics and regulatory issues in psychology.

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	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	75	99	99	99	99
Annual Indicator	99	99	99	99	99
Numerator					

Denominator					
Data Source	No reliable data source	No reliable data source	No reliable data source	No reliable data source	No reliable data source
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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	99	99	99	99	99

Notes - 2013
Prior to data year 2003, Idaho hospitals with a NICU were used as a proxy measure. However, Idaho has since found errors in that proxy measure and currently does not have a replacement measure. 99 entered to save form.

Notes - 2012
Prior to data year 2003, Idaho hospitals with a NICU were used as a proxy measure. However, Idaho has since found errors in that proxy measure and currently does not have a replacement measure. 99 entered to save form.

Notes - 2011
Prior to data year 2003, Idaho hospitals with a NICU were used as a proxy measure. However, Idaho has since found errors in that proxy measure and currently does not have a replacement measure. 99 entered to save form.

a. Last Year's Accomplishments
While Idaho does not have any faciliaties specifically for high-risk deliveries and neonates, the Department of Health and Welfare works with partners to reduce the prevalence of low birthweight newborns.

In 2012, the Idaho Division of Public Health has joined the partnership between the March of Dimes and the Association for State and Territorial Health Officers (ASTHO) to reduce preterm births and ensure more healthy births in Idaho. As part of this partnership, Idaho has accepted the challenge to reduce the state's preterm birth rate by 8 percent by 2014. Although Idaho fairs better than the nation on preterm birth, there is still work to be done. In 2009, Idaho's preterm birth rate was 10.1 percent of live births compared with the national rate of 12.2 percent. An 8 percent reduction by 2014 would result in approximately 200 fewer preterm births statewide. The MCH Program began working with the local March of Dimes chapter on the Healthy Babies are Worth the Wait campaign to encourage pregnant women and healthcare providers to wait until labor occurs naturally or until 39 completed weeks of gestation before elective delivery. At the Idaho Perinatal Nurse Leadership Summit in October 2012, the March of Dimes provided awareness-building kits to all nurse managers for distribution at their hospitals and facilities, and a physician champion lectured on the topic. Kits were also sent to the Public Health Districts and approximately 40 OB/GYN clinics throughout the state. In 2013, turnover in the March of Dimes position leading this initiative resulted in a pause of the project.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. PRATS survey will monitor utilization of neonatal intensive care services.				X
2. Contractors with family planning, Title X services, will provide pregnancy testing and make referrals as appropriate.	X			
3. MCH staff will serve on the board of the Idaho Perinatal Project.				X
4. MCH staff will continue to promote the Text4Baby program through partnerships with Idaho birth centers, hospitals, and providers.			X	
5. MCH staff will partner with March of Dimes and Association of State and Territorial Health Officers to meet the 8% challenge to reduce prematurity in Idaho.			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In July 2014, the Title V MCH and CYSHCN Directors along with other stakeholders will be attending the Infant Mortality Collaborative Improvement and Innovation Network (CoIIN) Summit in Arlington, VA. The Idaho team intends to glean best practices and lessons learned regarding strategies and drivers of infant mortality and morbidity.

Once the March of Dimes position is filled to lead the ASTHO initiative to reduce preterm births and ensure more healthy births in Idaho, the MCH program will reconvene with stakeholders to continue work to address this issue.

c. Plan for the Coming Year

The MCH Program will continue participation in the national expansion of CoIIN. Proposed activities to align with CoIIN include the development of a state action plan and identify evidence-based approaches to addressing the disparities among perinatal morbidity and mortality.

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	2009	2010	2011	2012	2013
Annual Performance Objective	73.2	73.2	73.2	73.6	75
Annual Indicator	71.5	73.6	74.4	73.9	73.9
Numerator	16880	17016	16529	16884	16884
Denominator	23611	23104	22206	22841	22841
Data Source	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate
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
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	75	75.1	75.1	75.1	75.2

Notes - 2013
2004, the Idaho birth certificate was revised. Beginning in 2004, Idaho prenatal care data are based on date of first prenatal care visit as reported in the mother's medical record. Data are not comparable with Idaho or national data based on month prenatal care began. Prior to the revision, month prenatal care began may have been estimated from mother's recollection or based on information in mother's medical record

Denominator is the total number of births to Idaho women minus the number of births in which trimester prenatal care began was unknown.

Due to out-of-state birth certificates not received as of date of entry 2012 values are used as estimate.

Notes - 2012
2004, the Idaho birth certificate was revised. Beginning in 2004, Idaho prenatal care data are based on date of first prenatal care visit as reported in the mother's medical record. Data are not comparable with Idaho or national data based on month prenatal care began. Prior to the revision, month prenatal care began may have been estimated from mother's recollection or based on information in mother's medical record

Denominator is the total number of births to Idaho women minus the number of births in which trimester prenatal care began was unknown.

Notes - 2011
2004, the Idaho birth certificate was revised. Beginning in 2004, Idaho prenatal care data are based on date of first prenatal care visit as reported in the mother's medical record. Data are not comparable with Idaho or national data based on month prenatal care began. Prior to the revision, month prenatal care began may have been estimated from mother's recollection or based on information in mother's medical record

Denominator is the total number of births to Idaho women minus the number of births in which trimester prenatal care began was unknown.

a. Last Year's Accomplishments
During CY 2013, 19,058 (unduplicated) women received counseling from the Title X Family Planning Program. There were a total of 2,329 pregnancy tests, of which 25.6% (597) were planned and 28% (652) were unplanned. All women were screened for high-risk behaviors and referrals were made as indicated. All women having positive pregnancy tests were provided with options counseling, if indicated, and referred appropriately to obstetricians to begin early (first trimester) prenatal care. Those seeking pregnancy (521) were counseled on preconceptionl/reproductive life planning.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. The Family Planning Program will provide pregnancy testing and referral for prenatal care.	X		X	
2. Utilize PRATS.				X
3. The WIC Program will provide nutritional counseling and information on other pregnancy risk factors.			X	
4. The 2-1-1 Idaho CareLine will provide referrals for prenatal care.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Women continue to receive program services, including counseling, from the Title X Family Planning Program. Women with positive pregnancy tests are screened for high-risk behaviors and referred appropriately. Pregnant women are appropriately referred to obstetricians to begin early prenatal care and options counseling if indicated.

Funding was received from the Title X Family Planning Program for year 3 (ended June 29, 2013) of a three-year special project, "Family Planning HIV Integration Project". Title X clinics started implementing HIV Rapid Test screenings in all Title X clinic sites on January 3, 2011. All Title X clients were offered, and continue to be offered, HIV Rapid screening testing through CYs 2013-2014.

c. Plan for the Coming Year

Women will continue to receive program services including counseling from the Title X Family Planning Program. Women with positive pregnant tests will continue to be screened for high-risk behaviors and appropriately referred. Pregnant women will be appropriately referred to obstetricians to begin early prenatal care. Those seeking pregnancy will be provided with preconception/reproductive life planning educational information.

HIV Rapid Test screenings will continue per activities specified in year 3 of the three-year special project, "Family Planning HIV Integration Project," funded by the Title X Family Planning Program. Clients with reactive screening test will be offered confirmatory testing. Clients with a positive confirmatory test are referred for medical management of the diagnosis.

D. State Performance Measures

State Performance Measure 1: *Percent of 9th - 12th grade students that report having engaged in sexual intercourse.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective		35.5	39	39	39
Annual Indicator	39	39	40	40	38.5
Numerator					

Denominator					
Data Source	YRBS	YRBS	YRBS	YRBS	YRBS
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	39	38.9	38.9	38.9	38.9

Notes - 2013
Results from: RESULTS OF THE 2013 IDAHO YOUTH RISK BEHAVIOR SURVEY , Numerator and denominator not available. Latest data available.

Notes - 2012
Results from: RESULTS OF THE 2011 IDAHO YOUTH RISK BEHAVIOR SURVEY , Numerator and denominator not available. Latest data available.

Notes - 2011
Results from: RESULTS OF THE 2011 IDAHO YOUTH RISK BEHAVIOR SURVEY , Numerator and denominator not available. Latest data available.

a. Last Year's Accomplishments
During CY 2013, family clinics around the state served a total of 2,134 teens 15-17 years of age compared with 2,165 teens aged 15-17 years of age who received services in CY2012 --a decrease of 1.4 % or 31 clients, who were served in CY2013 (Ahlers table AL-12). Idaho's 2011 teen pregnancy rate for 15-17 year olds is 15.1% (provisional data). The 2010 teen pregnancy rate as 15.1% (final). The data shows a slight decrease in teen pregnancy rates for 2008 and 2009 and a slight decrease in the rates for 2010.

The 15-17 year old teen clients received a physical assessment, education, and counseling services. All clinics continued to emphasize adolescent education which focuses on abstinence, parental involvement, relationship safety including screening for human trafficking, contraception and STIISTD prevention.

All health districts provide family planning services to teen clients aged 13-19 years of age. Many districts provide extended clinic hours in the evening to accommodate teen client's schedules.

Funding was received for the Title X Family Planning Program for year 3 of a three-year special project, "Family Planning HIV Integration Project." Title X clinics offered and performed HIV Rapid Test screening from January 3, 2011 -- December 31, 2012 and January 1, 2013- June 29, 2013.

January 2011 noted one HIV Rapid test screening, which the client was referred for medical management following the positive confirmatory test. All other HIV Rapid Test screenings performed since January 3, 2011 to date (December 31, 2013) have been unreactive.

During CY2013, the Ada County (Boise) Juvenile Detention Center project provided access to reproductive health care services for 96 high-risk adolescents. Residents were provided with the opportunity to receive services through weekly preventive reproductive health clinics. Pre- and post-test evaluations were given to measure the level of intention to change risky sexual behaviors.

During CY2013, the Adolescent Pregnancy Prevention Manager, the Family Planning Coordinator, the STD Prevention Coordinator, and the HIV Prevention Coordinator met to discuss collaboration and coordination efforts between their programs.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Provide family planning services to teens through the public health districts.	X		X	
2. Develop compehensive educational messages trgted to teens.		X	X	X
3. Continue to conduct Teen Education Afternoon (TEA) local district clinic project.		X	X	
4. Continue program collaboration and coordination activities with the Adolescent Pregnancy Prevention Program.				X
5. Continue to conduct HIV Rapid Screening tests on all Title X family planning clients.	X		X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

All health districts provide family planning services to teen clients. Districts provide extended clinic hours in the evening to accommodate teen clients' schedules. Districts have active advisory boards which guide the content of educational materials and provide direction for outreach activities. Advisory boards have committee members with various backgrounds representing communities from within each agency's service areas. Members include, but not limited to, faith-based members and teen representatives. These relationships have allowed the boards to develop more trusting relationships with local groups.

Funding was received for the Title X Family Planning Program, "Family Planning HIV Integration Project." Clinics began implementing HIV Rapid Test screening on January 3, 2011, making it available to all Title X family planning clients and continued to provide HIV Rapid Test • screening through CY 2013. The actual grant funding project ended June 29, 2013, sub-recipients continued to screen Title X clients using the remaining test kits purchased during the grant

During CY2013, the Ada County Juvenile Detention Center project continued to provide access to reproductive health care services for high-risk adolescents. Residents are provided with the opportunity to receive services through weekly preventive reproductive health clinics. Pre- and. post-test evaluations were given to measure the level of intention to change risky sexual behaviors.

c. Plan for the Coming Year

Comprehensive educational messages will continue to be developed targeting teens and provide information on issues like abstinence, STI/STDs, parental involvement, relationship safety including human trafficking, sexual coercion, and birth control methods.

HIV Rapid Test screenings were continued per activities with the remaining test kits that were purchased during year 3 of the three-year special project, "Family Planning HIV Integration Project," despite the discontinuation of funding for HIV Integration activities by the Title X Family Planning Program. Clients receiving a reactive(+) HIV Rapid screening test will be offered confirmatory testing. Clients with a positive confirmatory test will be referred for medical management of the diagnosis.

The Ada County Juvenile Detention Center project continued during CY2013. The project provided access to reproductive health care services for high-risk adolescents. Residents were

given the opportunity to receive services through weekly preventive reproductive health clinics.

The Adolescent Pregnancy Prevention Manager, Family Planning Coordinator, STD Prevention Coordinator, and HIV Prevention Coordinator continued to meet together periodically to discuss collaboration efforts between their programs.

State Performance Measure 2: *Percent of pregnant women 18 and older who received dental care during pregnancy.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective		55	55	55	55
Annual Indicator	53.9	53.9	51.1	54.4	54.4
Numerator					
Denominator					
Data Source	PRATS	PRATS	PRATS	PRATS	PRATS
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	55	55	55	55	55

Notes - 2013
Data source is the 2011 Idaho PRATS survey. Data for 2013 births is not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision.

Due to the nature of the survey data variability the target goals are not adjusted based on a single year's values.Received at a minimum teeth cleaning or regular check-up.

Notes - 2012
Data source is the 2011 Idaho PRATS survey. Data for 2012 births is not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision.

Due to the nature of the survey data variability the target goals are not adjusted based on a single year's values.Received at a minimum teeth cleaning or regular check-up.

Notes - 2011
Data source is the 2010 Idaho PRATS survey. Data for 2011 births is not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numerator and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision.

Due to the nature of the survey data variability the target goals are not adjusted based on a single year's values.

Received at a minimum teeth cleaning or regular check-up.

a. Last Year's Accomplishments
Last year all of the Public Health Districts either provided oral health education and dental home referrals to pregnant women through Women, Infants, and Children (WIC) Clinics, or worked on increasing the oral health knowledge of healthcare providers on the effects of poor oral health on

pregnancy outcomes. Even though the program does not have a systematic approach to ensure pregnant women receive dental care during pregnancy, the program does continue to work with one Community Health Center (CHC) on a medical-dental collaboration model specifically focused on pregnant women. The development of this model has been due to funding from the DentaQuest Foundation. With this funding, the CHC has been able to provide a "Healthy Smile" folder with various oral health educational materials to every new pregnant woman seen in their center, and a dental voucher to receive a comprehensive dental screening. In addition, changes to the patient workflow for pregnant women have changed to include oral health aspects at certain points during the entire appointment process.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue evaluation of PRATS and Idaho birth certificate data.				X
2. Continue to educate healthcare providers and pregnant women regarding the link between good oral health and improved birth outcomes, and educate them on establishing good oral health behaviors for their newborns.			X	
3. Continue to provide oral health education and dental home referrals if needed to pregnant women.			X	
4. Idaho Oral Health Action Plan 2015-2020: Plan Update				X
5. Finalize Oral Health Burden Report				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Idaho Oral Health Program (IOHP) supports Idaho Medicaid's Smiling Stork Program which educates pregnant women on the importance of oral health before and during pregnancy, and helps them to establish good oral health habits with their newborns. The Public Health Districts support the Smiling Stork Program by providing oral health education and dental home referrals if needed to pregnant women presenting in WIC Clinics. The Public Health Districts also continue to work with educating healthcare providers on the relationships between poor oral health and pregnancy outcomes, and have encouraged them to include oral health education during appointments with pregnant women. The IOHP continues to work with the CHC on further developing their medical-dental collaboration model targeted on pregnant women, and developing a method to track the oral health information given to pregnant women during their appointments in their new Electronic Health Records System. Lastly, funding from the DentaQuest Foundation has allowed healthcare providers at three CHCs, family medicine residents at the Family Medicine Residency of Idaho, and physician assistant students at Idaho State University to complete the Smiles for Life: A National Oral Health Curriculum, which includes a specific module on oral health and the pregnant patient.

c. Plan for the Coming Year

The Public Health Districts will continue to provide oral health education and dental home referrals as needed to pregnant mothers who present to WIC Clinics and other settings. They will also continue to work with healthcare providers and increase their oral health knowledge in relation to the effects of poor oral health on pregnancy outcomes. The IOHP will be updating the Idaho Oral Health Action Plan 2015-2020 which may include specific goals and objectives

focused on improving the oral health of pregnant women and helping them to establish good oral health behaviors with their newborns.

State Performance Measure 3: *Percent of 9th – 12th grade students that are overweight.*

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

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective		18	18	18	18
Annual Indicator	20.8	20.8	22.6	22.6	25.3
Numerator					
Denominator					
Data Source	YRBS	YRBS	YRBS	YRBS	YRBS
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	18	18	18	18	18

Notes - 2013
Results from: RESULTS OF THE 2013 IDAHO YOUTH RISK BEHAVIOR SURVEY , Numerator and denominator not available. Latest data available.

Notes - 2012
Results from: RESULTS OF THE 2011 IDAHO YOUTH RISK BEHAVIOR SURVEY , Numerator and denominator not available. Latest data available.

Notes - 2011
Results from: RESULTS OF THE 2011 IDAHO YOUTH RISK BEHAVIOR SURVEY , Numerator and denominator not available. Latest data available.

a. Last Year's Accomplishments
IPAN began work on the CDC 1305 grant activities which included promoting physical activity and nutrition guidelines and physical activity in early child care settings, worksites, schools, and communities at large. IPAN contracted with partners such as the local public health districts, the State Department of Education, the Idaho Farmer's Market Association and Vitruviann Planning to help complete these activities. Each of the local public health districts visited 25 child care facilities to promote best practices addressing nutrition, physical activity, screen time and infant feeding in the child care arena. They also promoted the Let's Move! Child Care initiative and had 20 of the 25 facilities complete the Let's Move! checklist and action plan. The local public health districts each also worked with 10 worksites on completing the National Healthy Worksite Scorecard, including the Lactation Support section, and action plans. The State Department of Education provided statewide education and technical assistance on nutrition guidelines in the entire school environment, Comprehensive School Physical Activity Programs (CSPAP), and the new proposed PE legislation. The Idaho Farmer's Market Association worked to recruit farmer's markets to become EBT vendors to increase access to fresh fruits and vegetables to low income individuals. And Vitruviann Planning worked with three small communities in south central Idaho on Activity Connection Plans, to enhance opportunities to walk and be physically active for their community members.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Number of local education agencies that received professional development and technical assistance on strategies to create a healthy school nutrition environment and comprehensive			X	

physical activity environment				
2. Number of early child care and education setting that develop and/or adopt policies to implement food service guidelines/nutrition standards including sodium and physical activity policies			X	
3. Number of worksites that develop and/or adopt policies to implement food service guidelines/nutrition standards including sodium and physical activity			X	
4. Number of farmers' markets that accept federal or state nutrition assistance benefit programs			X	
5. Number of adults or youth who have access to places for physical activity, with a focus on walking				X
6. Number of employers that provide space and time for nursing mothers to express breast milk				X
7.				
8.				
9.				
10.				

b. Current Activities

IPAN will continue to work with the partners that were established last year on the activities to promote, educate and assess physical activity and nutrition activities in the early child care, school, worksite and community settings. IPAN is also moving a bit further this year into implementation of best practices in these settings. After the assessments and education, action plans have been created by participating early child care facilities, schools, worksites and communities. So the last half of this current year will be helping to implement these action plans and make steps towards achieving their goals. A couple specific activities to do this are the following:

o Implement Let's Move! Child Care workshops in each district to help teach and facilitate learning around the four Let's Move! goals of physical activity, healthy nutrition, screen time and infant feeding.

o Work with Lead Education Agency School districts to improve their school wellness policies and address implementation of those policies in each of their school buildings

o Work with city planners to incorporate suggestions of the Activity Connection Plan into their city plans

o Assist pilot farmers' markets that are new EBT vendors with their activities and sales this season

c. Plan for the Coming Year

IPAN will further it's work with all partners in implementing the best practice activities for physical activity and nutrition that resulted from their action planning steps. IPAN will also increase its reach by adding new child care sites, worksites, school lead education agencies, communities and farmers' markets. IPAN will also begin to look at larger policy changes in the coming year, including statewide PE legislation and healthy initiatives incorporated into city child care licensing.

State Performance Measure 4: *Percent of women 18 and older who fell into the "normal" weight category according to the body Mass Index (BMI=18.5 to 24.9) prior to pregnancy.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance		59	59	59	59

Objective					
Annual Indicator	49.8	48.2	49.7	48.9	48.9
Numerator	11475	10943	10890	11019	11019
Denominator	23036	22684	21909	22538	22538
Data Source	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	51	51	51	51.1	51.1

Notes - 2013
Based on records where valid pre-pregnancy height and weight were recorded on birth certificates.

Due to out-of-state birth certificates not received as of date of entry, 2012 values are used as estimate.

Notes - 2012
Based on records where valid pre-pregnancy height and weight were recorded on birth certificates.

Notes - 2011
Based on records where valid pre-pregnancy height and weight were recorded on birth certificates.

a. Last Year's Accomplishments
In 2010, the Idaho Physical Activity and Nutrition Program launched the Healthy Eating, Active Living (HEAL) Idaho Network to develop a comprehensive statewide strategic operations framework to address nutrition and physical activity for Idahoans of all ages. HEAL Idaho is a voluntary network of organizations, agencies, businesses, and individuals committed to creating an environment where all Idahoans have access to healthy food options and opportunities to be physically active to improve their health and well-being.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor BMI data through birth certificates.				X
2. Coordinate with HEAL Idaho to acknowledge nutrition and activity issues as important elements of preconception health.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
HEAL Idaho continues to build membership, exchange information and access resources via the statewide website, and hold regular regional and statewide meetings. Agencies and organizations work together to make recommendations for the framework and identify best practices for

addressing nutrition and physical activity. Idaho WIC program is a member of the HEAL Idaho Network. The HEAL Idaho Network is hosted three regional meetings throughout Idaho during the spring of 2014. The meetings feature speakers from local communities and highlight successes in addressing obesity in the community through nutrition and physical activity initiatives.

The MCH Program has ordered customized BMI wheels with adult and pediatric measurements for distribution to all pediatric and family practice providers. The BMI wheels are being distributed as part of a statewide learning collaborative facilitated by Medicaid's Children's Healthcare Improvement Collaborative (CHIC) focused on reducing pediatric obesity.

We will continue to monitor this data through birth certificates as well as explore other data sources. We will also be looking for opportunities to develop meaningful and effective interventions.

c. Plan for the Coming Year

The HEAL Idaho Network will continue with the implementation of recommended actions. There is a realization that there is room within the framework to address nutrition and physical activity issues relevant to pregnancy women, children, and youth. The MCH program will become more involved with HEAL Idaho and explore other opportunities to promote healthy weight among women as a part of preconception health.

With the realignment of the Title X Family Planning Program being placed under the Title V MCH Program, comes opportunity to address preconception health concerns with clients served in Title X clinics. As this transition occurs over the next year, the MCH program will explore ways to target Title X clients with preconception health messaging, such as using materials from CDC's Show Your Love campaign.

State Performance Measure 5: *Percent of women 18 and older who regularly (4 or more times per week) took a multivitamin in the month prior to getting pregnant.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective		43	43	43	43
Annual Indicator	40.3	40.3	41.3	41.8	41.8
Numerator					
Denominator					
Data Source	PRATS	PRATS	PRATS	PRATS	PRATS
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	43	43	43	43	43

Notes - 2013

Data source is the 2011 Idaho PRATS survey. Data for 2013 births is not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision.

Due to the nature of the survey data variability the target goals are not adjusted based on a single year's values.

Notes - 2012

Data source is the 2011 Idaho PRATS survey. Data for 2012 births is not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision.

Due to the nature of the survey data variability the target goals are not adjusted based on a single year's values.

Notes - 2011
Data source is the 2010 Idaho PRATS survey. Data for 2011 births is not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision.

Due to the nature of the survey data variability the target goals are not adjusted based on a single year's values.

a. Last Year's Accomplishments
This measure is obtained from the Pregnancy Risk Assessment Tracking System (PRATS). Idaho has been monitoring this data as a first step to identifying ways to positively impact preconception health.

Realizing the benefit of aligning with the Idaho's MCH Block Grant's state performance measures, the Idaho Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program identified multivitamin use among enrolled women of childbearing age as a preconception health indicator as part of their benchmark and data collection plan. This created another source of data to monitor this indicator since MIECHV service delivery began in June 2012. Home visitors also provide information to enrolled women about the benefits of regularly taking a multivitamin.

The Idaho MCH Program is the state's lead partner in the Text4Baby initiative. Mothers enrolled in the service receive weekly text messages with content relevant to their gestation (if pregnant) or baby's age (postnatal up to 1 year). Text messages encouraging use multivitamins containing folic acid are part of the package.

Another avenue to promote preconception health behaviors such as multivitamin use is through the Healthy Eating, Active Living (HEAL) Idaho Network which published a framework and made recommendations for best practices to impact nutrition and health behaviors. As HEAL Idaho continues to grow, impact to MCH populations will be monitored.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor PRATS data.				X
2. Monitor MIECHV enrollee data.				X
3. Provide education to MIECHV enrollees about the benefits of taking a multivitamin prior to pregnancy.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
MIECHV local implementing agencies are currently providing home visiting services to families in north and south central Idaho. Currently, home visitors discuss and gather information from non-pregnant women of childbearing age about the benefits of multivitamins and how often the women are taking a multivitamin.

c. Plan for the Coming Year
We will continue to monitor PRATS data and MIECHV enrollee data regarding multivitamin use once the data are available. The MCH program will explore opportunities to promote multivitamin and folic acid use as a part of preconception health among Idaho women.

With the realignment of the Title X Family Planning Program being placed under the Title V MCH Program, comes opportunity to address preconception health concerns with clients served in Title X clinics. As this transition occurs over the next year, the MCH program will explore ways to target Title X clients with preconception health messaging, such as using materials from CDC's Show Your Love campaign.

State Performance Measure 6: *Percent of women 18 and older who gave birth and drank alcohol in the 3 months prior to pregnancy.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective		35	50	50	50
Annual Indicator	79.2	79.2	78.7	79.4	79.4
Numerator					
Denominator					
Data Source	PRATS	PRATS	PRATS	PRATS	PRATS
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	50	50	50	50	50

Notes - 2013
Data source is the 2011 Idaho PRATS survey. Data for 2013 births is not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision.

Due to the nature of the survey data variability the target goals are not adjusted based on a single year's values.

Notes - 2012
Data source is the 2011 Idaho PRATS survey. Data for 2012 births is not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision.

Due to the nature of the survey data variability the target goals are not adjusted based on a single year's values.

Notes - 2011
Data source is the 2010 Idaho PRATS survey. Data for 2011 births is not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision.

Due to the nature of the survey data variability the target goals are not adjusted based on a single year's values.

a. Last Year's Accomplishments
This measure is obtained from the Pregnancy Risk Assessment Tracking System (PRATS). Idaho has been monitoring this data as a first step to identifying ways to positively impact preconception health.

Through the Idaho Maternal, Infant, and Early Childhood (MIECHV) program's steering committee, the MCH program strengthened its relationship with the Idaho Substance Abuse program's Pregnant Women and Women with Dependent Children (PWWC) program. The PWWC program has identified a network of providers to serve the specific needs of pregnant women and women with children who are facing substance use issues. This network will be used as a referral source for women enrolled in the MIECHV program.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor PRATS data.				X
2. Montor MIECHV enrollee data.				X
3. Provide education to MIECHV enrollees about the benefits of taking a multivitamin prior to pregnancy.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
MIECHV local implementing agencies are currently providing home visiting services to families in north and south central Idaho. Currently, home visitors discuss and gather information from pregnant and non-pregnant women about alcohol, tobacco, and illicit drug use prior to and during pregnancy. The MIECHV program has sought technical assistance for providing services to families with mental illness and substance abuse issues as many families enrolled in the programs are struggling with such issues.

c. Plan for the Coming Year
We will continue to monitor PRATS data and MIECHV enrollee data regarding alcohol use. The MCH program will explore opportunities to promote abstinence from alcohol and other substances prior to pregnancy as part of preconception health among Idaho women.

With the realignment of the Title X Family Planning Program being placed under the Title V MCH Program, comes opportunity to address preconception health concerns with clients served in Title

X clinics. As this transition occurs over the next year, the MCH program will explore ways to target Title X clients with preconception health messaging, such as using materials from CDC's Show Your Love campaign.

State Performance Measure 7: *Percent of children at kindergarten enrollment who meet state immunization requirements.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective		90	90	90	91
Annual Indicator	85.0	85.8	86.4	91.1	92.0
Numerator	19240	19654	19675	21761	22016
Denominator	22624	22913	22762	23888	23934
Data Source	SIR 2009	SIR 2010	SIR 2011	SIR 2012	SIR 2013
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	91.1	91.1	91.2	91.2	91.3

Notes - 2013
SIR = School Immunization Report, self-reported rates by schools. The immunizations required for Idaho school attendance are set by state policy not necessarily matching national standards.

The numerator includes a record category of "Conditional Admittance" which counts students with partial immunization series where parents/guardians indicated they would bring the child up to date within three weeks. Also students whose parents have filed an exemption to vaccinations for medical, religious or medical grounds.

Notes - 2012
SIR = School Immunization Report, self-reported rates by schools. The immunizations required for Idaho school attendance are set by state policy not necessarily matching national standards.

The numerator includes a record category of "Conditional Admittance" which counts students with partial immunization series where parents/guardians indicated they would bring the child up to date within three weeks. Also students whose parents have filed an exemption to vaccinations for medical, religious or medical grounds.

Notes - 2011
SIR = School Immunization Report, self-reported rates by schools. The immunizations required for Idaho school attendance are set by state policy not necessarily matching national standards.

In 2011 Idaho added Varicella and Hepatits A to required vaccinations. The numerator includes a new record category of "Conditional Admittance" which counts students with partial immunization series where parents/guardians indicated they would bring the child up to date within three weeks.

a. Last Year's Accomplishments
During the 2012-13 school year, several educational activities we conducted in an effort to make schools, physicians, nurses and families more aware of the updated school entry requirements. Additionally, 73 schools were randomly selected to participate in a validation study to determine whether school report data is reflective of true student immunization coverage. Another 66 schools were selected based on their immunization rates to receive non-compliance site visits.

The purpose of the non-compliance site visits is to improve immunization rates in schools with low reported compliance.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide free vaccines to all children 0 through 18 years of age by consistently supplying all Vaccine for Children (VFC) providers in the state of Idaho.			X	
2. Provide parent, school and daycare education, media and training.			X	
3. Maintain an immunization registry, which includes data quality monitoring.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During the 2013-14 school year, ongoing efforts are being made to ensure school staff, nurses and families were aware of the Kindergarten immunization requirements. School immunization reviews were conducted with 21 schools in conjunction with training to help schools with low compliance improve their immunization rates. A letter in partnership with the State Department of Education was also sent to each school principal and superintendent throughout Idaho. The letter included each school or school district's immunization rates over the past two years with a list of tools school administrators may utilize to improve immunization rates.

Idaho Immunization Program had three different School and Childcare Immunization Coordinators in 2013. Given the significant amount of turnover, current activities were impacted. The position is now permanently staffed.

c. Plan for the Coming Year

The Idaho Immunization Program is still in the process of identifying the best approach toward schools with high percentages of children who are neither up-to-date with their vaccines nor have exemption forms on file. Non-compliant students are in breach of Idaho Administrative Code, but enforcement mechanisms are unclear. The Immunization Program will continue discussions with the State Department of Education and look at realistic measures to take to increase enforcement of Idaho's Administrative Code.

State Performance Measure 8: *Percent of children at seventh grade enrollment who meet state immunization requirements.*

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

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective		95	95	95	95
Annual Indicator	93.8	93.5	78.3	81.3	86.8

Numerator	19997	20293	17736	18396	20160
Denominator	21317	21714	22659	22636	23232
Data Source	SIR 2009	SIR 2010	SIR 2011	SIR 2012	SIR 2013
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	90	90	90	90	90.1

Notes - 2013
SIR = School Immunization Report, self-reported rates by schools. The immunizations required for Idaho school attendance are set by state policy not necessarily matching national standards.

The numerator includes a record category of "Conditional Admittance" which counts students with partial immunization series where parents/guardians indicated they would bring the child up to date within three weeks. Also students whose parents have filed an exemption to vaccinations for medical, religious or medical grounds.

Notes - 2012
SIR = School Immunization Report, self-reported rates by schools. The immunizations required for Idaho school attendance are set by state policy not necessarily matching national standards.

The numerator includes a record category of "Conditional Admittance" which counts students with partial immunization series where parents/guardians indicated they would bring the child up to date within three weeks. Also students whose parents have filed an exemption to vaccinations for medical, religious or medical grounds.

In 2011 Idaho added Tdap and Mengitis to required vaccinations. There was an increase in the rate of incomplete records at least partially attributed to the additional vaccinations.

Notes - 2011
SIR = School Immunization Report, self-reported rates by schools. The immunizations required for Idaho school attendance are set by state policy not necessarily matching national standards.

In 2011 Idaho added Tdap and Mengitis to required vaccinations. There was an increase in the rate of incomplete records at least partially attributed to the additional vaccinations. The numerator includes a new record category of "Conditional Admittance" which counts students with partial immunization series where parents/guardians indicated they would bring the child up to date within three weeks.

Changes in data reporting make rates prior to 2011 not directly comparable.

a. Last Year's Accomplishments
During the 2012-13 school year, several educational activities were conducted in an effort to make schools, physicians, nurses and families more aware of the updated school entry requirements. Additionally, 73 schools were randomly selected to participate in a validation study to determine whether school report data is reflective of true student immunization coverage. Another 66 schools were selected based on their immunization rates to receive non-compliance site visits. The purpose of the non-compliance site visits is to improve immunization rates in schools with low reported compliance.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide free vaccines to all children 0 through 18 years of age			X	

by consistently supplying all Vaccine for Children (VFC) providers in the state of Idaho.				
2. Perform annual site visits to VFC providers and conduct provider education.			X	
3. Provide parent, school and childcare education, media and training.			X	
4. Maintain an immunization registry which includes data quality monitoring.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During the 2013-14 school year, ongoing efforts are being made to ensure school staff, nurses and families were aware of the 7th grade immunization requirements. School immunization reviews were conducted with 21 schools in conjunction with training to help schools with low compliance improve their immunization rates. A letter in partnership with the State Department of Education was also sent to each school principal and superintendent throughout Idaho. The letter included each school or school district's immunization rates over the past two years with a list of tools school administrators may utilize to improve immunization rates.

Please note that the Idaho Immunization Program had three different School and Childcare Coordinators in 2013. Given the significant amount of turnover, current activities were impacted.

c. Plan for the Coming Year

The Idaho Immunization Program is still in the process of identifying the best approach toward schools with high percentages of children who are neither up-to-date with their vaccines nor have exemption forms on file. Non-compliant students are in breach of Idaho Administrative Code, but enforcement mechanisms are unclear. The Immunization Program will continue discussions with the State Department of Education and look at realistic measures to take to increase compliance of Idaho's Administrative Code.

E. Health Status Indicators

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	121	104	2	4	2	0	1	8
Children 1 through 4	13	12	0	1	0	0	0	0
Children 5 through 9	14	14	0	0	0	0	0	0
Children 10	19	19	0	0	0	0	0	0

through 14								
Children 15 through 19	69	67	0	1	0	1	0	0
Children 20 through 24	94	90	0	0	2	0	0	2
Children 0 through 24	330	306	2	6	4	1	1	10

Notes - 2015

Narrative:
Through executive order in 2012, Idaho established a child fatality review team to allow comprehensive and multidisciplinary review of the deaths of children younger than 18 years of age in order to identify what information and education may improve the health and safety of Idaho's children. This was a significant accomplishment for Idaho as we were the only state without such a review team at that time. The team conducted full reviews of 82 child deaths occuring in 2011 and published an annual report of findings and recommendations. The deaths included sudden unexplained infant death, motor vehicle accidents, drowning, homicide, and suicide. The team will continue work to begin review of child deaths occurring in 2012.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	0
Living in urban areas	334801
Living in rural areas	109020
Living in frontier areas	27363
Total - all children 0 through 19	471184

Notes - 2015
Idaho has no areas considered metropolitan.

Narrative:
In 2013, the Idaho Division of Public Health (Title V MCH Program), Division of Medicaid (Children's Healthcare Improvement Collaborative Project), Eastern Idaho Public Health District, and Southeastern Idaho Public Health District partnered to address persistent health disparities among children with special health care needs residing rural Idaho communities. The goal of this multidistrict collaboration is to introduce a PCMH model to providers of pediatric and family care serving CYSHCN in rural parts of Idaho through the public health districts. A shared medical home coordinator operates from the health district and travels weekly to multiple participating practices to assist with quality improvement, patient education and referral coordination, PCMH transformation, and patient registry and workflow management.

F. Other Program Activities

The Genetics Services Program, Bureau of Clinical and Preventive Services, will continue to contract with physicians, Board Certified in Medical Genetics, and related disciplines to provide consultation to health care providers for all MCH populations needing genetic diagnosis,

evaluation and management.

The CSHP Program will continue to provide biannual regional PKU clinics, staffed by Dr. Cary Harding from Oregon Health and Science University, in Boise, Idaho Falls, Lewiston, and Coeur d'Alene. Families receive initial consultation from OHSU and Dr. Harding already comes to Idaho to see children with other metabolic disorders.

The Bureau of Clinical and Preventive Services outcome performance measures will continue to be maintained and updated by the MCH Director and the MCH research analyst. This document will be updated quarterly and will provide a method for the MCH programs to monitor performance on a statewide basis as well as provide information to the Department's administration in regard to the Bureau's contribution to the Department's goal of improving health status.

G. Technical Assistance

The Children's Special Health Program (CSHP) is unsure how to approach trying to impact Performance Measure #3 (Medical Home), and would appreciate some technical assistance on the subject.

Idaho is interested in technical assistance with strategies and methods to obtain unduplicated counts across agencies.

Region X Title V programs (Alaska, Washington, Idaho, Oregon) request assistance to sponsor a National Association of Chronic Disease Directors (NACDD) Regional State Academy on Life Course & the Chronic Disease Model in 2013. In Region X, two of the four states have merged Chronic Disease Programs with Maternal Child and Adolescent Health programs, leveraging the opportunity to implement Title V efforts according to a life course framework. Additionally, an "Academy" structure for learning, sharing, and applying knowledge to these structures is available with a partnership with the National Association of Chronic Disease Directors and the Association of Maternal and Child Health Programs.

Purpose: To develop a shared learning experience for MCAH and Chronic Disease epidemiology, evaluation and policy staff in our state programs.
Issue Category: General Systems Capacity Issues
Proposed Consultants: NACDD & AMCHP
Estimated Costs: In-person meeting costs
Estimated Dates: Between Nov 2012 - Jan 2013

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2013		FY 2014		FY 2015	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	3203380	2926860	3203380		3216931	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	2402535	2195146	2402535		2412699	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	5605915	5122006	5605915		5629630	
8. Other Federal Funds *(Line10, Form 2)*	40530062	38262321	38058901		40620256	
9. Total *(Line11, Form 2)*	46135977	43384327	43664816		46249886	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2013		FY 2014		FY 2015	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	314376	288549	369616		319956	
b. Infants < 1 year old	1377507	1215457	1381248		1396728	
c. Children 1 to 22 years old	2190196	2135248	2176867		2192348	
d. Children with	1255566	1050027	1164248		1269578	

Special Healthcare Needs						
e. Others	265870	251578	248620		248620	
f. Administration	202400	181147	265316		202400	
g. SUBTOTAL	5605915	5122006	5605915		5629630	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	0		0		0	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	32684119		30320679		31764360	
h. AIDS	2550540		2679762		2802196	
i. CDC	2049784		2182100		3338970	
j. Education	0		0		0	
k. Home Visiting	1317564		1000000		1000000	
k. Other						
Title X			1876360		1714730	
Title X	1928055					

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2013		FY 2014		FY 2015	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	1773050	1545680	1471550		1560482	
II. Enabling Services	46750	50251	45000		45000	
III. Population-Based Services	2937268	2872052	2921667		2931831	
IV. Infrastructure Building Services	848847	654023	1167698		1092317	
V. Federal-State Title V Block Grant Partnership Total	5605915	5122006	5605915		5629630	

A. Expenditures

/2014/ For details of budget variation from projected to actual, please refer to forms 3, 4, and 5 and their related notes.

Funds used for state match during federal fiscal year 2012 (FFY 12) are from local funds ($2,089,174), contributed by the local health districts to help support the childhood Immunization Program. No state general funds are used to support MCH programming.

The expenditures in FFY 12 that were directed to Pregnant Women included 25% of the MCH administrative budget ($22,746), 40% of the MCH STD budget ($7,127), 25% of the Office of Epidemiology, Immunization and Food Protection MCH budget ($58,177), 100% of the Perinatal funds for the PRATS survey ($30,000), 20% of the Reproductive Health MCH budget ($147,044), and 25% of the Idaho CareLine MCH budget ($11,634).

Funds used in FFY 12 for infants < 1 Year Old included 25% of the MCH administrative budget ($22,746), 25% of the Office of Epidemiology, Immunization and Food Protection MCH budget ($58,177), 25% of the Idaho CareLine MCH budget ($11,634), and 50% of the local match ($1,044,587).

Funds used in FFY12 for Children 1 to 22 Years Old included 25% of the MCH administrative budget ($22,746), 30% of the MCH STD budget ($5,345), 25% of the Office of Epidemiology, Immunization and Food Protection MCH budget ($58,177), 25% of the Idaho CareLine MCH budget ($11,634), 50% of the Immunization Program local funds used for block grant match ($1,044,587), 100% of the Oral Health Program ($348,172), 100% of the injury funds ($234,460) and 40% of the MCH budget for Reproductive Health ($294,087).

Expenditures for Children with Special Health Care Needs in FFY12 included 25% of the MCH administrative budget ($22,745), 25% of the Idaho CareLine MCH budget ($11,634), 25% of the Office of Epidemiology, Immunization and Food Protection MCH budget ($58,176), 100% of the Genetics Program ($131,278) and the Children's Special Health Program ($777,916).

Forty percent (40%) or $294,087 of the MCH funds directed to the Reproductive Health Program were spent in the Other category, which primarily includes women of reproductive age who are older than 22 years of age as well as males. Thirty percent (30%), or $5,345, of the MCH STD funds were spent in the Other category. Indirect costs charged against the MCH Block Grant in FFY 12 totaled $140,479 in the Administrative category.

FFY 12 expenditures by service category are as follows: Direct Health Care Services accounted for 90% of the genetics Program budget ($118,150), 100% of the Reproductive Health Program budget ($735,218) and 100% of the Children's Special Health Program budget ($777,916). The two programs included under enabling services were the Idaho CareLine ($46,536) and 10% ($1,782) of the MCH money supporting the STD program. Programs included in the Population-Based Services category were 100% of the Oral Health Program ($348,172), 100% of the Injury Prevention Program ($234,460), childhood Immunizations ($2,089,174 -- local match), and 90% of the MCH STD funds ($16,035).

Programs included under infrastructure Building Services included: 100% of MCH Administration ($90,983), 100% of Office of Epidemiology, Immunization and Food Protection ($232,707), 100% of Perinatal (PRATS survey-$30,000),10% of the Genetics Program ($13,128), and the indirect budget ($140,479).

Total reported MCH expenditures for Idaho during FFY 12 are $4,874,740. //2014//

/2015/ In order to meet the match requirement, the state will be utilizing $2,412,699 in state funds from the State Vaccine Assessment.

The priority areas identified for Idaho are children with special health care needs, reproductive health for young women, oral health of children, injury prevention, epidemiology services, pregnancy risk assessment data collection, patient-centered medical home demonstration project (year 2) for children with special health care needs and the Title V MCH needs assessment. These programs/projects account for the majority of block grant funds expenditures. Funding for the Maternal and Child Health Program, which Children and Youth with Special Health Care Needs (CYSHCN) falls under, and medical home demonstration project account for the majority of funds used to meet 30% minimum required for CYSHCN. In FFY13, CYSHCN and medical home project accounted for 34.4 % of the block grant funds. Preventive and Primary Care for Children accounted for 44.7% of block grant funds; the largest amount of funds directed toward Oral Health, Reproductive Health, and Injury Prevention. The total amount of block grant funds for Maternal and Infant Services was 15% and approximately 5.9% of funds for indirect costs.

MCH funds will again be used to fund a full-time research analyst dedicated to MCH programs and a full-time position who oversees the collection and analysis of the Pregnancy Risk Assessment Tracking Survey (PRATS). These positions, while housed in the Bureau of Vital Records and Health Statistics, are dedicated to MCH programming. Within MCH CSHP, there is planned funding to support a Quality Assurance and Improvement position. //2015//

/2015/ MCH Block grant funds were not used to support breast and cervical cancer screening data system enhancement, as planned. Upon further analysis of the breast and cervical data system, it was determined that priority be given to stabilization of the current system and exploration occur of moving the antiquated system onto a CDC-supported CaST data system. The data system has been stabilized and IT is exploring what is involved in moving to a CaST system. MCH funds were used to support the electronic birth record project enhancement. Anticipated completion of this project is September, 2014. In 2015, the planned infrastructure-building support will come from 1) PRATS position and survey collection and analysis and 2) MCH CSHP Quality Assurance and Improvement position. //2015//

/2015/ The MCH block grant provides support for the Idaho Poison Control hotline via a contract with Nebraska Poison Control Center. Beginning in July, 2014, the contract management will be moved from the Bureau of Community and Environmental Health to the Bureau of Clinical and Preventive Services, under the Maternal and Child Health Program. This change in oversight is being driven by the retirement of staff and re-alignment of contract content area. //2015//

/2015/ Funds used for state match during federal fiscal year 2013 (FFY13) are from the State Vaccine Assessment fund ($2,195,146). No state general funds are used to support the MCH program activities. //2015//

/2015/ The expenditures in FFY13 that were directed to Pregnant Women included 25% of the MCH administrative budget ($45,728), 100% of the Perinatal funds for the PRATS survey ($42,461), 40% of MCH STD budget ($3,864), 25% of the Office of Epidemiology ($59,835), 20% of Reproductive Health ($124,340) and 25% for the Idaho Careline ($12,321). //2015//

/2015/ Funds used in FFY13 for infants < 1 Year Old included 25% of the MCH administrative budget ($45,728), 25% of the Office of Epidemiology ($59,835), 25% of the Idaho Careline ($12,321) and 50% of the state immunization vaccine assessment match ($1,097,573). //2015//

/2015/ Funds used in FFY13 for Children 1 to 22 Years Old included 25% of the MCH administrative budget ($45,728), 100% of Oral Health budget ($388,975), 30% of the MCH STD budget ($2,897), 50% of the Office of Epidemiology ($59,835), 25% of the Idaho Careline ($12,321), 40% of Reproductive Health ($248,680), 100% of Injury Prevention ($279,239) and 50% of the state immunization vaccine assessment match ($1,097,573). //2015//

/2015/ Expenditures for Children with Special Health Care Needs in FFY13 included 25% of the MCH administrative budget ($45,727), 25% of the Office of Epidemiology ($59,833), 100% of Genetics ($81,658), 25% of the Idaho Careline ($12,322), and 100% of Children's Special Health Program ($850,487). //2015//

/2015/ Thirty percent (30%) of the MCH funds were spent in the 'Other' category, which

primarily includes women of reproductive age who are older than 22 years as well as males. for MCH STD ($2,897) and 40% for Reproductive Health ($248,681). Additionally, funds were spent for the Electronic Birth Certificate project ($15,224) and for Administrative indirect costs ($165,923). //2015//

/2015/ FFY13 expenditures by service category are as follows: Direct Health Care Services accounted for 90% of the genetics program budget ($73,492), 100% of the Reproductive Health budget ($621,701) and 100% of the Children's Special Health program budget ($850,487).

The two programs included under Enabling Services were the Idaho Careline ($49,285) and MCH STD program ($966).

Programs included in Population Based Services category were 100% of the Oral Health program ($388,975), 90% of the MCH STD program budget ($8,692), 100% of the Injury Prevention program ($279,239) an d100% of the childhood immunization program (match $2,195,146).

Programs included under Infrastructure Building Services included 100% of MCH Administration ($182,911), 100% of Perinatal (PRATS survey-$42,461), 100% of the Electronic Birth Certificate project ($15,224) 100% of Office of Epidemiology ($239,338), 10% of Genetics $8,166), and 100% of the Indirect costs ($165,923). //2015//

/2015/ Total reported MCH expenditures for Idaho during FFY13 are $5,122,006. //2015//

B. Budget

/2015/ In order to meet the match requirement, the state will be utilizing $2,412,699 in state funds from the State Vaccine Assessment.

The priority areas identified for Idaho are children with special health care needs, reproductive health for young women, oral health of children, injury prevention, epidemiology services, pregnancy risk assessment data collection, patient-centered medical home demonstration project (year 2) for children with special health care needs and the Title V MCH needs assessment. These programs/projects account for the majority of block grant funds expenditures. Funding for the Maternal and Child Health Program, which Children and Youth with Special Health Care Needs (CYSHCN) falls under, and medical home demonstration project account for the majority of funds used to meet 30% minimum required for CYSHCN. In FFY13, CYSHCN and medical home project accounted for 34.4 % of the block grant funds. Preventive and Primary Care for Children accounted for 44.7% of block grant funds; the largest amount of funds directed toward Oral Health, Reproductive Health, and Injury Prevention. The total amount of block grant funds for Maternal and Infant Services was 15% and approximately 5.9% of funds for indirect costs.

MCH funds will again be used to fund a full-time research analyst dedicated to MCH programs and a full-time position who oversees the collection and analysis of the Pregnancy Risk Assessment Tracking Survey (PRATS). These positions, while housed in the Bureau of Vital Records and Health Statistics, are dedicated to MCH programming. Within MCH CSHP, there is planned funding to support a Quality Assurance and Improvement position. //2015//

/2014/ To meet the match requirement, the state will be utilizing $2,402,535 in state funds from the State Vaccine Assessment.

The priority areas identified for Idaho are children with special health care needs, reproductive health for young women, oral health of children, injury prevention, epidemiology services,

pregnancy risk assessment data, infrastructure for electronic birth records and breast and cervical cancer screening data system enhancement and medical home services model for children with special health care needs. These programs/projects account for the majority of block grant funds expenditures. Funding for the Maternal and Child Health Program, which Children with Special Health Care Needs (CSHCN) falls under, and medical home project account for the majority of funds used to meet 30% minimum required for CSHCN. CSHCN and medical home project account for 36% of the block grant funds (based on $1,164,248 for CSHCN divided by requested block grant amount of $3,203,380). The programs under Preventive and Primary Care for Children that receive the largest amount of funds include Oral Health, Reproductive Health, and Injury Prevention.

MCH funds will again be used to fund a full-time research analyst dedicated to MCH programs and a full-time position who oversees the collection and analysis of the Pregnancy Risk Assessment Tracking Survey (PRATS). These positions, while housed in the Bureau of Vital Records and Health Statistics, are dedicated to MCH programming.

With diminishing federal funds and no state general funds supporting MCH programming, MCH funds used for "special projects" has been selective and must support the MCH priorities. For FFY14, three identified projects are planned and will be infrastructure-building in nature. These are the 1) PRATS position and survey collection and analysis, 2) electronic birth record project which will allow medical providers in the state to submit birth records to the state vital statistics bureau in an electronic format and 3) breast and cervical cancer screening data system enhancement.

/2015/ MCH Block grant funds were not used to support breast and cervical cancer screening data system enhancement, as planned. Upon further analysis of the breast and cervical data system, it was determined that priority be given to stabilization of the current system and exploration occur of moving the antiquated system onto a CDC-supported CaST data system. The data system has been stabilized and IT is exploring what is involved in moving to a CaST system. MCH funds were used to support the electronic birth record project enhancement. Anticipated completion of this project is September, 2014. In 2015, the planned infrastructure-building support will come from 1) PRATS position and survey collection and analysis and 2) MCH CSHP Quality Assurance and Improvement position. //2015//

MCH funds continue to support the Injury Prevention program. The majority of funds expended in this area support the poison control center which serves our very rural state.

/2015/ The MCH block grant provides support for the Idaho Poison Control hotline via a contract with Nebraska Poison Control Center. Beginning in July, 2014, the contract management will be moved from the Bureau of Community and Environmental Health to the Bureau of Clinical and Preventive Services, under the Maternal and Child Health Program. This change in oversight is being driven by the retirement of staff and re-alignment of contract content area. //2015//

Idaho's MCH Program (CSHCN) has improved efficiencies and effective service delivery for CSHCN. In April 2013, the MCH Program contracted with St. Luke's Children's Hospital for the operation of metabolic clinics and care coordination for CSHCN. The MCH Program has a separate contract to continue to ensure services for this population is provided in other areas of the state, where St. Luke's Children's Hospital does not operate. This has proven to be a very successful change and has resulted in improved customer service to our families. While the majority of the metabolics clinics are conducted at the Children's Hospital in Boise, the two physicians that support these clinics do travel and hold clinics throughout the state. //2014//

During the 2010 state legislative session a vaccine assessment fund was created to provide funding to maintain Idaho's status as a universal vaccine provision state. In state fiscal year

2011, the Division of Public Health used approximately $6,400,000 from the fund to provide childhood vaccines at no cost to all Idaho children. While this assessment fund helps ensure the health of Idaho children, the money cannot be used for any purpose other than the purchase of childhood vaccines.

/2014/ In state fiscal year 2012, the expenditure from the fund was approximately $13,618,979. During state fiscal year 2012, changes to legislation allowed administrative costs to be charged to the immunization program for insured children in Idaho, as well as brought the list of vaccines required to be covered through the program into line with national recommendations. //2014//

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.