

# Maternal and Child Health Services Title V Block Grant

## Idaho

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### FY 2016 Application/ FY 2014 Annual Report

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## I. General Requirements

### I.A. Letter of Transmittal

### I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

### I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

### I.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 2015; expires December 31, 2017.

### I.E. Application/Annual Report Executive Summary

Based on the emergent needs from the five-year needs assessment, Idaho selected eight state MCH priorities for 2016 – 2020. Each of these priorities, noted below, serves as an overarching area of need for at least one of the six defined MCH population domains.

Prenatal Care: Increase percent of women accessing prenatal care (Women/Maternal Health) Data supports this area as a gap in service for women as Idaho's rate of annual well-woman visits is 14% lower than the national rate (2013 BRFSS data).

Perinatal Nutrition: Improve breastfeeding rates (Perinatal/Infant Health) Although national data indicate Idaho is faring better than the national averages for breastfeeding and safe sleep practice, the MCH team chose to identify these as priority areas in order to leverage the momentum behind current program activities and initiatives to continue to improve state rates.

Healthy Home Environments: Increase the number of families who practice safe and healthy parenting behaviors (Perinatal/Infant Health) As part of the Infant Mortality CoIIN work, Idaho is addressing safe sleep practices through increasing child care and health provider education.

Childhood Healthy Weight: Decrease the prevalence of childhood overweight and obesity (Child Health) Idaho

Children's Physical Activity and Nutrition: Increase the percentage of children who are overweight or obese (Child Health) Idaho children get slightly less daily physical activity on average than those nationally and are faring slightly better for the percentage of children who are overweight or obese than those nationally (National Survey of Children's Health, 2011/12). The MCH program plans to collaborate with the Idaho Physical and Nutrition program to increase state activities focused on helping children achieve a healthy weight.

Childhood Immunizations: Improve childhood immunization rates (Child Health) Although the percentage of Idaho children being current on key vaccinations has increased by 18% since 2008, Idaho still lags behind the national average. The MCH program will be supporting the work of the Idaho Immunization program to provide education to the public and health care providers about the importance of immunizations, addressing immunization hesitancy, and best practices to increase immunization rates.

Access to Medical Specialists: Improve access to medical specialists for children and youth with special health care needs (CYSHCN) According to the 09/10 NS-CSHCN, Idaho mirrors the national rate of CYSHCN who receive coordinated, ongoing, comprehensive care within a medical home at about 43%. Idaho plans to continue to provide financial support for pediatric specialty clinics and will partner with local public health districts and hospitals to identify specialist needs and recruit specialists. Idaho's work through the SHIP model testing grant will also help increase the number of CSHCN who are linked to a medical home.

Substance Abuse: Decrease substance abuse among maternal and child health populations (Cross-Cutting/Life Course) "NPM 14: Smoking" aligns with the state's priority need to decrease substance abuse among MCH populations. As part of the Infant Mortality CoIIN work, Idaho is addressing smoking cessation for pregnant women and women of reproductive age. This priority also aligns with the priorities to be addressed by Idaho's SHIP model testing grant and the Idaho Division of Public Health's "Get Healthy Idaho" plan.

Medical Home Access: Improve maternal and child health population access to medical homes (Cross-Cutting/Life Course) "NPM 13: Oral Health" aligns with the state's priority need to improve MCH population access to medical homes. The MCH program plans to partner with primary care providers to develop education messages for women and children about the importance of oral health care and link them to a dental medical home.

Following is a description of specific MCH accomplishments and challenges. The information is broken out by the three legislatively defined areas and associated population health domains.

#### Preventive and Primary Care services for pregnant women, mothers and infants:

To support the on-going efforts of the Title X Family Planning program in Idaho, FFY14 MCH block grant funds were used. Funding was provided directly to local public health agencies to assist women of reproductive age. Services included a broad range of family planning methods, services for adolescents, access to effective contraception and counseling, education and outreach. This directly impacts the Women/Maternal Health population domain, along with Child Health-adolescents.

MCH block grant funds support the Pregnancy Risk Assessment Tracking System (PRATS) survey which is Idaho's equivalent to PRAMS. This is an annual survey of new mothers regarding maternal experiences and health behaviors surrounding pregnancy. PRATS provides information on a variety of perinatal health topics, including unintended pregnancy, prenatal care, substance use, breastfeeding patterns, postpartum depression and immunizations.

MCH Block grant funds helped support the Sexually Transmitted Disease (STD) program which enabled local providers to screen, treat and prescribe appropriate medications for the public seeking STD services. These services included the population of pregnant women and mothers.

The formation of the Idaho CoIIN team and associated activities belongs with the MCH CYSHCN Director and

the MCH Director who both reside within the Bureau of Clinical and Preventives Services in the Division of Public Health. Idaho selected Tobacco Cessation and Safe Sleep as the two strategies to focus efforts toward reducing infant mortality and morbidity. Idaho identified pilot site(s) to collect data that will inform the selected strategies.

FFY14 block grant funds helped support the Idaho Bureau of Epidemiology in multiple population domains by providing funding for contracts with the Idaho Public Health Departments (PHDs), as well as staff support. Specifically, funds were used in support of the Women/Maternal Health and Perinatal/Infant Health population domains by helping to fund Epidemiology's efforts to inform and educate the public regarding the outbreaks of multiple viruses and bacteria in 2014, including an outbreak of pertussis in southwest and central Idaho.

MCH block grant dollars were used to support the public health services and systems that serve the infant population through an enhanced data system update that allows medical providers to send birth records electronically to the Bureau of Vital Records and Health Statistics.

Another area of significant support to the infant and women/maternal populations occurred when block grant dollars were provided to the Idaho WIC Program to facilitate completion of a peer counseling platform in the WIC information system. The system now has a dedicated place for peer counselor to enter notes and refer on for more intensive breastfeeding support from a registered dietitian or the local breastfeeding coordinator.

#### Preventive and Primary Care services for children:

FFY14 block grant funds helped support the Idaho Bureau of Epidemiology in multiple population domains by providing funding for contracts with the Idaho Public Health Departments (PHDs), as well as staff support. Specifically, funds were used in support of the Child Health and Adolescent Health population domains by helping to fund Epidemiology's efforts to inform and educate the public regarding the outbreaks of multiple viruses and bacteria in 2014. These included the Enterovirus D68 state-wide outbreak that affected mostly children, an outbreak of pertussis in southwest and central Idaho, the measles outbreak associated with Disneyland, a mumps outbreak in schools located in northern, central, and eastern Idaho. Epidemiology's infection control education of professionals within the healthcare community was also partially funded through MCH grant funds.

The Idaho Oral Health Program (IOHP), during the prior year, was assigned an "A" grade for protecting children from tooth decay with the application of dental sealants by the PEW Charitable Trusts. Idaho was one of only five states to receive this distinguished grade. All seven Public Health Districts (PHDs) in Idaho provide dental sealants to elementary school children through School-Based/Linked Dental Sealant Clinics and Give Kids a Smile Day, two events focusing on the education and application of dental sealants. Along with providing dental sealants, the PHDs also provided oral health screenings or assessments, fluoride varnish applications, oral health education, and facilitated dental home referrals as needed.

The Idaho WIC Program participated in the 2014 Idaho Hunger Summit, the Idaho Hunger Relief Task Force, and a statewide Childhood Hunger Coalition. The Idaho WIC Program also participated in Healthy Eating Active Living (HEAL), which has a purpose of developing and maintaining an active engaged network of partners working together, investing resources and expertise to create/support an active living, healthy eating population in Idaho towards reducing/preventing childhood obesity. WIC is also assisting in piloting a Screen and Intervene Project as a targeted intervention for families with children who are food insecure.

In July 2014, contract with the Nebraska Regional Poison Center for the Poison Prevention hotline was moved under the MCH Program area. 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 2014, the Nebraska Regional Poison Center received over 15,000 calls from Idaho residents; the majority of these calls were received from parents of children age 5 years and younger.

...continue, the majority of these cases were reported from patients or children age 5 years and younger.

With the support of the MCH Block grant funds, the Idaho STD Program was able to increase services to screen, test, treat and prescribe medications around STD's. In addition, monies were used to support outreach and education services, specifically to address teen sexuality and inform about STD' and prevention.

#### Services for CYSHCN:

The Idaho patient-centered medical home demonstration project for CYSHCN is mid-way through year two of two. In 2013, the Title V MCH Program, Division of Medicaid Children's Healthcare Improvement Collaborative (CHIC Project), Eastern Idaho Public Health District and Southeastern Idaho Public Health District partnered to address persistent health disparities among CYSHCN residing in rural Idaho communities. The goal of the collaboration was to introduce a patient-centered medical home 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. The project is evaluating the model of a shared medical home coordinator as an effective method to engage rural practices in comprehensive care coordination.

The Idaho Maternal and Child Health Program utilized FFY14 block grant funds in the purchase and dissemination of transition kits for CYSHCN. Issues like health insurance, finding a doctor who takes care of adults, choosing a work or school setting, transportation and housing present new and sometimes overwhelming challenges and are covered in an interactive and step-by-step approach in the transition kits by providing information and guidance about gaining healthcare independence. On average, the Idaho MCH Program releases around 1,250 kits annually to interested individuals and entities.

The Idaho Newborn Screening (NBS) Program will add Severe Combined Immunodeficiency (SCID) to the panel of conditions screened in November 2015. The Idaho NBS Program also instituted a courier service through UPS, which is free to all birthing centers, that has reduced specimen transit times from three-four days to an average of one day. This courier service has not only reduced transit times, which ensures specimens are handled and processed as quickly as possible, but it has also reduced errors in screening, including lost to follow up claims.

#### MCH Challenges:

Despite the noted success of the patient-centered medical home project for CYSHCN in rural Idaho, the MCH program is faced with the challenge of whether or not to continue the project. The original intent of the project was to expand to additional local public health districts across Idaho. Since the Children's Healthcare Improvement Collaborative (CHIC) funding ends February, 2016, the medical home coordinator 'coach' and 'project manager' positions tied to that funding will no longer exist. The challenge for the MCH program is not so much the funding source to continue these positions, but rather the authority to hire the positions. In Idaho, the Full Time Equivalent (FTE) authority for the Department of Health and Welfare resides with the Idaho Legislature. This means that the department/division/programs are not authorized to add positions, even if there is an identified funding stream, unless FTE's are allocated.

There is no question of the importance of CoIIN, yet there have been some challenges for MCH in taking on this initiative. The staff capacity to implement CoIIN strategies in large part fell on already very full workloads of the department team members. The timelines for CoIIN are aggressive and have not allowed for as much planning as would be desired. Further, funding for CoIIN activities largely fell on the MCH block grant. Because the CoIIN initiative expansion was not known when the prior grant application was due, funding allocation did not account for CoIIN and this has created some challenge in identifying funding source within the block grant.

Family involvement remains a challenge for Idaho. The MCH Program does not have an open FTE to hire a family member and a historic effort to engage families has not been successful. In order to further this effort, the CYSHCN Director is a member of the Idaho Parents Unlimited which is comprised of families and is a platform for sharing concerns for CYSHCN. In addition, the MCH Director is part of the Governor appointed Early Childhood Coordinating Council that has parent representatives on the council. As noted in our Needs Assessment Summary and successes, Idaho engaged families of CYSHCN in the Capacity Assessment meeting and identification of priority MCH National Performance Measures.

In Idaho, there is strong support for the maternal and child health population, in terms of collaboration and referrals to existing programs and resources. No state funds are provided for specific maternal and child health programming, thus the block grant, WIC, MIECHV and various other grants remain the primary source of funding for MCH needs.

## II. Components of the Application/Annual Report

### II.A. Overview of the State

#### **Background Overview-Idaho**

Idaho is a large western state with impressive mountain ranges, large areas of high desert and massive expanses of forested terrain. Idaho contains the second largest wilderness area in the lower 48 states, the Frank Church – River of No Return Wilderness, which covers almost 2.4 million acres. Geography and distance impact both the demographic characteristics and social determinants of health within Idaho. Idaho is ranked 39<sup>th</sup> of the 50 United States for total population and 14<sup>th</sup> for geographic size. The 2013 estimated population for Idaho was 1,612,136 and because of its large size and relatively small population, Idaho remains one of the most rural states in the nation. With approximately 19.0 people per square mile Idaho ranks 44<sup>th</sup> of the 50 states in population density. The national average population density is 87.4 people per square mile, a four-fold greater density than Idaho. Thirty four of Idaho's 44 counties are rural with 19 of these considered frontier, having fewer than six people per square mile.

Idaho has seven population centers throughout the state with approximately 66 percent of the population residing in one of these populated areas. Delivering adequate health services to the entire state remains a challenge in this very rural environment.

The racial groups that comprised Idaho's population in 2013 were: (a) white, 93.7 percent; (b) black, 0.8 percent; (c) American Indian/Alaska Native, 1.7 percent; and (d) Asian or Pacific Islander, 1.4 percent. It is estimated that 2.2 percent of Idahoans identify as being of two or more races. Persons of Hispanic or Latino origin comprised 11.8 percent of Idaho's total population (US Census Bureau). Idaho is home to six federally recognized tribes: Coeur d'Alene Tribe, Kootenai Tribe of Idaho, Nez Perce Tribe, Shoshone-Bannock Tribes, the Northwestern Band of the Shoshone Nation, and the Shoshone-Paiute Tribe. Idaho also has two refugee centers, one located in Ada County in southwest Idaho and one located in Twin Falls County in south central Idaho.

According to the 2013 American Community Survey: Five Year Profile Tables, 15.5 percent of Idahoans were living below the poverty level; placing Idaho 22<sup>nd</sup> out of the 51 states and District of Columbia.

The most recent economic recession significantly impacted small business in Idaho, in addition to some of the major industries including construction and logging. Unemployment rose steadily and rapidly from 2.7 percent of the labor force being unemployed (seasonally adjusted) in 2007 to a high of 8.8 percent in 2010. In recent years, Idaho's economy has stabilized with an unemployment rate of 3.6 percent in December of 2014. Idaho's per capita income in 2013 was \$36,146. Idaho is an important agricultural state, producing nearly one-third of the potatoes grown in the United States. Wheat, sugar beets, and alfalfa hay are also major crops. Other industries contributing to Idaho's economy include information technology, mining, lumber, tourism and manufacturing.

The most recent national data indicate that the percentage of Idahoans over the age of 25 who have graduated from high school is higher than the national average (88.8 percent and 86.0 percent, respectively). However, college attendance rates are among the nations lowest with fewer than 52 percent of Idaho's 2013 high school graduates enrolled in a two- or four-year college (National Student Clearinghouse). A quarter (25.1 percent) of Idahoans over the age of 25 holds a bachelor's degree or higher, compared with the national average of 28.8 percent.

To facilitate the availability of public health services, contiguous counties in Idaho have been aggregated into seven public health districts (Attachment I-Map 7 PH Districts). These seven areas are defined by geographic barriers as well as transportation routes and population centers. As reflected in the priorities, access to health care and other services have been identified as barriers to improving health outcomes for Idaho residents.

Idaho does not have a private or public medical or osteopathic school within the state for the training and development of physicians. In 2014, 100 percent of Idaho was a federally-designated mental health professional shortage area, 96.4 percent of Idaho was a federally-designated shortage area in primary care, and 97.0 percent of Idaho was designated a dental health professional shortage area. Idaho had 70 primary care physicians per 100,000 population in 2012, ranking 49<sup>th</sup> of 50 states (Idaho Department of Health and Welfare, Division of Public Health, Bureau of Rural Health and Primary Care). (See Maps at end of narrative)

In 2014, the Idaho Hospital Association membership directory reported 48 member hospitals (this includes one in Ontario, Oregon and one in Clarkston, Washington). Twenty-seven of these hospitals are critical access hospitals, owning fifty-five clinics. These clinics include primary care and specialty services and may be co-located with the hospital as well as remote clinics.

Idaho Medicaid enrollment averaged 252,598 participants per month in State Fiscal Year (SFY) 2014 (July-June), an increase of 5.5 percent from 2013. The rate of growth continues to decline compared to the Medicaid growth experienced during the peak of the recession and is now more closely approaching a growth pattern for a normal economy. The enrollment increase in SFY2014 can be attributed primarily to the Affordable Care Act (ACA) requiring people to have insurance coverage. Once past the ACA enrollment period, Idaho expects to return to a 2 to 3 percent enrollment growth rate (Facts, Figures and Trends 2014-2015, Idaho Department of Health and Welfare). In 2014 the Idaho Legislature did not authorize the state to expand Medicaid. In 2015, the governor-appointed workgroup developed options for expansion to share with legislators. During the 2015 legislative session other competing priorities arose which did not allow for the continued discussion of whether or not to expand Medicaid. As a result, it is estimated that Idaho has approximately 78,000 persons who fall in the coverage 'gap'. In essence, those individuals do not qualify for Medicaid coverage or for subsidized private insurance. Of those in the coverage gap, many access care through hospital emergency rooms, county indigent services and the state Catastrophic Fund and charity. For those that do get health insurance, many have very high deductibles.

In 2014, the Idaho Legislature approved and funded a plan to develop a statewide Time Sensitive Emergency (TSE) system of care that will include three of the top five causes of death in Idaho: trauma, stroke and heart attack. A TSE system of evidence-based care addresses public education and prevention, 911 access, response coordination, pre-

system of services based on patient needs from prevention and promotion, self care, response coordination, pre-hospital response, transport, hospital emergency/acute care, rehabilitation and quality improvement. A TSE program creates a seamless transition between each level of care and integrates existing community resources to improve patient outcomes and costs. The Bureau Chief for Emergency Medical Services and Preparedness is actively participating in this effort as the Division of Public Health Representative on the governor-appointed council.

In November of 2014, YourHealthIdaho began operating as Idaho's fully state-based health insurance marketplace. For the 2015 coverage year, eligibility and enrollment was conducted by YourHealthIdaho and the Idaho Department of Health and Welfare (the state Medicaid/CHIP agency). For the 2014 coverage year, Idaho was third in the nation per capita for the number of residents who selected health insurance plans just behind Vermont and Florida (State of Idaho, Your Health Idaho). At the close of the second enrollment period that ended February, 2015, Idaho had more than 85,128 individuals enrolled in health insurance plans through YourHealthIdaho. Idaho ranked fourth in the nation, per capita, for the number of residents who selected health insurance plans offered on the exchange. Florida, Maine and Georgia were ahead of Idaho.

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 health care 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 health care system participants throughout the state (health care professionals, other service providers, and consumers). At least 56 focus groups and five 'Town hall' meetings were held across the state. Idaho applied for the Model Testing grant proposal (MTP). [Source: State of Idaho Website]

In December, 2014 Idaho was awarded \$39,683,813 dollars to implement the SHIP strategies over a four-year model test period that began February, 2015 (Attachment A-SHIP Award). The SHIP indicators identified as focus areas of work are Tobacco Cessation, Obesity, and Diabetes.

In April 2014, the Division of Public Health leadership developed a strategic map that illustrates its commitment to advancing Public Health's influence in the changing health system in Idaho (Attachment B-Strategic Map). In November 2014, the Division of Public Health hosted the Idaho Health Assessment Statewide Partner Meeting. Partners were presented with fourteen top health issues that arose during initial data compilation. Partners selected priority issues utilizing a nominal group technique that reduced the list down to six issues and subsequently ranked those six issues. Those six top public health issues in priority order are:

- Health care Access
- Obesity
- Heart Disease and Stroke
- Vaccine Preventable Diseases
- Exercise
- Suicide

The work that Idaho will be doing over the next four years to improve health care, improve the health of the population, and reduce health care costs will build upon strengths, fill gaps, and implement innovative change.

Moving forward, it is anticipated that Get Healthy Idaho will serve as the foundation to satisfy both requirements for Public Health Accreditation as well as the model test grant. Internally, the process of reviewing data and improvement planning around the identified priorities will become a central focus of public health business. It will also become part of strategic planning discussed quarterly within the Division of Public Health and throughout the Department of Health and Welfare.

The partner base of this initiative will grow to include the Population Health Work Group of the Idaho Healthcare Coalition, charged with leading the implementation of the state innovation model testing grant. The Idaho Healthcare Coalition consists of representatives from the Idaho Health Care Council, the Idaho Medical Home Collaborative, others from the health care community, private and public health insurers, public health, behavioral health, the Idaho Hospital Association, the Idaho Medical Association, policy makers, and consumers.

The priorities from SHIP align with the Leading Health Indicators for Idaho (see Attachment C-Idaho Leading Health Indicators), the Get Healthy Idaho priorities identified through the Public Health Accreditation process, Idaho Infant Mortality Collaborative Improvement and Innovation Network (CoIIN) strategies for Idaho, as well as, the MCH Needs Assessment outcome priorities. The MCH Director and CYSHCN Director represent the public health team at various partner meetings, in addition to those noted above. Both the MCH Director and CYSHCN Director are part of a workgroup that is looking at the role of the Community Health Worker in Idaho. In March 2015, the Division of Public Health hosted the Idaho Community Health Worker Committee Planning Team Meeting. The meeting convened partners from across the state to review definitions and models of community health worker (CHW) programs, social determinants of health and benefits, challenges, etc. Following this meeting, a survey of health care providers who use a CHW or someone in that capacity took place in May 2015 and a second survey of community based organizations occurred in June 2015.

The Division of Public health is working toward Public Health Accreditation to further support the national public health accreditation program goal of improving and protecting the health of the public by advancing the quality and performance of state, local, territorial and tribal health departments. In August 2014, the Division of Public Health completed the pre-application checklist with the goal to submit the formal application in July 2015. The MCH Director is co-leading the PHAB team 2 which is over domains 1, 5 and 9. Domain 1 is to conduct and disseminate assessments focused on population health status and public health issues facing the community, domain 5 is develop public health policies, and domain 9 is evaluate and continuously improve health department processes, programs, and interventions.

As noted in the Executive Summary of MCH priorities, both the MCH Director and the CYSHCN Director are leading the CoIIN team. The identified CoIIN strategies are tobacco cessation for women of reproductive age and safe sleep. Currently, Idaho has pilot activities underway to address the two strategies. In an effort to increase referrals to tobacco cessation programs and /or nicotine replacement therapies, a pilot of two health care provider clinics is assessing impact of electronic referrals vs. the paper fax method that has historically been in place. It is assumed that ease of referral using the electronic method will yield increased referrals to cessation services. To address safe sleep, Idaho has a pilot occurring with child care providers in the northern part of the state. Forty-five child care providers have been trained on giving safe sleep messages by the Inland Northwest SID organization representative on the CoIIN team. A pre-post-test of safe sleep practices and messages was conducted using information from Dr. Goodstein with the American Academy of Pediatrics Task Force. In addition, a small group of nursing students were given the same pre-post-test on safe sleep practices and messages. The Idaho Pregnancy Risk

Assessment Tracking System (PRATS) which is similar to PRAMS in other states is gearing up for its annual survey of new mothers regarding maternal experiences and health behaviors surrounding pregnancy. The survey provides information on a variety of perinatal health topics, including unintended pregnancy, prenatal care, substance use, breastfeeding patterns, postpartum depression, and immunizations. As part of the incentive to complete the survey, respondents are being provided a board book, "Sleep Baby, Safe and Snug".

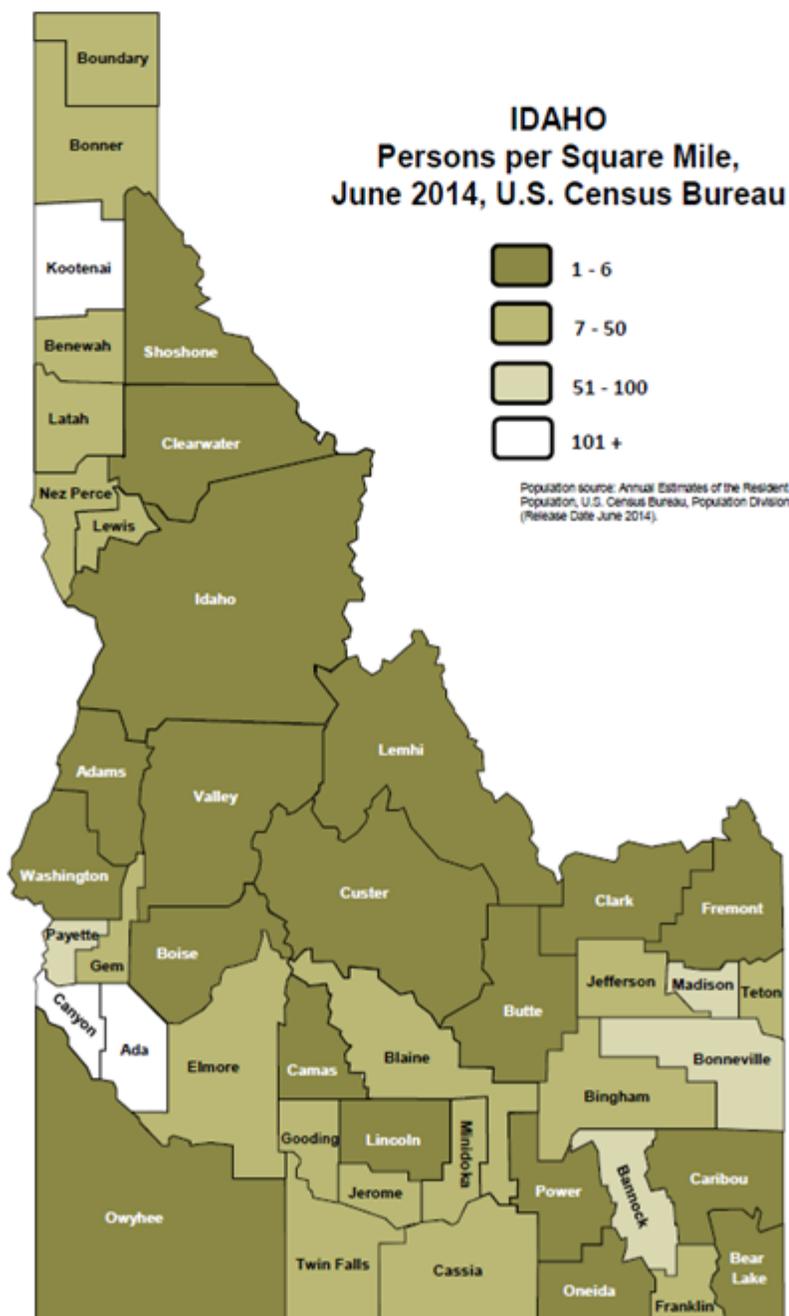
In February 2015, the Division of Public Health participated in a conference call with the Catalyst Center in cooperation with the Office of Assistant Secretary for Planning and Evaluation to assess early impact of the Affordable Care Act (ACA) in Idaho on the Title V MCH and Title X Family Planning programs. HIV Care was also a participant. The CYSHCN Director and MCH Director, along with the Deputy Division Administrator for Public Health responded to a variety of questions about program activities aimed at helping the MCH population with emphasis on the CYSHCN and women of reproductive age, and ACA. Following the initial call, a virtual site visit was held on April 27, 2015 with the Catalyst Center/National Opinion Research Center (NORC) staff to expand on content provided by Idaho. At this writing, a final report is pending summarizing the results from the eight participating states.

The State agency has strengthened coordination in many ways that benefits the Maternal and Child Health programs. The Division of Public Health created a Collaborative Bureau Integration Team (CBIT) in 2014 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 Idaho Child Death Review Team (CDRT) was formed by the Governor's Task Force for Children at Risk, under Executive Order 2012-2013 to review deaths to children under the age of 18 using a comprehensive and multidisciplinary process. The Division of Public Health Medical Advisor is a member of this team. She informs the MCH program of findings for program activity prioritization and general awareness of review determinations. The team utilizes information gathered by coroners, law enforcement, medical personnel and state government agencies in their reviews. The first report of findings (2011) was issued in April 2014. There were 195 child deaths in Idaho in 2011. Of those deaths, the team conducted 82 full reviews after screening each death cause. Sudden Infant Death Syndrome (SIDS) or Sudden Unexplained Infant Death (SUID) was the recorded death for 14 infants. There were 18 Motor Vehicle deaths in Idaho. The majority of motor vehicle deaths were due to accidents involving a teen driver. There were 8 accidental drowning deaths in 2011. Most of the victims were children under the age of 5 years and occurred in open water. The team reviewed 6 homicide deaths to children. Of those, one-half died by abusive head trauma and one-half by firearm shooting. Most of these children lived in families with a history of domestic violence. There were 14 suicides occurring in Idaho in 2011. Thirteen of these were to males. All were to teens. Firearms were the most common mechanism of injury. Idaho's child suicide rate is higher than the national average. One response to this was the creation of the Idaho Suicide Hotline in 2013. In 2015, Idaho expanded hotline coverage to 24/7 phone response.

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. Disney-Spencer, who was the former Title V MCH Director prior to her promotion into her current position. IHAWCC aims to

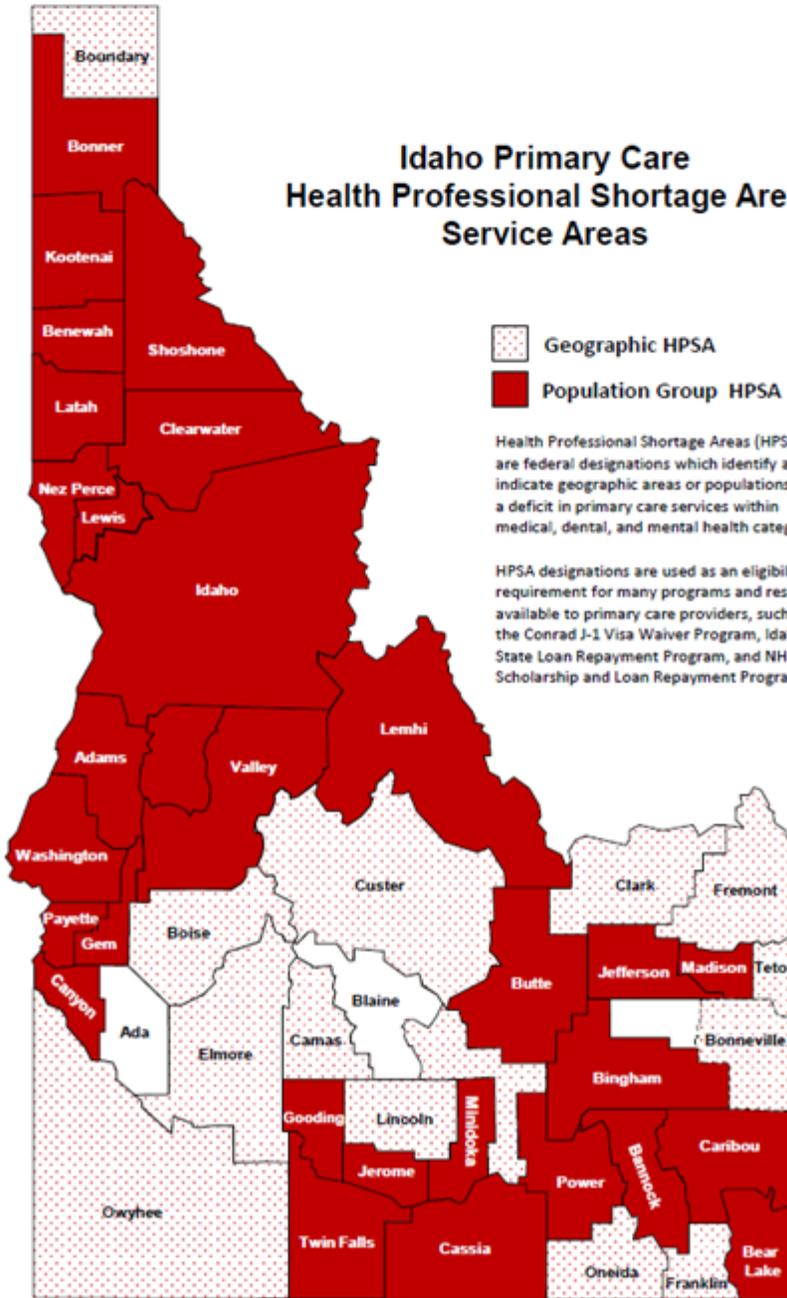
who was the former Title V MCH Director prior to her promotion into her current position. IHAWCC aims to create a meaningful, long term collaboration of stakeholders invested in child health care quality, with the common purpose of improving the health of the children and youth of Idaho. IHAWCC works 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.



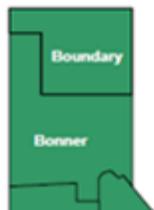
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## Idaho Primary Care Health Professional Shortage Area Service Areas

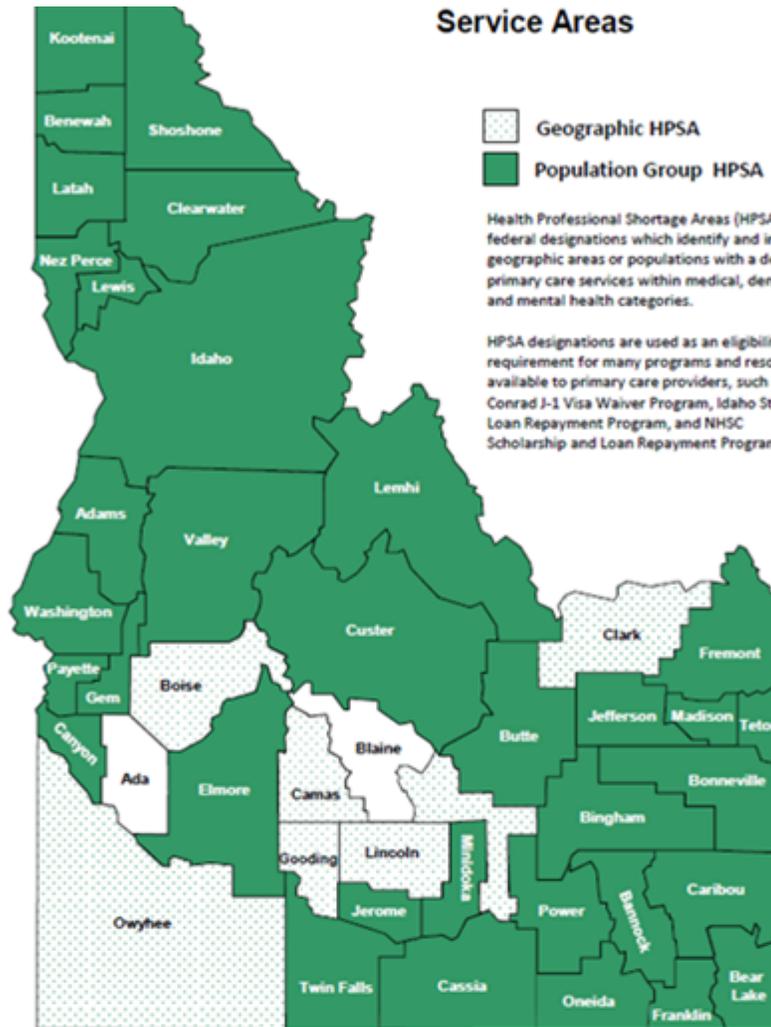


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## Idaho Dental Health Professional Shortage Area

## Service Areas



-  Geographic HPSA
-  Population Group HPSA

Health Professional Shortage Areas (HPSAs) are federal designations which identify and indicate geographic areas or populations with a deficit in primary care services within medical, dental, and mental health categories.

HPSA designations are used as an eligibility requirement for many programs and resources available to primary care providers, such as the Conrad J-1 Visa Waiver Program, Idaho State Loan Repayment Program, and NHSC Scholarship and Loan Repayment Programs.



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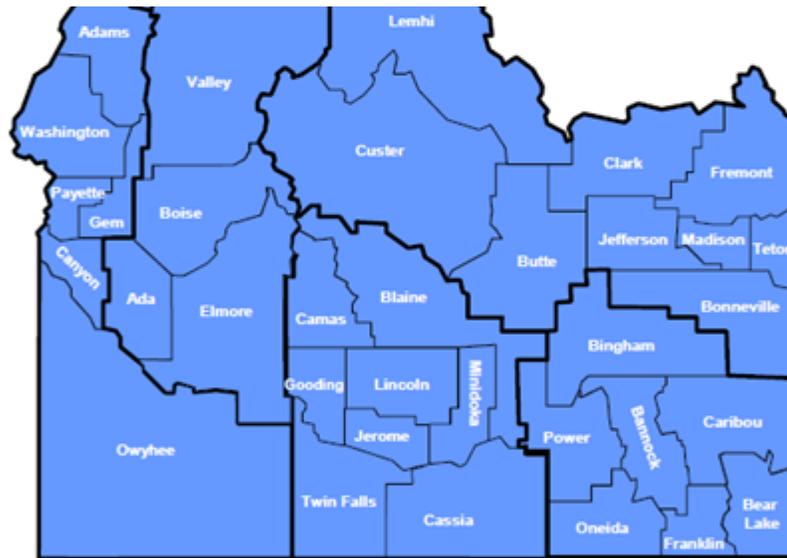
## Idaho Mental Health Professional Shortage Area Service Areas



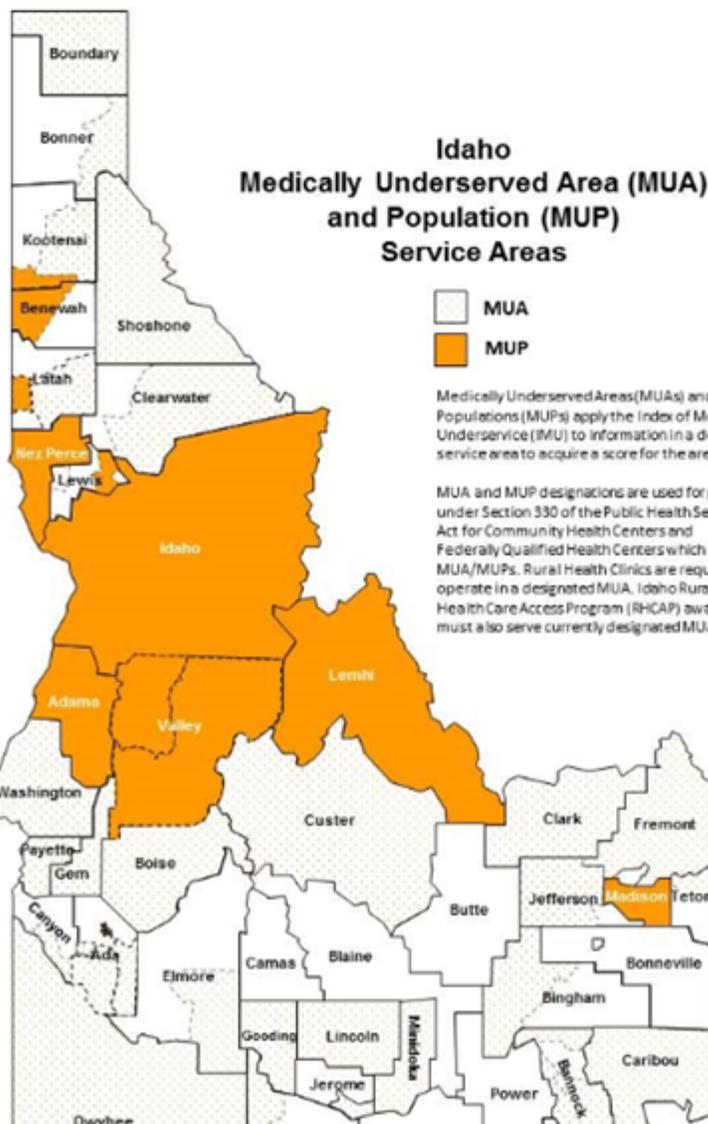
-  Geographic HPSA

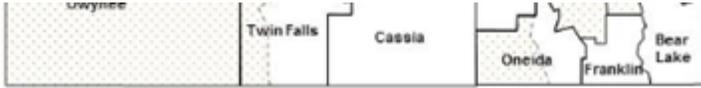
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## II.B. Five Year Needs Assessment Summary

### II.B.1. Process

#### Idaho Title V Five-Year Comprehensive Needs Assessment Summary

##### 1. Process

The processes used in the Title V Five-Year Comprehensive Needs Assessment (FY-CNA) involved three phases. Phase 1 involved the collection and analysis of data through five methodologies. These included: 1) collection of secondary/archival data related to each of the six identified population health domains (PHDs); 2) a random survey of adults in all residential households in Idaho, stratified into urban, rural, and frontier regions; 3) a survey of adult consumers of MCH services, those who had children that received MCH services, or others associated with organizations that serve, represent, or advocate for MCH consumers, which was weighted heavily toward parents of children and youth with special health care needs (CYSHCNs); 4) a survey of primary care providers who serve members of the six PHDs; and 5) interviews of key stakeholders including public health district directors, tribal health department directors, and administrators of a variety of state, local, and non-profit organizations that serve or represent members of the six PHDs. Phase 2 involved the synthesis of themes identified during Phase 1 data collection, and ultimately in the distillation of these themes into common needs. These needs were shared with a broad base of MCH stakeholders at an all-day workshop (formally titled the 2015 Title V MCH Capacity Assessment and State Prioritization Meeting) at Boise State University (BSU), where the stakeholders voted on what they considered to be important MCH priorities in Idaho. Phase 3 involved Idaho Department of Health and Welfare (IDHW) MCH program and division leadership considering all data from Phases 1 and 2, in combination with current initiatives in the program, division, and department, to inform decisions about where there was alignment for final state priorities.

##### *Phase 1*

Each of the five Phase 1 methodologies is described in considerable detail in pages 10-15 of the McDonald, Reis, Siemon, Gazieva, and Lindsay (2015) report titled “A Multimodal Assessment of Stakeholder Perceptions of Maternal and Child Health Needs in Idaho,” which is included as Supporting Document #3. However, a more concise description of each methodology, all of which were performed by members of a BSU evaluation team, is provided below.

- *Secondary/archival data.* Some information related to the six PHDs in Idaho was available through existing reports and other data sources, including Idaho’s Pregnancy Risk Assessment Tracking System (PRATS), Behavioral Risk Factors Surveillance System (BRFSS), and the IDHW Bureau of Vital Statistics. Information gathered from these sources included data on well-woman visits, breastfeeding, low birth weight and preterm births, children with up-to-date vaccinations, child and adolescent abuse, neglect, and suicide, CYSHCNs’ health insurance and school attendance, among others.
- *General population (GP) survey.* Postcard invitations were sent to 3,000 randomly selected households throughout Idaho (stratified equally to 1,000 households each in urban, rural, and frontier counties), inviting adult residents to complete an online survey related to population health. The random sampling procedure was performed to ensure that every Idaho adult had a specified opportunity (i.e., defined probability) to participate in helping guide MCH services in the state. Responses were received from 102 household residents, for a response rate (adjusting for invalid addresses) of 3.4%. Questions on the survey (which was available in both the English and Spanish languages) asked about issues germane to each PHD, including perceptions of the most important issues for the following MCH population groups: pregnant women, infants and young children, and youth and teens; responses were both quantitative and qualitative, with open-ended responses being analyzed using a content analysis procedure. Crosscutting issues for all

with open-ended responses being analyzed using a content analysis procedure. Crosscutting issues for all PHDs were also explored.

- *Consumer survey.* Email invitations to complete a survey, including an embedded link to an online survey, were sent to directors or administrators of multiple organizations and agencies in state and local government, as well as in the non-profit sector. Each agency was one that provided services to MCH populations (e.g., public health agencies, WIC programs, MCH medical home coordinators, staff, and partners), or represented or advocated for MCH populations (e.g., Idaho Early Childhood Coordinating Council, Idaho Council on Developmental Disabilities, Idaho Hunger Relief Task Force, Idaho Parents Unlimited). Each director or administrator was invited to complete the survey (which again was made available in both English and Spanish), but more importantly was asked to send the invitation to all clients of MCH services (or their parents, if the clients were children) for whom they had an email address. A total of 265 individuals completed the survey (because it is not known how many people were sent an invitation, it was impossible to calculate a response rate). The distribution method was chosen because it seemed to maximize the potential to reach those who were eligible for MCH services either for themselves or their children. An effort to oversample parents of CYSHCNs was made (by specifically targeting organizations serving or representing/advocating for this PHD), and seems to have been successful; nearly 39% of the respondents identified themselves as parents of CYSHCNs. Many items on the survey were similar to those on the GP survey in asking questions about the most important issues and needs for many of the PHDs, however, a number of the items on the Consumer survey asked about issues specific to CYSHCNs, including items related to access to medical specialists and the types of specialists needed by the respondents' CYSHCNs; responses were both quantitative and qualitative, with open-ended responses being analyzed using a content analysis procedure. Crosscutting issues for all PHDs were also explored.
- *Providers survey.* IDHW, through its Bureau of Rural Health and Primary Care, annually conducts a telephone survey of all primary care physicians (PCPs) who practice in Idaho; the survey asks PCPs a number of questions related to their practice. Between early June and the end of September 2014, four questions were added to this survey; two of which asked about issues related to serving CYSHCNs and one each which asked about issues related to pediatric patients and adult women, including mothers. During the data collection period, 65 PCPs completed the survey; of these, 52 reported serving CYSHCNs. Responses were transcribed verbatim and then were coded for themes using a content analysis procedure.
- *Key informant/Stakeholders interviews.* An interview protocol was developed to elicit perceptions about the most important needs for preventive and primary care for most MCH populations, including pregnant women, mothers and infants, women of reproductive age, children under the age of five, children from 5-18 years of age, and CYSHCNs. Nineteen individuals, including public health department directors and staff (including women's health and WIC program coordinators), tribal health program staff members, and directors of non-governmental health and service agencies that provide services to MCH populations, completed an interview on issues important to those populations. Each interview, most of which were conducted by telephone and lasted approximately 30 minutes, followed a semi-structured protocol. Responses were transcribed as completely as possible and then coded for themes using a content analysis procedure.

## *Phase 2*

Several commonly reported needs for each MCH population were identified through triangulation of the five data collection methodologies in Phase 1. These common needs, now considered possible priorities for targeted MCH efforts, were broken out by MCH population group, and crosscutting needs. A diverse group of MCH stakeholders (consisting of government and public health district officials, directors of non-profit organizations, regional medical center administrators, and parents of CYSHCNs) were convened at a full-day workshop (the 2015 Title V MCH Capacity Assessment and State Prioritization Meeting) at Boise State University on May 4, 2015 to review the possible priorities, and then help make decisions about resources and capacity for addressing each priority. The ultimate goal of the workshop was to help guide Phase 3 decisions about the selection of final state priorities. Each workshop activity is described

below.

- An overview was provided on the history of Title V and its services, both nationally and in the State of Idaho
- A summary of the needs assessment activities in Phase 1 was presented, first covering the five methodologies, then the individual results by methodology, and then presenting the commonly identified needs/possible priorities by MCH population. Finally, crosscutting needs/possible priorities were identified
- Workshop attendees then divided themselves into small groups, each of which targeted one of the MCH populations; the attendees were invited to work on the population they believed they had the most expertise or interest in (for example, the parents of CYSHCNs chose to work in the CYSHCN group). Each group was tasked with determining the successes/strengths and gaps/limitations of resources for each need/possible priority, with a member of the evaluation team in each group taking detailed notes for later analysis. After conclusion of the 70-minute activity, the BSU evaluators created PowerPoint slides to present the results of each group's determinations, and a member of each group reported-out by adding additional detail and context from group discussion
- All attendees were then invited to participate in voting on state priority needs and national performance measures (NPMs), considering what they had learned about common needs/possible priorities and decisions they had made about the extent to which Idaho had the capacity to address them. State priority needs and NPMs were presented on PowerPoint slides and the 23 attendees voted anonymously on them, ranking their choices using an electronic audience response system ("clickers"). The results were tabulated and presented in aggregate form to the entire audience. The percentages reported under Findings represent the cumulative points assigned to each priority within a population health domain divided by the total possible number of points (e.g., women and infant health with seven priorities gave 28 points for each person to assign for a total of 644 points as the denominator)
- In closing remarks, all workshop attendees were thanked for their involvement and assured that their perspectives would help guide the determination of final state priorities

### *Phase 3*

Phase 3 involved a meeting between the MCH leadership team and Division of Public Health leadership to decide upon the final seven to 10 state priority needs. When narrowing down the priority needs, leadership started with the results from Phase 1 and Phase 2 of the prioritization process. Potential priorities were evaluated against the following criteria:

- Ability to make a measurable impact in the short- and long-term
- Feasibility of population-based approaches
- State and local capacity
- Incidence/prevalence
- Severity
- Cost of potential strategies
- Alignment with existing programs and initiatives

Alignment with National Performance Measures Leadership selected eight state priority needs, ensuring that needs of all the six MCH population domains were represented (Women/Maternal Health, Perinatal/Infant Health, Child Health, Adolescent Health, CYSHCN, and Cross-Cutting/Life Course). During the prioritization and selection process, these needs were phrased as broad, categorical areas. To align with the federal guidance, the leadership team re-stated the needs as simple, and often more specific, statements. For example, the categorical need of "Prenatal Care" for the women's and maternal health domain was re-stated as "Increase percent of women accessing prenatal care."

### *Additional activities*

Although they do not constitute a separate "phase" of needs assessment activities, BSU evaluation team members

throughout the study to not conduct a separate phase of needs assessment activities, CDC staff have frequently interviewed the MCH Program Manager, Bureau of Clinical and Preventive Services Bureau Chief, and other IDHW personnel to determine sources of data, clarify information, and learn more about initiatives, strategies, and partnerships relevant to those receiving MCH services in Idaho.

## II.B.2. Findings

### 2. Findings

#### MCH Population Needs

- i. Health status overview for MCH populations. In this section, key findings, are reported and organized by PHD, with the Phase 1 methodology used to collect the data reflected either in the text or in parentheses (ASD = Archival/secondary data; GPS = General population survey; CS = Consumer survey; PS = Provider survey; KSI = Key informant/Stakeholder interviews). Findings resulting from questions not directly related to the six identified PHDs, but which may still comment on important considerations regarding MCH populations in Idaho, can be found in the McDonald et al. (2015) report which is included as Supporting Document #3.
  - *Women/Maternal Health*
    - Idaho women were 14% less likely than the national average to have had a preventive medical visit in 2013, yet they were 11% more likely to have had a dental visit during pregnancy (ASD)
    - Idaho women were 26% less likely than the national average to have a low-risk Cesarean delivery. They were also 7% more likely than the national average to have ever breastfed, and 15% more likely to have breastfed exclusively through six months (ASD)
    - The most important issues for women aged 18-44 in the GPS were access to health insurance (59%), access to mental health services (48%), nutrition (32%), physical activity (28%), and regular doctor visits (25%)
    - The most important issues for pregnant women in the GPS were avoiding harmful substances (49%), prenatal care (40%), health insurance (34%), nutrition (34%), and partner involvement (27%)
    - The most important issues for pregnant women in the CS were adequate health insurance (39%), prenatal care (33%), avoiding harmful substances (31%), pregnancy and parent education (28%), and access to mental health services (25%)
    - Common challenges identified for pregnant women and women aged 18-44 in the PS included problems with prenatal care (40%), mental health (32%), and health care costs (28%)
    - The most important preventive and primary care needs for pregnant women, mothers, and infants in the KSI were breastfeeding (47%), good nutrition (41%), prenatal care (41%), a medical home (41%), and avoiding harmful substances (29%)
    - The most important preventive and primary care needs for women aged 18-44 in the KSI were a medical home (46%), regular doctor visits (36%), dental care (36%), and family planning (36%)
  - *Perinatal/Infant Health*
    - Idaho is 19% below the national average in low birth weight, and 11% lower in preterm births. Idaho's infant mortality, having fallen nearly 30% between 2000 and 2012, is 13% lower than the national average (ASD)
    - Idaho is 28% higher than the national average in the incidence of infant death from birth defects, but 20% lower in the incidence of infant death from short duration and low birth weight (ASD)
    - Safe sleep (placing infants to sleep on their backs) is 10% more common in Idaho than nationally (ASD)
    - The most important issues for infants and young children on the GPS were home environment (38%), parenting (32%), getting immunizations (32%), access to health care (29%), child abuse/neglect (29%), and nutrition (25%)

- *Child Health*
  - Although the percentage of Idaho children who are current with key vaccinations has increased by 18% since 2008, Idaho still lags behind the national average (ASD)
  - Reported child abuse and neglect cases are 25% lower than the national average, and have decreased 25% from 2008 (ASD)
  - The percentage of Idaho children receiving a developmental screening using a parent-completed screening tool is 19% lower than the national average (ASD)
  - Idaho's children are 9% less likely than the national average to be physically active at least 20 minutes per day (ASD)
  - The most important issues for young children in the CS were healthy parenting/home environment (49%), immunizations (40%), regular doctor visits (31%), adequate health insurance (30%), child abuse/neglect (28%), and screening for healthy environment (25%)
  - Common challenges identified for pediatric patients in the PS included family problems/issues (56%), obesity (44%), immunization problems (41%), mental health (37%), and poor diet (26%)
  - The most important preventive and primary care needs for young children in the KSI were dental care (61%), immunizations (44%), and regular doctor visits (22%)
- *CYSHCN*
  - CYSHCNs in Idaho are 12% less likely to be covered by private insurance than the national average, and 39% more likely than the national average to have gone without health insurance at some point in 2010. Idaho's CYSHCNs were also 17% less likely than the national average to have had adequate insurance to pay for needed health services in the same year (ASD)
  - Idaho's CYSHCNs were 5% more likely than the national average to have a medical home in 2011. Adolescent CYSHCNs were also 17% more likely to have received services necessary to make transitions to adult health care
  - The greatest health care challenges for CYSHCNs in the CS were cost of health care (60%), access to community resources (55%), lack of specialists in the area (50%), and lack of affordable insurance (42%)
  - The greatest needs for CYSHCNs in the CS were access to specialty care (40%), inclusive school-based programs (32%), early intervention (32%), helping families coordinate care (31%), early identification of special needs (28%), and inclusive community programs (25%)
  - The most common types of medical specialists seen by CYSHCNs in Idaho include developmental specialists (69%), speech therapists (60%), psychiatric specialists (54%), and physical therapists (44%) (CS)
  - The greatest challenges serving CYSHCNs in the PS were family issues (57%), available resources (36%), accessing/available care (32%), lack of sub-specialists (29%), and knowledge of available resources (25%)
  - The most important preventive and primary care needs for CYSHCNs in the KSI were helping families coordinate care for CYSHCNs (44%), lack of medical specialists (44%), and inclusive school-based programs (33%)
- *Adolescent Health*
  - Teen pregnancy fell 25% in Idaho between 2002 and 2012. Live births to teen mothers fell by nearly one-third between 2008 and 2012 (ASD)
  - Idaho's bullying rate is 30% higher than the national average, and its suicide rate is 84% higher than the national average (ASD)
  - The percentage of Idaho adolescents completing a preventive medical visit in the past year was 24% lower than the national average
  - The most important issues for youth/teens in the GPS were substance use (66%), home environment (38%), and physical activity (26%)
  - The most important issues for teens in the CS were sexual health (43%), access to mental health services (42%), substance use (40%), bullying (31%), adequate health insurance (29%), child abuse/neglect (28%), and increasing physical activity (26%)
  - The most important preventive and primary care needs for older children in the KSI were teen

- The most important preventive and primary care needs for older children in the KSI were teen sexual health (56%), physical activity (44%), and dental care (39%)
- *Crosscutting or Life Course*
  - Of Idaho's 44 counties, 41 (or 93%) are federally-designated Primary Care Health Professional Shortage Areas, 42 (or 95%) are Dental Health Professional Shortage Areas, and 44 (or 100%) are Mental Health Professional Shortage Areas (ASD)
  - Idaho is among the last in the nation for number of primary care physicians per capita, and also suffers a severe shortage of specialists (including last in the nation, per capita, for internists, pediatricians, and psychiatrists) (ASD)

## II.B.2.a. MCH Population Needs

### ii. Population-specific strengths and needs.

To assess population-specific needs, common themes for each PHD across all five Phase 1 methodologies (i.e., ASD, GPS, CS, PS, and KSI) were identified. They are listed below.

- The most common themes *across all methodologies* for pregnant women were: 1) prenatal care; 2) nutrition; and 3-tie) health insurance, health care costs, mental health services, and substance abuse
- The most common themes *across all methodologies* for women aged 18-44 were: 1-tie) health insurance/costs, a medical home, and mental health services; and 2) regular doctor visits
- The most common themes *across all methodologies* for infants were: 1) immunizations; 2) nutrition; and 3) parenting/healthy home environment
- The most common themes *across all methodologies* for children and teens (these two PHDs were combined for this measure) were: 1) healthy weight/diet/nutrition/physical activity; 2-tie) well visits/routine care/immunizations and parenting/healthy home environment (this latter category included injury prevention); and 3) suicide/mental health/bullying
- The most common themes *across all methodologies* for CYSHCNs were: 1) access to specialists; 2) care coordination/medical home; 3) inclusive school-based programs; and 4) access to resources
- The most common crosscutting themes *across all methodologies* for the other five PHDs combined included: 1-tie) nutrition (including healthy weight) and mental health (including bullying and suicide); and 2-tie) parenting/healthy home environment, regular doctor visits, health insurance/costs, medical home (including care coordination), immunizations, and substance use/abuse

Questions about population-specific strengths were not asked about in any of the Phase 1 survey or interview methodologies. However, such strengths are easily identified in the ASD, Phase 2 workshop discussions, and through interviews with IDHW administrators.

- *Women/Maternal Health*
  - As noted earlier, Idaho women are more likely than their national counterparts to have had a dental visit during pregnancy. They are also considerably less likely to have low-risk Cesarean deliveries
  - A robust WIC system provides nutrition to pregnant women through more than 50 clinics throughout the state
  - There is increased insurance coverage for women through the Affordable Care Act (ACA), both in terms of overall health care and for specific types of services such as mental health and contraception
  - Many pregnant women and mothers have received home visiting services through Idaho's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. This program, which began offering services in two of seven health districts in the state in 2012, is expanding to all seven districts in 2015. MIECHV services to pregnant women and mothers include prenatal health screenings, smoking cessation and substance use/abuse resources, and postpartum depression,

stress, and domestic violence screening and resources

- *Perinatal/Infant Health*

- As noted earlier, Idaho is considerably lower than the national average in low birth weight babies and preterm births. Infant mortality is lower than the national average and has dropped substantially since 2002. Idaho's infants are more likely to have ever been breastfed and tend to have higher rates of breastfeeding through six months of age; they are also more likely to engage in safe sleep (by putting the infant to sleep on their backs)
- There is an increased understanding of adverse childhood experiences and toxic stress; plans to screen for and remediate these problems are becoming more systematic
- Many infants have received services through Idaho's MIECHV program, and more will now receive the same services through the program's expansion to all seven health districts. MIECHV services benefitting infants include preventive health services and resources to pregnant women and new mothers (e.g., encouragement to take a prenatal multivitamin and breastfeed, parenting support, etc.)

- *CYSHCNs*

- Key challenges, including access to specialists and the need for care coordination, have been identified as priorities and are being addressed
- Community-based resources often exist, though they are not always known to parents of CYSHCNs
- Early identification of cognitive, social, and emotional problems is a key component of Idaho's MIECHV program, as is sharing resources for families whose children are identified with developmental delays

- *Adolescent Health*

- As noted earlier, Idaho's teen pregnancy rate has dropped by one-fourth since 2002, and live births to teens have dropped by one-third
- There have been increased efforts (through local hospitals, YMCAs, Boys and Girls Clubs, schools, and others) to focus on healthy nutrition and exercise
- A suicide prevention hotline now operates 24 hours per day, seven days per week
- An innovative program in juvenile detention centers aims to identify mental health and substance abuse problems in detained juveniles, and link them to resources upon their release
- Targeted substance use prevention programs are operated throughout the state by numerous organizations (many funded through Millennium Fund grants, or through the Idaho Office of Drug Policy)

iii. State of Idaho's MCH successes/strengths and gaps/limitations.

Priority areas were identified through triangulation of data from the needs assessments described in sections i and ii. By each MCH population, these priorities are: 1) Children and Youth with Special Health Care Needs - Access to specialists, Care coordination/medical home, Inclusive school-based programs, and Access to resources; 2) Women of Reproductive Age (18-44)- Health insurance/costs, Medical Home, Mental Health Services, Regular Doctor visits; 3) Pregnant women- Prenatal care, Nutrition, Mental Health services, Substance use/abuse; 4) Youth/Teens- Healthy weight/diet and nutrition/physical activity, Well visits/routine care/Immunizations/ Parenting/healthy home environment, Suicide/mental health/bullying; and 5) Infants and young children - Parenting/healthy home environment, Nutrition, Immunizations. The issues relate primarily to risk reduction and maintenance of health and wellness.

The State of Idaho's MCH program successes/strengths and gaps/limitations are summarized below by population health domains and priority areas as generated from the 2015 Title V MCH Capacity Assessment and State Prioritization Meeting.

- Prenatal Care
  - Strengths include areas such as pregnancy covered by Medicaid, WIC collaboration with other programs (e.g., many home visiting program referrals occur via WIC), and emerging technologies to support mental health in remote communities
  - Limitations include poor access to prenatal care in remote areas, level of literacy, preconception health, limited access to prenatal care for noncitizens, upfront cost as a barrier to home visiting programs, and misconception of home visiting programs as “big government”
- Nutrition
  - Strengths consist of WIC available in all counties, 40% of mothers use WIC, collaboration emerging between WIC and the Idaho Food Stamp Program (SNAP), and education coupled with food benefits
  - Limitations include federal regulation to access WIC vouchers versus SNAP card, transportation barriers, folic acid availability at pregnancy, healthy weight gain during pregnancy and returning to healthy pre-pregnancy weight, and short medical office visits with limited time to address important issues
- Mental Health Services
  - Strengths include emerging support for crisis centers in the state and the patient-centered medical model
  - Limitations include short office visits resulting in providers not having the time to address mental health, stigma regarding mental health, providers unsure of referral sources, and lack of universal screening for mental health
- Substance Use/Abuse
  - Strengths include partnership and smoking cessation programs through the 2-1-1 line, and a home visiting program that includes non-judgmental interviewing
  - Limitations include awareness of risks associated with prescription medication use during pregnancy, interviewing may be judgmental or leading, and increased need for home visiting programs

### *Perinatal/Infant Health*

- Immunizations
  - Strengths include collaboration with several organizations and coalitions (e.g., Immunization Advisory Group, Idaho Chapter of Family Medicine, Idaho Medical Association, Idaho Chapter of American Academy of Pediatrics), medical home model, parent education cards, and school laws
  - Limitations include small ability to reach parents, ease of opting out of immunizations, lack of knowledge and education, lack of capacity to address national concerns (e.g., social media, celebrity support), lack of information, and relying on pediatricians to spread the information
- Nutrition
  - Strengths include ACA breast pump coverage, SNAP, national campaigns, WIC, and USDA summer feeding program
  - Limitations include lack of awareness, lack of regulation of health foods obtained through SNAP, breastfeeding awareness and employer support, difficulty targeting this group outside of pediatricians’ offices, and lack of parent education
- Parenting/Health Home Environment
  - Strengths include parenting education, housing, community action with car seat checks, and programs such as Crying Plan, Smoking Cessation, and Safe Sleep
  - Limitations include Idaho residents’ concerns about government involvement, underutilized technology to spread information, programs are not advertised for healthy home education, lack of information and sole reliance on pediatrician to provide information, early implementation of PRAT, CoIIN, Crying Plan, etc.

## *CYSHCN*

- Care Coordination/Medical Home
  - The Idaho State Healthcare Innovation Plan (SHIP) is an opportunity for innovation and funding
  - Limitations include capacity, ownership, disparate systems that communicate poorly, administrative burden, no reimbursement or funding source, a lack of standardized processes, entry points, and referrals
- Access to Specialists
  - Strengths include telehealth (where available), access to specialists has been identified as a priority and is being worked on, outreach specialty clinics, specialists in Idaho are perceived to be good, compassionate physicians who practice for the right reasons
  - Limitations include a lack of specialist choice, lack of knowledge about best referral source outside of area, cost for travel and care, population volume and need versus call burden, and life balance for providers
- Inclusive School-based Programs
  - Strengths consist of school inclusion where available
  - Limitations include lack of pre-school availability in every district, education philosophy (inclusion vs. non-inclusion) is not the same in every district, teachers not equally experienced or trained, lack of professional development, and individualized education program (IEP) coordination is sometimes lacking
- Access to Resources
  - Strengths include parent-to-parent connections and the Infant-Toddler Program. Resources exist, however, making the connection for those in need can be a challenge
  - Limitations include the lack of a common way to provide information to families, information is not patient/family-friendly and requires interpretation and education, language and cultural barriers, physician and clinic education about existing resources and how they can disseminate the information

## *Adolescent Health*

- Healthy Weight/Diet and Nutrition/Physical Activity
  - Strengths include several programs that are currently in place (HEAL, St. Luke's, etc.), focus on nutrition and physical activity, Boys and Girls Clubs, and school policies centered around wellness
  - Limitations include the need for intervention strategies, programs are difficult to facilitate in rural areas, lack of consistency in programming, lack of quality data
- Well Visits/Routine Care/Immunizations
  - Strengths include vaccines for children that are becoming more available, oral health opportunities are becoming more readily available, and school-based immunization records are increasing
  - Limitations include items such as vaccine programs not covering costs of administration, lack of education on the importance of dental health for long term health outcomes, and barriers to well child visits including taking time off from work and accessing transportation
- Parenting/Healthy Home Environment
  - Strengths include child advocacy centers that provide counseling, Boys and Girls clubs, after school programs, and Safe Kids (provides accidental childhood injury prevention services), where available
  - Limitations include lack of data about home environments, transportation to programming, limited funding, injury prevention programs lack wide reach, and absence of child advocacy centers in many communities
- Suicide/Mental Health/Bullying
  - Strengths include the Green Dot intervention program, school-based bullying prevention training, a suicide prevention hotline that now operates 24 hours per day, seven days per week, and the

- Successes include a new, continuously-operating suicide hotline and a continuous-operating 2-1-1 CareLine. Disclosure laws are improving and now allow for more discrete communication of information about patients' mental health
- Limitations include a lack of funding, lack of mental health practitioners in rural areas, Idaho's high rate of suicide, lack of high school counselors, cyber-bullying, and a lack of integration of mental health services into primary care settings, where the stigma would be lower

### *Woman of Reproductive Age*

- Health Insurance/Costs
  - Strengths include pregnant women are typically covered by insurance, an increase in the number of women approved for insurance, post-partum depression screening, and preconception planning. Idaho also has three residencies that provide access to rural and refugee populations, and there is increased coverage for contraception through ACA
  - Limitations include a limited supply of doctors due to cost of liability insurance, aging providers, limited and reduced reimbursement rates, contraception coverage may not be consistent with patient choices, women may not understand which services are covered and therefore not seek care, refugee mothers with language and cultural barriers, differences in citizenship statuses between mothers and infants, and the ACA coverage gap (with no Medicaid expansion)
- Medical Home
  - Strengths include that primary care doctors usually know patients' history of care, specialties and care being "owned," and transitional (teen to adult) care
  - Limitations include geographic distance to providers, piece-meal services, lack of education on Medical Home definition, and lack of clarity regarding where and how different types of providers will "fit" in this model
- Mental Health Services
  - Strengths include a new, continuously-operating suicide hotline and a continuous-operating 2-1-1 CareLine. Disclosure laws are improving and now allow for more discrete communication of information about patients' mental health
  - Limitations include lack of providers in rural/frontier areas, limited information regarding mental health and preventive care, the stigma around mental health which prevents individuals in need from seeking help, and the undertreated homeless population
- Regular Doctor's Visits
  - Strengths include early detection, opportunities for education on needed topics, improved preconception planning, and telemedicine (where available)
  - Limitations include often poor access to care, shortage of care providers, lack of education, lack of telemedicine availability in many areas

For a broader view of the feedback received, workshop participants' responses to the successes/strengths and gaps/limitations of resources available within the State of Idaho were coded according to issues of access to services, knowledge/education and communication needs, costs of services and positive (strength) or negative (limitations) concerns regarding services. Regarding successes/strengths and across all five MCH populations, citation of quality services being available accounted for 43 (70%) of the 61 comments recorded. Three (5%) comments were on cost, 12 (20%) comments were on knowledge/communication, and three (5%) comments were on access. Within each MCH population, the presence of quality services accounted for 57% of comments for CYSHCNs, 50% for women aged 18-44, 78% for pregnant women, 76% for infants and children, and 85% for youth and teens.

A similar analysis performed on gaps/limitations found that knowledge/education and communication concerns accounted for 31 (40%) of the 77 comments recorded across the five MCH populations. Seventeen (22%) comments were on access, seven (9%) were on costs, and 22 (29%) were on unavailable or low quality services. Knowledge/education and communication concerns accounted for 46% of comments for infants and

children, 56% for CYSHCNs, 35% for women 18-44, and 36% for pregnant women. Youth/teens were an exception to this pattern with unavailable services (46%) accounting for the largest group of comments on gaps/limitations.

#### iv. Analysis of Title V-Specific Programmatic Approaches

In this section, Title V-specific programmatic approaches were assessed for each PHD, discussing where current efforts are working well and should be continued and areas in which new or enhanced strategies/program efforts are needed.

- *Women/Maternal Health*

- Improvements have been made in the Family Planning Program by moving it under the umbrella of the MCH Program, by dedicating a full-time employee (FTE) to oversight and coordination of the program, improving communication with the Title X Family Planning regional project officer, and improving program operations through Title X policy clarification and support to local health districts
- Some MCH-related processes and procedures that require collaboration between IDHW and public health districts have been streamlined. For example, public health districts are now able to order supplies such as contraceptives autonomously, rather than having to process orders through IDHW
- Improved services and resources are now available to eligible pregnant women and mothers through the MIECHV program
- Enhancements could be made through improving collaboration between the MCH Program and the WIC Program, as WIC services are accessed by women and children who are often eligible for MIECHV program participation

- *Perinatal/Infant Health*

- Improvements have been made in the Newborn Screening (NBS) Program, including the addition of next-day courier service for first-specimen processing. This addition has decreased transit time to the Oregon State Public Health Laboratory from an average of 4-5 days to one day
- The Idaho NBS Panel has been expanded to include an additional condition, Severe Combined Immunodeficiency (SCID). The Idaho NBS panel now includes 46 conditions, which is well above the minimum core conditions as identified by the Recommended Uniform Screening Panel per the Advisory Committee on Heritable Disorders in Newborns and Children
- Title V funding supported data system enhancement for Breastfeeding Peer Counseling by allowing peer counselors to enter contact information and track follow-up for continuity of care
- Improved services and resources are now available to eligible pregnant women and infants through the MIECHV program
- Enhancements could be made through improving collaboration between the MCH Program and the WIC Program, as WIC services are accessed by mothers with infants who are often eligible for MIECHV program participation

- *Child Health*

- Through collaborations with healthcare providers and schools, the IDHW Idaho Immunization Program has helped increase the percentage of children vaccinated according to the recommended schedule
- Idaho established a Child Death Review Team to complete systematic and collaborative reviews of all deaths of children under the age of 18. Team members include coroners, medical examiners, several doctors/nurses, and others
- Improved services and resources are now available to eligible young children through the MIECHV program
- Enhancements could be made through improving collaboration between the MCH Program and the WIC Program, as WIC services are accessed by mothers with young children who are often eligible for MIECHV program participation

- *CYSHCNs*

- There are very close collaborations between IDHW and those who provide services to, advocate

- There are very close collaborations between IDHW and those who provide services to, advocate for, or are parents of CYSHCNs. For example, either the MCH Program Manager, the Clinical and Preventive Services Bureau Chief, or both are members of the advisory boards of organizations such as Idaho Parents Unlimited (a statewide organization that assists families with CYSHCNs), Idaho Sound Beginnings (which coordinates early hearing detection and intervention), and the Idaho Early Childhood Coordinating Council (which is a clearinghouse of information and services available to children, including CYSHCNs, in Idaho). An effort to improve collaboration included the inclusion of two parents of CYSHCNs at the 2015 Title V MCH Capacity Assessment and State Prioritization Meeting
- The Transition to Adult Health Care toolkits developed by IDHW, and made available at no cost to families with CYSHCNs, have been well received by users. These toolkits are available in both paper and electronic versions, and in both English and Spanish languages
- The Medical Home Demonstration for CYSHCNs in rural Idaho has been viewed as an innovative approach to overcoming barriers to providing high-quality health care to this population in rural areas. This innovation involves a partnership between MCH, Medicaid, local public health districts, and primary care providers
- Although efforts have been made to improve collaboration with CYSHCNs' families and community partners, enhancements to these efforts are warranted. With the MCH transformation and increased emphasis placed on family/consumer partnerships, the MCH program must identify or develop strategies to include family input and feedback into program operations. One consideration is forming a MCH advisory council that would include representation of family partners, and the council would help inform/drive operations
- A mechanism to evaluate the efficacy of the Transition to Adult Health Care toolkits would be an improvement, as data beyond anecdotal reports could help justify continued investment
- The Medicaid CHIC funding that supports the care coordinator coach for the Medical Home Demonstration for CYSHCNs in rural Idaho is ending; therefore, the MCH Program must explore ways to sustain the effort
- The Children's Special Health Program is a legislatively-defined, financial support program for children with certain diagnoses who do not have health insurance. Currently, approximately 130 children are served by the program, and decreased enrollment is anticipated as more families gain insurance through YourHealthIdaho. The MCH Program must explore ways to repurpose the program to continue serving the CYSHCN population
- *Adolescent Health*
  - The collaborative partnership between IDHW, the Idaho Department of Juvenile Corrections, and the Idaho Juvenile Justice Commission to support the Clinical Services Program in juvenile detention centers helps to identify mental health and substance abuse problems in detained juveniles, and link them to resources upon their release
  - The Idaho Suicide Prevention Hotline now operates 24 hours per day, seven days per week
  - Targeted substance use prevention programs are operated throughout the state by numerous organizations; many of these programs specifically target adolescents
  - Title X Family Planning and Idaho Physical Activity and Nutrition programs both provide preventive services to adolescents
  - The SHIP initiative with broad implementation of patient-centered medical homes throughout the state presents an opportunity to better coordinate the transition of adolescents from their pediatric provider to a family medical provider
  - Adolescent programming is largely absent in the Division of Public Health, with the exception of the Adolescent Pregnancy Prevention (APP) program. The MCH Program could benefit from increased collaboration with APP and in considering other ways to enhance adolescent health
- *Crosscutting Issues*
  - Title V administration has developed a new approach to funding programs, which involves a funding request that outlines the amount requested, proposed activities, expected outcomes/impact to the relevant MCH population, and alignment with MCH priorities. This new approach aligns with the

- Title V Transformation to increase accountability
- o Idaho received a state innovation model grant (SHIP) for nearly \$40 million dollars to redesign the state's healthcare system, evolving from a fee-for-service, volume-based system to a value-based system of care that rewards health outcomes. The redesign is expected to benefit the quality of care provided to MCH populations
- o Reportedly, 85,000 more Idahoans (including members of MCH populations) have been enrolled in health insurance due to the ACA
- o Idaho has not elected to participate in the Medicaid Expansion, meaning an estimated 78,000 Idahoans (including members of MCH populations) fall into the 'coverage gap'

## II.B.2.b Title V Program Capacity

### II.B.2.b.i. Organizational Structure

- b. Title V Program Capacity
  - i. Organizational Structure

- a. (See Supporting Document #2) The State Title V Agency in Idaho exists within the Division of Public Health, Idaho Department of Health and Welfare (IDHW). The IDHW 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 which is charged with formulating the rules and regulations for IDHW. Administrative oversight of the MCH block grant is vested with the Bureau of Clinical and Preventive Services (BOCAPS). Other programs in BOCAPS are HIV Care/Prevention, STD, Breast and Cervical Cancer Screening, WIC, and MCH programs.
- b. The following comprises a listing of programs and activities that Title V MCH funded in support of the administration (or supervision of administration) with allotments under Title V [Section 509(b)]: MCH Sexually Transmitted Disease Program; MCH Needs Assessment/contractor; MCH Epidemiology; Oral Health Program; Title X Family Planning Program; Idaho Careline (2-1-1); Idaho Poison Control Center; Children's Special Health Program; Newborn Screening Program; Pediatric Specialty Clinics; Patient Centered Medical Home Demonstration for CYSHCN; and Perinatal Surveillance. Other special projects included: Transition to Adult Healthcare Toolkits; WIC Breastfeeding Peer Counseling Data Platform; Electronic Birth Record Data Improvement Project; and Infant Mortality Reduction Initiative.

## II.B.2.b.ii. Agency Capacity

### ii. Agency Capacity

- a. Administrative oversight of the MCH block grant is vested with the Bureau of Clinical and Preventive Services (BOCAPS). The Chief of BOCAPS serves as the Title V MCH Director and provides fiscal and consultative support to a variety of programs within IDHW and to external partners.
- a. For each population domain, the following describes Title V's capacity for service provision:
  - Women/Maternal Health
    - Family planning services, including STD/HIV screening, are offered in 6 of Idaho's 7 health districts
    - Home visiting services have been expanded to all health districts
    - Fetal development materials and promotional materials for Text4Baby are distributed annually to Medicaid mothers and others
  - Perinatal/Infant Health
    - Newborn Screening Program currently requires double screens and screens for 45 conditions
    - Home visiting services have been expanded to all health districts
    - Perinatal data collection/analysis is conducted annually to inform Title V programming
  - Child Health
    - The Immunization Program offers free vaccines to insured children through the vaccine assessment program, as well as provider and public education to increase immunization rates
    - Home visiting services for children to age 5 have been expanded to all health districts
    - All health districts provide dental sealants, fluoride varnish, oral health education and referrals to elementary school children
  - Adolescent Health
    - Emphasis has been placed on increasing HPV vaccination rates
    - Family planning services, including STD/HIV screening, are offered in 6 of Idaho's 7 health districts
  - CYSHCN
    - The Children's Special Health Program (CSHP) is governed by Idaho code and provides financial support to children with certain diagnoses who do not have health insurance (subject to residency, income, and payment cap restrictions)
    - Rehabilitation services for blind or disabled children who receive Title XVI benefits are not offered unless the child qualifies for assistance through CSHP
    - A variety of specialty pediatric clinics are funded throughout the state with specialty physicians "imported" from other states to conduct the clinics
    - Approximately 1,250 transition-to-adulthood kits for CYSHCN are developed and distributed annually free-of-charge to help empower children to take a primary role in their healthcare
    - A medical home demonstration for CYSHCN living in rural Idaho provided improved clinical care and coordination to 50 children/families
  - Cross-Cutting
    - Epidemiology services for infectious disease and foodborne illness investigation and reporting are partially fund; these services are essential public health services impacting MCH populations
    - Per OBRA legislation, an informational hotline for MCH and other services called Idaho CareLine is funded, as well as the Poison Control Hotline
    - Data analysis and consultation is supported for a variety of MCH-related programs

## II.B.2.b.iii. MCH Workforce Development and Capacity

### iii. MCH Workforce Development and Capacity

- a. The State Title V program has two Full Time Equivalent (FTE) professionals holding administrative positions (Kris Spain, Bureau of Clinical and Preventive Services Chief 1.0 FTE, Jacquie Watson, Maternal and Child Health Programs and Family Planning Program Manager 1.0 FTE and Diane Prince, Administrative Assistant .5 FTE). Additionally, the MCH program has four support staff (Jason Helsley, Health Program Specialist 1.0 FTE, Carol Christiansen, Registered Nurse 1.0 FTE, Pamela Simmons, Medical Claims Examiner 1.0 FTE and Carrie Weaver, Administrative Assistant .5 FTE.)

Currently the State Title V program has no paid consultants representing CYSHCN. However, there are very close collaborations between IDHW and those who provide services to or advocate for CYSHCNs. For example, either the MCH program manager, the Clinical and Preventive Services Bureau Chief, or both are members of the advisory boards of organizations such as Idaho Parents Unlimited (a statewide organization that assists families with CYSHCNs), Idaho Sound Beginnings (which coordinates early hearing detection and intervention), The Idaho Council on Developmental Disabilities (a governor-appointed council focused on individuals with developmental disabilities) and the Idaho Early Childhood Coordinating Council, (a governor-appointed council focused on issues impacting early childhood).

Few changes in current staffing are anticipated in the next five years. However, due to the aging workforce retirements are likely to happen over the next several years. Because of this, the Division of Public Health has placed emphasis on succession planning.

- a. The State Title V program utilizes a range of mechanisms to promote and provide culturally-competent approaches in its services delivery. Vital records data are routinely analyzed and reported by race, ethnicity, age and gender. All print materials are translated from English to Spanish by certified translators and interpreters are available as needed for clinical services.

A liaison for the Native American Tribes in Idaho regularly works with the State Title V program. An example of the care taken in approaching cultural issues is seen in the tobacco cessation services offered throughout the state. Project Filter contracts with three Idaho tribes (Shoshone-Bannock, Coeur d'Alene, and Nez Perce) to offer tobacco prevention and contract activities within their communities. The tobacco cessation approach recognizes and honors the sacred history and ceremonial status of tobacco within the tribes. Tobacco cessation is referred to as "Keep it Sacred." The point is that tobacco should be used for its traditional purpose and commercial tobacco should not be used for any reason. This message is consistently conveyed to youth in preventive educational classes. Furthermore, the Idaho QuitLine uses a specific protocol for those identifying themselves as Native American. Questions asked and print materials sent to participants are 'Native-specific' to help address unique cultural barriers and concerns.

Within the Division of Public Health, staff are working collaboratively to achieve Public Health Accreditation. Part of these efforts is an evaluation of staff performance and cultural competency. A workgroup has been created to assess the current status of staff performance, as well as to identify needed training and areas for improvement (including cultural competency). All staff have mandatory training requirements for initial orientation to the department. To expand on this, the Division of Public Health will add to these training requirements based on the input from the workgroup. A recent effort to assist staff with communication and cultural competency is a Plain Language training to be held in June 2015. The anticipated outcome for staff is a greater understanding on how to create readable print information for the public in simple, clear and concise wording.

The IDHW incorporates performance standards for all staff and contractors in department practices, policies, and contracts/sub grants. For department staff, there is a dedicated site that staff access, known as the Knowledge and Learning Center (KLC), for mandatory cultural competency training. Some examples of the trainings offered include: Cultural Diversity, Cultural Sensitivity Training (for specific populations such as LGBT), Cultural Competency-Ethical Considerations for working with Latino Families, and Cultural Diversity and Cultural Competency and Linguistics Policy, to name a few. The department also provides a tribal liaison for program staff to work with for specific Native American Tribal populations. In addition, efforts within the Division of Public Health have been taken to ensure internal and external partners adhere to client confidentiality. A new

of Idaho Health have been taken to ensure internal and external partners adhere to strict confidentiality. A new division policy was created, along with a confidentiality statement that external partners must sign, regarding the confidentiality of client data. Additional confidentiality and/or cultural competency courses are available to external staff through the KLC.

## II.B.2.c. Partnerships, Collaboration, and Coordination

### a. Partnerships, Collaboration and Coordination

Idaho's Title V program maintains an ongoing effort to leverage resources and partnerships with other programs within IDHW, other state agencies, public health districts, and community to serve members of MCH populations.

The following partnerships, collaborations, and coordination exist with other MCHB investments in Idaho:

- State System Development Initiative (SSDI) Grants
- MIECHV Grants
- Early Childhood Systems of Care (ECCS) Grants
- Universal Newborn Hearing Screening and Intervention grants
- Family to Family Health Information Center grant
- Emergency Medical Services for Children grant
- Community Integrated Services grant
- Traumatic Brain Injury Implementation grant

The following partnerships, collaborations, and coordination exist with other Federal investments in Idaho:

- SHIP effort to transform Idaho's healthcare delivery system from a fee-for-service to a value-based model is funded by the Center for Medicare and Medicaid Innovation
- WIC services are offered in all seven public health districts in the state and two Native American health agencies. More than 50 clinics provide these services statewide
- The Children's Healthcare Improvement Collaboration (CHIC) is funded by the Centers for Medicare and Medicaid Services to support a collaborative effort between Idaho and Utah to improve health among families and children in the two states
- The Centers for Disease Control and Prevention (CDC) funds several programs in Idaho, including the Women's Health Check breast and cervical cancer screening program, HIV Prevention and Sexually Transmitted Disease program, and provides epidemiological guidance and specialized public health laboratory testing as needed
- Title X Family Planning Program
- Idaho Immunization grant
- Adolescent Pregnancy Prevention grant

The following partnerships, collaborations, and coordination exist with other HRSA investments in Idaho:

- The Idaho Emergency Medical Services for Children (EMSC) Project, which provides for essential pediatric equipment and supplies in EMS providers
- The Idaho Ryan White Part B Program, which provides medical case management for persons with HIV disease

The following partnerships, collaborations, and coordination exist with other MCH programs in Idaho:

- Idaho Perinatal Project
- March of Dimes

- WATCH OF DIETES
- Idaho Health and Wellness Collaborative for Children (IHAWCC)
- Idaho Sound Beginnings
- Idaho Kids Count Editorial Board
- Northwest Bulletin Editorial Board
- Idaho Chapter of AAP
- Idaho Head Start
- Hunger Relief Task Force
- Idaho Academy of Nutrition and Dietetics

The following partnerships, collaborations, and coordination exist with other IDHW programs in Idaho:

- Child Care Program
- Child Protection Program
- Children’s Mental Health Program
- Developmental Disabilities Program
- Early Hearing Detection and Intervention (Idaho Sound Beginnings)
- Adolescent Pregnancy Prevention Program
- Adult Mental Health Program
- Substance Use Disorder Services Program
- Infant Toddler Program
- Tobacco Prevention Program
- Idaho Immunization Program
- Idaho Medicaid
- Idaho Physical Activity and Nutrition Network (IPAN)
- Cross Bureau Integration Team (CBIT)
- Public Health Integration Team (PHIT)
- Get Healthy Idaho
- Idaho Vital Records and Statistics
- Comprehensive Cancer Alliance of Idaho

The following partnerships, collaborations, and coordination exist with other government agencies in Idaho:

- Idaho Commission on Hispanic Affairs, which is a non-partisan state agency that serves as a liaison between the Hispanic community and state agencies
- Idaho Department of Juvenile Corrections, which collaborates with IDHW on dual commitments of children and in cases which juvenile justice intersects with child protection
- County Probation Departments, which supervise youth that both enter state custody and those who do not
- County Juvenile Detention Centers, which frequently house youth in need of or receiving services for mental health and substance abuse problems
- Idaho State Department of Education

The following partnerships, collaborations, and coordination exist with Tribes or Tribal organizations in Idaho:

- As specified under the Indian Child Welfare Act of 1978, IDHW works closely with Idaho’s four federally-recognized tribes (Coeur D’Alene, Kootenai, Nez Perce, and Shoshone-Bannock)
  - IDHW maintains a health equity program specialist who is a cultural liaison with the tribes regarding health issues

The following partnerships, collaborations, and coordination exist with public health and health professional educational programs, and universities

- Idaho Child Welfare Research Training Center
- Title IV-E child welfare student stipends support students at EWU
- Idaho State University
- Lewis and Clark State College
- Northwest Nazarene University
- Boise State University
- University of Idaho
- 7 Local Public Health Districts

The following partnerships, collaborations, and coordination exist with family/consumer partnership and leadership programs in Idaho:

- Early Childhood Coordinating Council
- Court Appointed Special Advocates and Guardians ad Litem (CASA/GAL)
- Idaho Federation of Families for Children's Mental Health
- Idaho Parents Unlimited
- Idaho Children's Trust Fund
- Faith-Based Organizations
- Idaho Foster and Adoptive Parents Coalition
- Community Council of Idaho
- Keeping Children Safe Panels
- Idaho Council on Children's Mental Health (ICCMH)

The following partnerships, collaborations, and coordination exist with other State and local public and private organizations that serve the State's MCH population in Idaho:

- Public Health Departments
- St. Luke's Children's Hospital in Boise
- Family Medical Residency of Idaho
- Centro de Comunidad y Justicia

## **II.C. State Selected Priorities**

	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1 .	Increase percent of women accessing prenatal health care	New	
2 .	Improve breastfeeding rates	New	
3 .	Increase the number of families who practice safe and healthy parenting behaviors	New	
4 .	Decrease the prevalence of childhood overweight and obesity	Continued	
5 .	Improve childhood immunization rates	Continued	This priority need does not have a corresponding National Performance Measure. A corresponding State Performance Measure will be developed for the FY2017 Application.
6 .	Improve maternal and child health population access to medical homes	New	
7 .	Improve access to medical specialists for children and youth with special health care needs	Continued	
8 .	Decrease substance abuse among maternal and child health populations	New	

### ***Selection Process***

Based on the findings of the five-year needs assessment, Idaho selected eight state MCH priorities for 2016 – 2020. Each of these priorities serves as an overarching area of need for at least one of the six defined MCH population domains. Idaho’s eight priority needs and respective population domains are listed below:

1. Increase percent of women accessing prenatal care (Women/Maternal Health)
2. Improve breastfeeding rates (Perinatal/Infant Health)
3. Increase the number of families who practice safe and healthy parenting behaviors (Perinatal/Infant Health)
4. Decrease the prevalence of childhood overweight and obesity (Child Health)
5. Improve childhood immunization rates (Child Health)
6. Improve access to medical specialists for children and youth with special health care needs (CYSHCN)
7. Decrease substance abuse among maternal and child health populations (Cross-Cutting/Life Course)
8. Improve maternal and child health population access to medical homes (Cross-Cutting/Life Course)

A phased approach was used to arrive at the state’s final priority needs. The prioritization process consisted of three phases. The first phase was conducted by the MCH Program’s needs assessment partner and involved the systematic review of quantitative and qualitative data for the purpose of theme identification. Twenty-nine common themes were identified across a variety of data collection methods and were then ranked in accordance with the number of times a theme appeared within and across MCH population groups. Ranking was conducted within six MCH population groups. However these population groups differed slightly from the Maternal and Child Health Bureau population domains identified for Title V MCH Block Grant Application and Report in order to align with question wording on the surveys. Please see the Five Year Needs Assessment Summary for further explanation about theme identification methodology. Below are the results of theme ranking by population group:

## Phase 1: Common Theme Identification Across Data Collection Methods

### **Pregnant Women**

Prenatal Care, 1  
Nutrition, 2  
Mental Health Services, 3  
Substance Use/Abuse, 3  
Health Insurance, 3  
Health Care Costs, 3

### **Infants & Young Children**

Immunizations, 1  
Nutrition, 2  
Parenting/Healthy Home Environment/Injury Prevention 3

### **Youth & Teens**

Healthy Weight/Diet and Nutrition/Physical Activity, 1  
Well visits/Routine Care/Immunizations, 2  
Parenting/Healthy Home Environment/Injury Prevention, 2  
Suicide/Mental Health/Bullying 3

### **Women of Reproductive Age (18 – 44)**

Health Insurance/Health Care Costs, 1  
Medical Home, 1  
Mental Health Services, 1  
Regular Doctor's Visits, 2

### **CYSHCN**

Access to Specialists, 1  
Medical Home/Care Coordination, 2  
Inclusive School-Based Programs, 3  
Access to Resources, 4

### **Cross-Cutting Priorities (Across All Groups)**

Nutrition/Healthy Weight/Physical Activity, 1  
Mental Health/Bullying/Suicide, 1  
Parenting/Healthy Home Environment/Injury Prevention, 2  
Regular Doctor's Visits, 2  
Health Insurance/Health Care Costs, 2  
Medical Home, 2  
Immunizations, 2  
Substance Use/Abuse, 2

In the second phase, the MCH program and the needs assessment partner gathered broad and diverse stakeholder input on the priorities for the state by hosting the “2015 Maternal and Child Health Capacity Assessment and State Prioritization Meeting”. This was the first time in at least a decade that a variety of internal and external stakeholders were convened to provide input on the state’s MCH block grant. Approximately 35 stakeholders attended from around the state and included representation from local public health districts, parents of CYSHCN, hospitals, public health programs, the state’s only children’s hospital, Medicaid, and others. Attendees were provided information about the MCH block grant, the needs assessment data collection process

and findings, and were provided with state and national data related to the 16 National Performance Measures.

Meeting attendees participated in two facilitated exercises. The first was a group activity to brainstorm and document the perceived strengths and limitations of the state's maternal and child health care system in meeting the top needs of the various MCH populations. The second was a voting exercise in which individual attendees used electronic devices to privately rank priority needs from most important to least important for each MCH population group. Please see the Five Year Needs Assessment Summary for results from and further explanation about the capacity assessment and state prioritization meeting.

Priority needs were ranked by four collapsed population groups (population groups were collapsed for ease of voting/ranking) and included 24 selections. These selections included the 16 National Performance Measures and eight of the top ranked needs from the first phase of data collection. Certain criteria were used to determine if a priority need from Phase 1 would be included in the Phase 2 stakeholder voting and ranking exercise. These criteria were:

- State priority need captured by one of the 16 National Performance Measures
- Ability to make a measurable impact in the short- and long-term
- Feasibility of population-based approaches
- State and local capacity

The results from the Phase 2 stakeholder voting and ranking exercise are below.

#### Phase 2: Results from Idaho MCH Capacity Assessment and Prioritization Meeting

##### **Woman and Infant Health**

Prenatal care, 19%

Immunizations, 18%

Well woman visit, 17%

Breastfeeding, 17%

Low risk cesarean delivery, 12%

Safe sleep, 9%

Perinatal regionalization, 8%

##### **Child and Adolescent Health**

Child/adolescent mental health, 18%

Developmental screening, 16%

Healthy home environment, 15%

Physical activity, 14%

Bullying, 13%

Adolescent well visit, 13%

Child injury, 12%

##### **CYSHCN**

Access to specialty care & community resources, 36%

Medical home, 29%

Inclusive school-based programs, 20%

Transition, 15%

##### **Cross-Cutting/Life Course**

Adequate insurance coverage, 20%

Medical home, 19%

Nutrition and physical activity, 19%

Substance use/abuse 16%

Smoking 14%

Oral health 12%

Note: Priorities in blue indicate a state need and priorities in pink indicate a national need (based on the 16 National Performance Measures).

Phase 3 involved a meeting between the MCH leadership team and Division of Public Health leadership to decide upon the final seven to ten state priority needs. When narrowing down the priority needs, leadership started with the results from Phase 1 and Phase 2 of the prioritization process. Potential priorities were evaluated against a variety of criteria:

- Ability to make a measurable impact in the short- and long-term
- Feasibility of population-based approaches
- State and local capacity
- Incidence/prevalence
- Severity
- Cost of potential strategies
- Alignment with existing programs and initiatives
- Alignment with National Performance Measures

Ultimately, leadership selected eight state priority needs, ensuring that needs of all the six MCH population domains were represented (Women/Maternal Health, Perinatal/Infant Health, Child Health, Adolescent Health, CYSHCN, and Cross-Cutting/Life Course). During the prioritization and selection process, these needs were phrased as broad, categorical areas. To align with the federal guidance, the leadership team re-stated the needs as simple, and often more specific statements. For example, the categorical need of “Prenatal Care” for the women’s and maternal health domain was re-stated as “Increase percent of women accessing prenatal care.”

### Phase 3: Final Selection of State Priority Needs

1. Prenatal Care: Increase percent of women accessing prenatal care (Women/Maternal Health)
2. Perinatal Nutrition: Improve breastfeeding rates (Perinatal/Infant Health)
3. Healthy Home Environments: Increase the number of families who practice safe and healthy parenting behaviors (Perinatal/Infant Health)
4. Childhood Healthy Weight: Decrease the prevalence of childhood overweight and obesity (Child Health)
5. Childhood Immunizations: Improve childhood immunization rates (Child Health)
6. Access to Medical Specialists: Improve access to medical specialists for children and youth with special health care needs (CYSHCN)
7. Substance Abuse: Decrease substance abuse among maternal and child health populations (Cross-Cutting/Life Course)
8. Medical Home Access: Improve maternal and child health population access to medical homes (Cross-Cutting/Life Course)

### ***Strongly Considered Priority Needs***

The needs assessment process helped to illuminate gaps in care and services for MCH populations. Realizing that not all gaps can be addressed by the MCH block grant, there were a number of priority needs that were strongly considered by MCH leadership team but were not selected. Throughout the needs assessment process, access to mental health services was identified as a top need across most MCH population domains. Although the MCH leadership team realized the importance of mental health services, the lack of these services is due to a fragmented mental health system in the state, which lacks resources such as providers, Medicaid options, and skilled treatment facilities. Adequacy of mental health services is a systemic issue and must be addressed to

skilled treatment facilities. Adequacy of mental health services is a systemic issue and must be addressed to improve access to services for all Idahoans, including the state's MCH populations.

Another priority need that ranked high in the needs assessment process was access to health insurance and the high cost of health care. The MCH leadership team acknowledged the importance of health care coverage and reducing health care costs and noted a number of initiatives and programs currently underway to transform the health care system. First, Idaho's state-based health insurance marketplace, established as part of the Affordable Care Act, ranked fourth in the nation, per capita, for the number of residents who enrolled in health insurance plans offered by the exchange as of February 2015. Second, Idaho was awarded more than \$39 million to implement the Statewide Healthcare Innovation Plan (SHIP) with the primary goal of transforming the Idaho healthcare delivery system from a fee-for-service, volume-based system to a value-based model driven by improved health outcomes. Finally, local MCH programs, such as home visiting and family planning, refer families to the marketplace for insurance needs. As more families become enrolled under the marketplace and changes to the health care delivery system begin to take shape, the MCH program will continuously monitor progress and identify ways to link MCH populations with adequate health care coverage.

### *Changes in Priority Needs Since 2010 MCH Needs Assessment*

In 2010, seven state priorities were identified through the five-year MCH needs assessment for three population groups: pregnant women and infants, children and adolescents, and children with special health care needs. The table below identifies the seven state priorities from 2010 and the eight state priorities from 2015 organized by the newly implemented MCH population domains and indicates whether the priority was continued, discontinued, replaced, or added.

<b>Domain</b>	<b>2010 Priority Need</b>	<b>2015 Priority Need</b>	<b>Status</b>
<b>Women/Maternal Health</b>	Increase percent of women incorporating preconception planning and prenatal health practices	Increase percent of women accessing prenatal care	Replaced
	Reduce the incidence of teen pregnancy		Discontinued
<b>Perinatal/Infant Health</b>	Reduce premature births and low birth weight		Discontinued
		Improve breastfeeding rates	Added
<b>Child Health</b>	Reduce intentional injuries in children and youth	Increase the number of families who practice safe and healthy parenting behaviors	Replaced
	Decrease the prevalence of childhood overweight and obesity	Decrease the prevalence of childhood overweight and obesity	Continued
<b>Adolescent Health</b>	Improve immunization rates	Improve immunization rates	Continued
		Improve MCH population access to medical homes (cross-cutting)	Added
<b>CYSHCN</b>	Improve access to medical specialists for CSHCNs	Improve access to medical specialists for CYSHCNs	Continued
<b>Cross-cutting/ Life Course</b>		Decrease substance abuse among MCH populations	Added
		Improve MCH population access to medical homes	Added

For women and maternal health, the need to increase women incorporating preconception planning and prenatal health practices was replaced with increasing women who access prenatal health care. In the 2015 needs assessment, prenatal care was identified as a common theme of need across data collection methods although preconception care practices were available for selection on surveys. Focusing solely on prenatal care will allow for more targeted strategies, such as linking pregnant women to providers through local home visiting programs. The need to reduce incidence of teen pregnancy was discontinued as live births to teen mothers fell by nearly one-third between 2008 and 2012 and the need was not reflected in the 2015 needs assessment findings.

For perinatal and infant health, the priority need of reducing premature births and low birth weight was discontinued because these are complex birth outcomes that can be related to a number of perinatal factors, such as well-visits, prenatal care, oral health, and substance use. Improving breastfeeding rates was added as a priority need as perinatal nutrition was ranked as a top need in the 2015 needs assessment. Reduction of intentional injuries was revised to reflect a broader need to support families with healthy and safe parenting behaviors during infancy and early childhood. This need links nicely to the work currently done by the state’s Infant Mortality CoIIN team.

For child health, both of the priority needs for reducing childhood overweight and obesity and improving immunization rates from 2010 were continued in 2015. Although some progress has been made on immunizations, needs assessment results reflect an overwhelming need to continue work in both areas.

For adolescent health, the 2015 needs assessment results reflected a combined need for routine care, immunizations, and annual well-visits for this age group. While the need to link MCH populations to a medical home was identified as a cross-cutting life course priority, it is particularly relevant for youth as the state selected “NPM 10: Adolescent Well-Visits” as one of the eight areas to focus efforts for the next five years.

For CYSHCN, the priority need to improve access to medical specialists was once again reflected as a top need in the 2015 needs assessment. Efforts to support existing specialty clinics and increase the number and type of clinics will be continued in this area for the next five years.

The cross-cutting/life course domain is a newly added category for the 2015 application year, therefore both priority needs are newly added.

#### II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

##### NPM 1-Percent of women with a past year preventive medical visit

	2016	2017	2018	2019	2020
<b>Annual Objective</b>	54.7	54.8	54.8	54.9	54.9

##### NPM 4-A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

	2016	2017	2018	2019	2020
<b>Annual Objective</b>	85	85.5	85.8	86	86.1
<b>Annual Objective</b>	25.3	25.7	25.8	25.9	26

**NPM 5-Percent of infants placed to sleep on their backs**

	2016	2017	2018	2019	2020
<b>Annual Objective</b>	82	82.2	82.3	82.5	82.6

**NPM 8-Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day**

	2016	2017	2018	2019	2020
<b>Annual Objective</b>	28	28.1	28.2	28.2	28.3

**NPM 10-Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

	2016	2017	2018	2019	2020
<b>Annual Objective</b>	66.2	66.3	66.4	66.5	66.6

**NPM 11-Percent of children with and without special health care needs having a medical home**

	2016	2017	2018	2019	2020
<b>Annual Objective</b>	59.8	59.9	60	60.1	60.2

**NPM 13-A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year**

	2016	2017	2018	2019	2020
<b>Annual Objective</b>	61.2	61.4	61.6	61.7	61.8
<b>Annual Objective</b>	79.3	79.4	79.5	79.5	79.6

**NPM 14-A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes**

	2016	2017	2018	2019	2020
<b>Annual Objective</b>	10.3	10.3	10.2	10.2	10.1
<b>Annual Objective</b>	20.2	20.1	20	20	19.9

programming. The MCH team ensured that at least one NPM from each of the six MCH population domains was selected. The table below identifies Idaho's eight state priority needs and linked NPMs by the six MCH population domains.

<b>Domains</b>	<b>State Priority Needs</b>	<b>National Performance Measure (NPM)</b>
<b>Women/Maternal Health</b>	Increase percent of women accessing prenatal care	<b>NPM 1: Well-woman visits</b> Percent of women with a past year preventive medical visit
<b>Perinatal/Infant Health</b>	Improve breastfeeding rates	<b>NPM 4: Breastfeeding</b> A. Percent of infants who are ever breastfed. B. Percent of infants who are breastfed exclusively through 6 months.
	Increase the number of families who practice safe and healthy parenting behaviors	<b>NPM 5: Safe Sleep</b> Percent of infants placed to sleep on their backs.
<b>Child Health</b>	Decrease the prevalence of childhood overweight and obesity	<b>NPM 8: Child Physical Activity</b> Percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day.
	Improve childhood immunization rates	N/A
<b>Adolescent Health</b>	Improve maternal and child health population access to medical homes (Cross-Cutting/Life Course)	<b>NPM 10: Adolescent Well-visit</b> Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
<b>CYSHCN</b>	Improve access to medical specialists for children and youth with special health care needs	<b>NPM 11: CYSHCN Medical Home</b> Percent of children with and without special health care needs having a medical home.
<b>Cross-Cutting/Life Course</b>	Decrease substance abuse among maternal and child health populations	<b>NPM 14: Smoking</b> A. Percent of women who smoke during pregnancy. B. Percent of children who live in households where someone smokes.
	Improve maternal and child health population access to medical homes	<b>NPM 13: Oral Health</b> A. Percent of women who had a dental visit during pregnancy. B. Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.

For women and maternal health, selection of “NPM 1: Well-Woman Visits” was based on the results from the needs assessment indicating the need to focus on routine care for women, including prenatal care for pregnant women. Under the Affordable Care Act, the Health Resources and Services Administration Women's Preventive Services Guidelines indicates that well-woman visits include a “visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception care and many services necessary for prenatal care” (<http://www.hrsa.gov/womensguidelines>). Further, data supports this area as a gap in service for women as Idaho’s rate of annual well-woman visits is 14% lower than the national rate (2013 BRFSS data).

For perinatal and infant health, two national priority areas were selected to align with the state’s priority needs: “NPM 4: Breastfeeding” and “NPM 5: Safe Sleep”. The needs assessment identified perinatal nutrition, specifically breastfeeding and supporting a healthy home environment, including injury prevention and healthy parenting practices as state priority needs. Although national data indicate Idaho is faring better than the national averages for breastfeeding and safe sleep practice, the MCH team chose to identify these as priority areas in order to leverage the momentum behind current program activities and initiatives to continue to improve state rates. According to the CDC Report Card issues in 2014 (2011 rates) on Breastfeeding, Idaho has an 84.4% rate of ever breastfed and strong initiation of breastfeeding rates. However, duration of exclusive breastfeeding is 40.2% at three months and 24.8% at six months. The MCH program, including the MIECHV program has strengthened collaboration with the WIC program over the past few years and will continue to promote breastfeeding as part of MCH programming. As part of the Infant Mortality CoIIN work, Idaho is addressing safe sleep practices through increasing child care and health provider education.

For child health, the MCH team chose to continue two priority needs identified for this population from the last five-year reporting cycle (FY 2011 – FY 2015): reducing childhood overweight and obesity and increasing immunization rates. The 2015 needs assessment reflected that both areas are still weaknesses for Idaho children. Although the percentage of Idaho children being current on key vaccinations has increased by 18% since 2008, Idaho still lags behind the national average. The MCH program will be supporting the work of the Idaho Immunization program to provide education to the public and health care providers about the importance of immunizations, addressing immunization hesitancy, and best practices to increase immunization rates. When comparing Idaho children to children nationally on measures related to overweight and obesity, Idaho children get slightly less daily physical activity on average than those nationally and Idaho has a lower percentage of children who are overweight or obese than national averages (National Survey of Children's Health, 2011/12). The MCH program plans to collaborate with the Idaho Physical and Nutrition program to increase state activities focused on helping children achieve a healthy weight. Additionally, both priorities align with the priorities to be addressed by Idaho’s SHIP model testing grant and the Idaho Division of Public Health’s “Get Healthy Idaho” plan.

For adolescent health, the MCH team selected “NPM 10: Adolescent Well-Visits.” Selection of this NPM for the adolescent health domain is supported by the state’s cross-cutting/life course priority need of improving maternal and child health population access to medical homes. Establishing a medical home for adolescents is particularly important as Idaho teens, aged 12 to 17, lag behind the national rate for a preventive well-visit in the past year by about 20% (65.7% compared with 81.7%, respectively) (National Survey of Children’s Health (NSCH), 2013).

For CYSHCN health, “NPM 11: Medical Home” was selected to align with the state’s priority need of improving access to medical specialists for children and youth with special health care needs. This priority need is a carryover from the previous five-year reporting cycle. According to the 09/10 NS-CSHCN, Idaho mirrors the national rate of CYSHCN who receive coordinated, ongoing, comprehensive care within a medical home at about 43%. A component of a medical home is referral to and coordination with specialty and sub-specialty care providers – something that Idaho significantly lacks when compared with more populous states. Idaho plans to continue to provide financial support for pediatric specialty clinics and will partner with local public health districts and hospitals to identify specialist needs and recruit specialists. Idaho’s work through the SHIP model testing grant will also help increase the number of CSHCN who are linked to a medical home.

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For the cross-cutting/life course health domain, the MCH program selected two NPMs that align with state priority needs. “NPM 14: Smoking” aligns with the state’s priority need to decrease substance abuse among MCH populations. As part of the Infant Mortality CoIIN work, Idaho is addressing smoking cessation for pregnant women and women of reproductive age. Smoking cessation aligns with the priorities to be addressed by Idaho’s SHIP model testing grant and the Idaho Division of Public Health’s “Get Healthy Idaho” plan. “NPM 13: Oral Health” aligns with the state’s priority need to improve MCH population access to medical homes. The MCH program plans to partner with primary care providers to develop education messages for women and children about the importance of oral health care and link them to a dental medical home.

#### **II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures**

Idaho will develop three to five State Performance Measures (SPMs) as part of the FY2017/2015 Title V MCH Block Grant Application/Annual Report. These SPMs will address the unique needs of the state’s MCH populations which are not already addressed by NPMs.

## II.F.1 State Action Plan and Strategies by MCH Population Domain

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Increase percent of women accessing prenatal health care	Increase the number of women who initiate prenatal care during the first trimester by July 2020.	Through collaboration with the Idaho WIC program, MIECHV program, and the Family Planning program, increase referrals of pregnant women to prenatal care.	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births	Percent of women with a past year preventive medical visit		

### Women/Maternal Health - Plan for the Application Year

To address the priority need of increasing the percent of women who access prenatal care, the MCH program will collaborate with the MIECHV program, Title X Family Planning, and the WIC program to access pregnant women for referral to prenatal care. Idaho received two competitive MIECHV expansion grants for FY2014 and FY2015 which allowed the program to expand from four home visiting sites to ten sites across the state, with potential to add one or two more sites in the coming year. Through MIECHV funding, Idaho is supporting two Nurse-Family Partnership (NFP) programs and two Early Head Start, Home-Based

programs (EHS), and six Parents as Teachers (PAT) programs. At full capacity, the programs are expected to serve about 490 families combined. While NFP exclusively serves pregnant women, all of the programs can enroll women prenatally. The local MIECHV programs are expected to develop their own community-based referral systems, which includes referral to OB/GYNs, family practices, and other providers for prenatal care. The new expansion sites are expected to begin service delivery between May and July 2015. As programs are ramping up, the MCH program will work with the MIECHV program to assure that prenatal care is discussed with all pregnant women and that an appropriate referral is made. Among the four original MIECHV program sites, there were 112 women who were pregnant at program enrollment. Approximately 75% indicated they had a primary care or prenatal care provider at intake. Of those who did not have a provider, only 46% received a referral for prenatal care. Clearly, there is opportunity for improvement for programs to aim for 100% of women to receive a prenatal care referral. MCH will work with MIECHV to determine if additional training or resources are needed for the local home visiting programs to increase prenatal care referrals.

In the Title X Family Planning program, women who receive a positive pregnancy test are offered a variety of information based on their disposition during the visit. If a client was planning the pregnancy, desires the pregnancy, or seems clear about wanting to continue the pregnancy, the client receives a packet which includes a list of prenatal care providers who accept Medicaid, as well as information about Medicaid and WIC. If a client seems unsure about the pregnancy, the same packet is offered with a list of prenatal care providers, Medicaid, and WIC information, and other options such as adoption and/or termination are discussed. In health district 7, a program called Medicaid Ineligible Pregnancy Services (MIPS) helps pregnant women who are Medicaid ineligible navigate the prenatal process. Medicaid Ineligible women include non-residents such as international students, refugees, and those who are undocumented. Women are given a list of prenatal care providers who will accept the Medicaid rate (which would be paid out-of-pocket). These women can get their prenatal lab work through the health district, which is less expensive than through a private provider. MIPS also includes paperwork to get a Medicaid Emergency Card for post-delivery. In CY 2014, the Idaho Title X Family Planning clinics had 17,184 unduplicated clients. Among these clients, 1,061 received positive pregnancy tests. An estimated 79% of women who received a positive pregnancy test were given a referral to prenatal care and approximately 3% were given a referral for high risk pregnancy care. MCH will work with the Title X program to determine how to increase the prenatal care referral rate through training or other resources.

For the WIC program, any pregnant woman who does not have a prenatal care provider at the point of program entry receives an automatic referral. During follow-up visits, the client is asked about receipt of prenatal care. MCH will work with WIC to determine a baseline for the prenatal care referral rate and then identify ways to address any gaps in prenatal care referral and follow-up.

The MCH block grant will continue to support the Idaho Oral Health Program's efforts to provide oral health education to pregnant women and health care providers and assisting with dental home referral. Realizing the barrier of lacking a systematic approach to ensuring pregnant women receive dental care, MCH will support the collaboration between the Oral Health Program and WIC to identify strategies to link pregnant women with dental homes. These activities align with the cross-cutting state priority need of improving MCH access to medical homes and NPM 13: Oral Health.

The MCH block grant will continue to fund Idaho Family Planning Program's subgrants to local public health districts to provide family planning services in accordance with Title X regulations. Funding of family planning services aligns with the state priority need of increasing prenatal care visits and the NPM of increasing preventive well-visits for women.

NPM 1 - Percent of women with a past year preventive medical visit

**Annual Objectives**

	2016	2017	2018	2019	2020
Annual Objective	54.7	54.8	54.8	54.9	54.9

The MCH block grant provides funding to the Idaho Family Planning Program to support subgrants to the local public health districts to provide family planning services on a sliding-fee scale in accordance with Title X to women of reproductive age, as well as adolescents and men. Family planning services at the local level include reproductive health exams, pregnancy testing, counseling, and preventive health education. In 2014, the family planning programs served 17,184 unduplicated clients. In the fall of 2014, the health district in south central Idaho determined they could no longer provide family planning services to their designated counties due in part to another Title X grantee receiving funds to serve their area and losing a clinician to oversee the family planning services. Currently, six of the seven local public health districts provide family planning services.

FFY14 block grant funds were used in the Women/Maternal Health and Cross-Cutting/Life Course population domains by helping to fund the Idaho Oral Health Program (IOHP). During the prior year, the PEW Charitable Trusts assigned the state of Idaho an “A” grade for protecting children from tooth decay with the application of dental sealants. Idaho was one of only five states to receive this distinguished grade. The reason Idaho is top in the nation for protective sealants is due to many collaborative networks involving private and public entities. All seven Public Health Districts (PHDs) in Idaho provide dental sealants to elementary school children through School-Based/Linked Dental Sealant Clinics and Give Kids a Smile Day, two events focusing on the education and application of dental sealants. Along with providing dental sealants, the PHDs also provided oral health screenings or assessments, fluoride varnish applications, oral health education, and facilitated dental home referrals as needed. One of the major challenges for the IOHP is that, currently, there is not a systematic approach to ensure pregnant women receive dental care during pregnancy besides providing oral health education to both pregnant women and healthcare providers, and assisting with the facilitation of a dental home referral. An ongoing and improved collaboration with Women, Infants, and Children clinics and education surrounding the effects of poor oral health on pregnancy outcomes should help combat this challenge in the future. Also, the IOHP recently began the process of updating the 2015-2020 Idaho Oral Health Action Plan to be released later this year. The goals outlined in this plan, among others, will help ensure oral health professionals and settings in Idaho are working toward the same objectives and are able to reach more children and pregnant women.

The MCH Program supported a collaboration between the Idaho Lives Project (ILP), the Idaho State Department of Education (SDE), the Suicide Prevention Action Network of Idaho (SPAN Idaho), and their partners to reduce suicide in Idaho by targeting the Adolescent Health domain, which has suicide rates significantly higher than the national average. The ILP is a systematic and comprehensive approach using Sources of Strength (Sources), Shield of Care, community gatekeeper training and updated assessment and treatment training for health, mental health, and substance abuse professionals to foster resilience and connectedness through Idaho communities and prevent youth suicide. Sources is at the core of the ILP and is an ongoing, strength-based, comprehensive wellness program that focuses on youth suicide prevention, but also impacts other issues that affect additional population domains, such as the substance abuse aspect of the Cross-Cutting/Life Course domain, as well as, the Women/Maternal Health and Child Health domains by helping to reduce the occurrences of violence within those domains. Another core component of the ILP is to provide gatekeeper training to all staff of participating Sources schools and their surrounding community members, “Train the Trainer” models. Gatekeeper training presents the warning signs of a suicide crisis and how to respond by questioning an individual’s intent

regarding suicide, persuading an individual to seek help, and referring the individual to resources, which aid in preventing crises from occurring.

The Idaho Women, Infants, and Children (WIC) Program used FFY14 block funds to support the Women/Maternal Health, Perinatal/Infant Health, and Child Health population domains. Specifically to the Women/Maternal Health and Perinatal/Infant Health domains, funds helped enhance the Management Information System, WIC Information System Program (WISPr), to allow for better documentation of breastfeeding aid inventory and issuance and breastfeeding peer counseling services in the prior year. These enhancements also streamlined paperwork, freeing clinicians' time to work with participants of the population domain. For the Child Health domain, the Idaho WIC Program participated in the 2014 Idaho Hunger Summit, the Idaho Hunger Relief Task Force, and a statewide Childhood Hunger Coalition. The WIC Program also collaborated with the Healthy Eating Active Living (HEAL) network, which has a purpose of developing and maintaining an active engaged network of partners working together, investing resources and expertise to create/support an active living, healthy eating population in Idaho towards reducing/preventing childhood obesity. Additional WIC activities in the prior year include participation in the Preventing Childhood Obesity Learning Collaborative meeting focused on the Maternal, Infant, and Early Childhood Home Visiting Program expansion and promoting food packages which align with the Dietary Guidelines for Americans by increasing the cash value voucher dollar amount for children (allowing caregivers to purchase more fresh fruits and vegetables for their child) and altering previous standards to reflect more healthy choices. WIC continues to participate in the coalitions and councils stated above and is assisting in piloting a Screen and Intervene Project as a targeted intervention for families with children who are food insecure.

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Improve breastfeeding rates	Increase the percentage of infants breastfeeding at 3 months postpartum by July 2020	Through collaboration with the Idaho WIC Peer Counseling program, peer counselors will educate postpartum women about baby behavior and feeding cues during the 3 months after delivery. Through collaboration with the Idaho Physical Activity and Nutrition Program, increase the number of worksites who offer lactation and breastfeeding support to breastfeeding employees.	Post neonatal mortality rate per 1,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months		
Increase the number of families who practice safe and healthy parenting behaviors	By July 2020, reduce infant sleep-related deaths by improving safe sleep practices.	Through CoINN Infant Mortality efforts, provide safe sleep practice education to families and providers. Through CoINN Infant Mortality efforts, increase safe sleep practices by new moms.	Infant mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	Percent of infants placed to sleep on their backs		

## **Perinatal/Infant Health - Plan for the Application Year**

To address the priority need of improving breastfeeding rates, the MCH program will collaborate with the Idaho WIC Peer Counseling program. The Idaho WIC Breastfeeding Coordinator will train Peer Counselors on Baby Behaviors using the Baby Behaviors Learning and Management System training guidebook. Strategies discussed in the guidebook regarding baby cues and normal baby behavior will be used to target specific information to provide to postpartum women at 3 target dates from birth of the baby to 3 months postpartum. The contacts will consist of an initial target contact within 72 hours postpartum, a 4-6 week postpartum contact, and a 3 month postpartum contact. During each contact, specific information on what the mother can expect and normal baby behavior during this time will be discussed. The goal of the contacts will be to support the continuation of breastfeeding during this critical early period.

Another strategy for improving breastfeeding will include collaboration between the MCH program and the Idaho Physical Activity and Nutrition (IPAN) Program. IPAN currently contracts with the seven local public health districts to conduct wellness assessments of 10 worksites annually. The local public health districts work with employers in their area to complete the CDC Worksite Health Scorecard, create action plans, and assist in wellness program implementation. Part of these wellness assessments includes whether or not a worksite offers breastfeeding or lactation support to working mothers. Lactation support includes having a written policy about breastfeeding for employees, providing a private space for breastfeeding (not a restroom), providing access to a breast pump, providing flexible breaks to accommodate breastfeeding mothers, providing breastfeeding education classes to employees, or providing paid maternity leave separate from accrued sick or vacation leave. The health districts will create action plans for employers who score low in lactation support or other areas. Together, MCH and IPAN will offer resources or tool kits to employers to support breastfeeding employees.

To address the priority need of increasing the number of families who practice safe and healthy parenting behaviors, the MCH program is going to leverage the work currently underway by the Infant Mortality CoIIN team to improve safe sleep practices. Both the Title V MCH and CYSHCN directors lead the CoIIN team. To address safe sleep, Idaho has a pilot occurring with child care providers in the northern part of the state. Forty-five child care providers have been trained safe sleep practices by the Inland Northwest SID organization representative on the CoIIN team. A pre-post-test of safe sleep practices and messages was conducted using information from Dr. Goodstein with the American Academy of Pediatrics Task Force. In addition, a small group of nursing students were given the same pre-post-test on safe sleep practices and messages. The Idaho Pregnancy Risk Assessment Tracking System (PRATS) is funded by Idaho's SSDI grant and is similar to PRAMS is gearing up for its annual survey of new mothers regarding maternal experiences and health behaviors surrounding pregnancy. For the 2015 survey, new questions were added to gauge parents practices related to infant sleeping. As part of the incentive to complete the survey, respondents are being provided a board book, "Sleep Baby, Safe and Smug". By FY 2016, the CoIIN team will have been through an entire cycle and will have information about which safe sleep messaging and training activities were successful and enhanced PRATS data about safe sleep practices. The MCH program will use this information to determine the next population group for targeted education and messaging.

The MCH block grant will continue to provide funding for personnel and operations of the Idaho Newborn Screening Program as this is considered an essential population-based public health screening program. Further, Idaho NBS Program leadership will move forward with adding Severe Combined Immunodeficiency (SCID) to the panel of screened conditions in November 2015. The NBS program will contract with a pediatric infectious disease specialist to provide consultation to the program and offer diagnostic, follow-along, and referral services in cases of presumptive positives.

## **Perinatal/Infant Health - Annual Report**

NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

**Annual Objectives**

	2016	2017	2018	2019	2020
Annual Objective	85	85.5	85.8	86	86.1
Annual Objective	25.3	25.7	25.8	25.9	26

NPM 5 - Percent of infants placed to sleep on their backs

**Annual Objectives**

	2016	2017	2018	2019	2020
Annual Objective	82	82.2	82.3	82.5	82.6

The FFY14 MCH state match funds supported the activities of the Idaho Immunization Program (IIP). The state match comes from the vaccine assessment program which keeps vaccines free for insured children (uninsured children are covered with federal funds). The IIP holds three annual ShotSmart conferences around the state that focus on improving the immunization rates of the stated population domain. Immunization education is also offered in conjunction with the Idaho Immunization Coalition and the Centers for the Disease Control (CDC). Funding also supplements the immunization registry, multiple informational mailings, and upkeep and monitoring of an electronic health records system. The 2015 Idaho Legislature was considered a success by the IIP. The legislature extended the vaccine assessment program for an additional two years in addition to passing a law that legalized bi-directional data exchange between the immunization registry and electronic health record systems. Due to a legal opinion from Idaho's Deputy Attorney General, the IIP is no longer allowed to do immunization record reviews in school, so during the 2014-2015 school year, the program made ongoing efforts to ensure school staff, nurses, and families were aware of the Kindergarten Immunization requirements through letters being sent to each school principal and superintendent throughout Idaho.

The MCH program supported the Idaho Sound Beginnings (ISB) program through service on the advisory board. The ISB program aims to increase the percentage of newborns that receive a hearing test prior to one month of age. In the past year, ISB has increased this percentage by 0.20%, up to 99.38%. ISB was able to dramatically increase the percent of infants undergoing hearing tests by periodically and systematically training newborn hearing screening staff in all birth facilities in Idaho. Another helpful factor was the improved communication to midwife clinics and other forms of out-of-hospital births to increase reporting. Some of the MCH block grant funds were used for technological advances including the installation of the ISB database web application on midwife computer systems for online reporting, creating an interface between the Idaho Vital Records database and the ISB database, creating an interface between the Idaho Infant Toddler Program (ITP) and the ISB database, and expanding the ITP database to include new data points.

In the fall of 2014, the MCH block grant provided additional funding to the Idaho NBS Program to implement a next-business-day courier service which is free to first specimen providers in the state in an effort to reduce transit times to the Oregon State Public Health Laboratory. The courier service has reduced specimen transit times from four-five days to an average of one day. This courier service has not only reduced transit times, which ensures specimens are handled and processed as quickly as possible, but it has also reduced errors in screening, including lost-to-follow-ups.

The Idaho Women, Infants, and Children (WIC) Program used FFY14 block funds to support the Women/Maternal Health, Perinatal/Infant Health, and Child Health population domains. Specifically to the Women/Maternal Health and Perinatal/Infant Health domains, funds helped enhance the Management Information System, WIC Information System Program (WISPr), to allow for better documentation of breastfeeding aid inventory and issuance and breastfeeding peer counseling services in the prior year. These enhancements also streamlined paperwork, freeing clinicians' time to work with participants of the population domain. For the Child Health domain, the Idaho WIC Program participated in the 2014 Idaho Hunger Summit, the Idaho Hunger Relief Task Force, and a statewide Childhood Hunger Coalition. The WIC Program also collaborated with the Healthy Eating Active Living (HEAL) Network, which has a purpose of developing and maintaining an active engaged network of partners working together, investing resources and expertise to create/support an active living, healthy eating population in Idaho towards reducing/preventing childhood obesity. Additional WIC activities in the prior year include participation in the Preventing Childhood Obesity Learning Collaborative meeting focused on the Maternal, Infant, and Early Childhood Home Visiting Program expansion and promoting food packages which align with the Dietary Guidelines for Americans by increasing the cash value voucher dollar amount for children (allowing caregivers to purchase more fresh fruits and vegetables for their child) and altering previous standards to reflect more healthy choices. WIC continues to participate in the coalitions and councils stated above and is assisting in piloting a Screen and Intervene Project as a targeted intervention for families with children who are food insecure.

State Action Plan Table						
Child Health						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Decrease the prevalence of childhood overweight and obesity	By July 2020, increase the number of child care providers and other educators who receive training on healthy behaviors for children.	Through collaboration with the Idaho Physical Activity and Nutrition Program, increase the number of child care providers trained on healthy behaviors for children.	Percent of children in excellent or very good health Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day		

<p>Improve childhood immunization rates</p>	<p>By July 2020, increase the number of health care providers who meet or make significant progress towards meeting Healthy People 2020 goals for immunizations.</p>	<p>Through collaboration with the Idaho Immunization Program, provide education to health care providers about how to recommend the HPV vaccine to families and how to address HPV vaccine hesitancy with families.  Through collaboration with the Idaho Immunization Program, provide public education about the HPV vaccine Through collaboration with the Idaho Immunization Program, provide public education through public awareness campaigns about the importance of vaccinations  Through collaboration with the Idaho Immunization Program, provide education to health care providers about how to address general vaccine hesitancy.  Through collaboration with the Idaho Immunization</p>				
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	Program, education providers about immunization rates for individual practices and offer best practices for rate improvement. Through collaboration with the Idaho Immunization Program, award health care providers for reaching Healthy People 2020 goals			
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## Child Health - Plan for the Application Year

To address the priority need of decreasing prevalence of childhood overweight and obesity, the MCH program will collaborate with the Idaho Physical Activity and Nutrition to support their work with child care providers. High quality child care is an essential component to a child's healthy physical, mental, emotional, and social development. In Idaho, more than 76,000 children birth-to-six attend child care while their parents work or attend school, 60% of which are enrolled full-time\*. (NACCRRA, 2010). "Nationally, 60% of children under 5 are in some form of child care, spending an average of 29 hours/week in that care." (www.letsmove.gov). Every child deserves the best start in life and the child care setting presents a unique opportunity to inspire healthy changes in our youngest population. Teaching kids healthy habits from the start will help them learn to make healthy choices as they grow older. Through the "Let's Move! Child Care" initiative, Idaho child care providers have the opportunity to promote children's health by encouraging healthier physical activity and nutrition practices through five main goals: increasing physical activity, limiting screen time, providing nutritious foods, providing nutritious beverages, and encouraging breastfeeding. From 2016 to 2020, the IPAN program will be providing 14 training workshops each year for child care providers through the Idaho STARS, which is the state's child care training and professional development system. Further, IPAN will be developing a special training track through Idaho STARS for supporting healthy children in child care, with a parent engagement piece and online training modules.

To address the priority need of improving childhood immunization rates, the MCH program will collaborate with the Idaho Immunization program (IIP) to provide education about the importance of vaccinations and support health care providers in increasing immunization rates for their clinics. With current focus on increasing Human Papillomavirus Virus (HPV) vaccination rates among preteens, the IIP will work with health care providers on how to recommend the HPV vaccine to families and how to address HPV vaccine hesitancy. Public education about the HPV vaccine will also occur via social media, print media, and television/radio commercials. To improve overall vaccination rates, the IIP will provide education through public awareness campaigns about the importance of vaccinations and provide education to health care providers about how to address general vaccine hesitancy. The IIP will work directly with health care providers to determine immunization rates for individual practices and support the practices with implementing best practices for rate improvement. Each year, the IIP offers awards to health care providers for reaching or who make significant progress toward meeting Healthy People 2020 goals for specific immunizations.

The MCH block grant will continue to provide funding to the Idaho Oral Health Program to support activities to improve oral health among children. Activities include the application of dental sealants to elementary school children, oral health screenings or assessments, fluoride varnish applications, oral health education, and facilitated dental home referrals as needed. This funding aligns with the priority need of linking children to medical and dental homes and the Oral Health NPM.

## Child Health - Annual Report

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

### Annual Objectives

	2016	2017	2018	2019	2020
Annual Objective	28	28.1	28.2	28.2	28.3

The Idaho Women, Infants, and Children (WIC) Program used FFY14 block funds to support the Women/Maternal Health, Perinatal/Infant Health, and Child Health population domains. Specifically to the Women/Maternal Health and Perinatal/Infant Health domains, funds helped enhance the Management Information System, WIC Information System Program (WISPr), to allow for better documentation of breastfeeding aid inventory and issuance and breastfeeding peer counseling services in the prior year. These enhancements also streamlined paperwork, freeing clinicians' time to work with participants of the population domain. For the Child Health domain, the Idaho WIC Program participated in the 2014 Idaho Hunger Summit, the Idaho Hunger Relief Task Force, and a statewide Childhood Hunger Coalition. The WIC Program also collaborated with the Healthy Eating Active Living (HEAL) Network, which has a purpose of developing and maintaining an active engaged network of partners working together, investing resources and expertise to create/support an active living, healthy eating population in Idaho towards reducing/preventing childhood obesity. Additional WIC activities in the prior year include participation in the Preventing Childhood Obesity Learning Collaborative meeting focused on the Maternal, Infant, and Early Childhood Home Visiting Program expansion and promoting food packages which align with the Dietary Guidelines for Americans by increasing the cash value voucher dollar amount for children (allowing caregivers to purchase more fresh fruits and vegetables for their child) and altering previous standards to reflect more healthy choices. WIC continues to participate in the coalitions and councils stated above and is assisting in piloting a Screen and Intervene Project as a targeted intervention for families with children who are food insecure.

The MCH Program supported a collaboration between the Idaho Lives Project (ILP), the Idaho State Department of Education (SDE), the Suicide Prevention Action Network of Idaho (SPAN Idaho), and their partners to reduce suicide in Idaho by targeting the Adolescent Health domain, which has suicide rates significantly higher than the national average. The ILP is a systematic and comprehensive approach using Sources of Strength (Sources), Shield of Care, community gatekeeper training and updated assessment and treatment training for health, mental health, and substance abuse professionals to foster resilience and connectedness through Idaho communities and prevent youth suicide. Sources is at the core of the ILP and is an ongoing, strength-based, comprehensive wellness program that focuses on youth suicide prevention, but also impacts other issues that affect additional population domains, such as the substance abuse aspect of the Cross-Cutting/Life Course domain, as well as, the Women/Maternal Health and Child Health domains by helping to reduce the occurrences of violence within those domains. Another core component of the ILP is to provide gatekeeper training to all staff of participating Sources schools and their surrounding community members, "Train the Trainer" models. Gatekeeper training presents the warning signs of a suicide crisis and how to respond by questioning an individual's intent regarding suicide, persuading an individual to seek help, and referring the individual to resources, which aid in preventing crises from occurring.

FFY14 block grant funds helped support the Idaho Oral Health Program (IOHP). During the prior year, the PEW Charitable Trusts assigned the state of Idaho an "A" grade for protecting children from tooth decay with the application of dental sealants. Idaho was one of only five states to receive this distinguished grade. The reason Idaho is top in the nation for protective sealants is due to many collaborative networks involving private and public entities. All seven Public Health Districts (PHDs) in Idaho provide dental sealants to elementary school children through School-Based/Linked Dental Sealant Clinics and Give Kids a Smile Day, two events focusing on the education and application of dental sealants. Along with providing dental sealants, the PHDs also provided oral health screenings or assessments, fluoride varnish applications, oral health education, and facilitated dental home referrals as needed. One of the major challenges for the IOHP is that, currently, there is not a systematic approach to ensure pregnant women receive dental care during pregnancy besides providing oral health education to both pregnant women and healthcare providers, and assisting with the facilitation of a dental home referral. An ongoing and improved collaboration with WIC clinics and education surrounding the effects of poor oral health on pregnancy outcomes should help combat this challenge in the future. Also, the IOHP recently began the process of updating the 2015-2020 Idaho Oral Health Action Plan to be released later this year. The goals outlined in this plan, among others, will help ensure oral health professionals and settings in Idaho are working toward the same objectives and are able to reach more children and pregnant women.

State Action Plan Table						
Adolescent Health						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Improve maternal and child health population access to medical homes	By July 2020, increase the number of adolescents who receive information about the importance of regular well-visits.	Through collaboration with the Adolescent Pregnancy Prevention Program (APP), increase awareness of the importance of adolescent well visits among teens and families.	Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000 Percent of children with a mental/behavioral condition who receive treatment or counseling Percent of children in excellent or very good health Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile) Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.		

## **Adolescent Health - Plan for the Application Year**

To address the priority need of improving access to medical homes for adolescents, the MCH program will provide funding to and collaborate with the Adolescent Pregnancy Prevention (APP) program to increase the number of adolescents who receive information about the importance of regular well-visits. The AAP program coordinates with agencies, educational organizations, and other partners throughout the state to provide adolescents with resources concerning their sexual health. Reducing the Risk is a sexual health education curriculum for students ages 12-18, focusing on building knowledge of abstinence and contraception while providing a positive perception of sexual health and relationships. The Reducing the Risk curriculum is delivered in all seven health districts by coordinators across 15 sites. In McCall, a special afterschool group is being piloted by the health district called the Youth Adult Partnership (YAP). Through the Reducing the Risk class, a group of engaged students is recruited to participate in YAP. YAP is an equal partnership of youth and adults coming together to create, develop and implement ideas that promote a healthy community and positive social change. For FY2016, the MCH program has proposed incorporating the importance of adolescents seeking regular well-visits into the in-class curriculum. Further, the APP will vet the idea of creating an in-school or community project related to promoting adolescent well-visits through the YAP. The MCH program would provide funding to develop resources, promotional materials, and/or tool-kits to support the project.

## Adolescent Health - Annual Report

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

### Annual Objectives

	2016	2017	2018	2019	2020
Annual Objective	66.2	66.3	66.4	66.5	66.6

For the Adolescent Health domain, the MCH program supported the work of the Idaho Physical Activity and Nutrition Program (IPAN). Prior year activities from the IPAN include partnering with the Department of Education to provide statewide technical assistance to middle, junior high, and high schools on Comprehensive School Physical Activity Programs, healthy nutrition best practices, and the Smart Snacks regulations. The IPAN has also worked with seven pilot school district wellness councils throughout Idaho to help identify appropriate council members, provide an in-person training on physical activity and nutrition, and assist them in writing a wellness policy that is compliant with USDA regulation.

The MCH Program supported a collaboration between the Idaho Lives Project (ILP), the Idaho State Department of Education (SDE), the Suicide Prevention Action Network of Idaho (SPAN Idaho), and their partners to reduce suicide in Idaho by targeting the Adolescent Health domain, which has suicide rates significantly higher than the national average. The ILP is a systematic and comprehensive approach using Sources of Strength (Sources), Shield of Care, community gatekeeper training and updated assessment and treatment training for health, mental health, and substance abuse professionals to foster resilience and connectedness through Idaho communities and prevent youth suicide. Sources is at the core of the ILP and is an ongoing, strength-based, comprehensive wellness program that focuses on youth suicide prevention, but also impacts other issues that affect additional population domains, such as the substance abuse aspect of the Cross-Cutting/Life Course domain, as well as, the Women/Maternal Health and Child Health domains by helping to reduce the occurrences of violence within those domains. Another core component of the ILP is to provide gatekeeper training to all staff of participating Sources schools and their surrounding community members, "Train the Trainer" models. Gatekeeper training presents the warning signs of a suicide crisis and how to respond by questioning an individual's intent regarding suicide, persuading an individual to seek help, and referring the individual to resources, which aid in preventing crises from occurring.

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Improve access to medical specialists for children and youth with special health care needs	Increase the number of pediatric specialty clinics supported by the MCH block grant by the addition of one or more clinics by July 2020.	Increase financial support for pediatric specialty clinics. Partner with hospitals and local public health districts to identify specialist needs and recruit medical specialists	Percent of children with special health care needs (CYSHCN) receiving care in a well-functioning system Percent of children in excellent or very good health Percent of children ages 19 through 35 months, who have received the 4:3:1:3 (4):3:1:4 series of routine vaccinations Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	Percent of children with and without special health care needs having a medical home		

### Children with Special Health Care Needs - Plan for the Application Year

To address the priority need of improving access to medical specialists for CYSHCN, the MCH program will increase funding to increase the number and/or type of pediatric specialty clinics offered throughout the state. Currently, the MCH program supports phenylketonuria (PKU) clinics in Boise, northern Idaho, and eastern Idaho; genetic and metabolic clinics in Boise; cystic fibrosis clinics in Boise; and cardiac, craniofacial, and orthopedic clinics in eastern Idaho. Specialists currently travel from Utah and Oregon to Idaho to hold the specialty clinics. The MCH program will plan meetings with the children's hospital in Boise and the health district and hospital in eastern Idaho to assess specialist needs in the respective areas and assist with the recruitment and funding of pediatric specialty clinics. Recently, a need for a pediatric endocrinologist has been expressed in the eastern Idaho area. The MCH program will explore this need and funding for FY 2016.

The MCH block grant will continue to provide funding to Idaho's primary CYSHCN programs, including the Children's Special Health Program, Transition-to-Adulthood kits, and support for existing specialty pediatric clinics. Funding for the Title V Medical Home Demonstration for CYSHCN in Rural Idaho will be continued through December 2015. Further funding could be provided if the two local health districts involved in the demonstration identify methods to sustain the medical home coaching and training piece of the project provided through the Medicaid CHIC project. Funding for the CHIC project ends in February 2016.

## Children with Special Health Care Needs - Annual Report

NPM 11 - Percent of children with and without special health care needs having a medical home

### Annual Objectives

	2016	2017	2018	2019	2020
Annual Objective	59.8	59.9	60	60.1	60.2

The Idaho Children's Special Health Program (CSHP) is a statewide program for children with significant health problems or chronic illnesses/conditions requiring long-term medical treatment and rehabilitative measures. CSHP's family-centered, community-based and culturally sensitive care is provided through private providers and clinics around the state and includes diagnosis, evaluation, and medical rehabilitation services. CSHP provides financial support to residents of Idaho, from birth to eighteen years of age, who are uninsured. The program covers eight major diagnostic categories: Cardiac, Cleft Lip/Palate, Craniofacial, Cystic Fibrosis (no insurance restrictions), Neurologic, Orthopedic, Phenylketonuria (PKU) (no insurance restrictions), and Plastic/Burn. Children must meet the following criteria to be eligible for support from CSHP: Idaho resident, less than 18 years of age, and have no health insurance. The extent of CSHP financial support is determined by a sliding scale based on a family's annual income and size, and is subject to annual payment limits per client. In 2014, there were a total of 113 unique patients enrolled in the CSHP across eight diagnostic areas.

In an effort to address the need for access to medical specialists, the MCH program funds specialty pediatric clinics for PKU, Cystic Fibrosis, and others throughout the state. Annually, the MCH program supports 32 pediatric genetic clinics, 12 pediatric metabolic and PKU clinics, and 13 pediatric cystic fibrosis clinics through contracts with St. Luke's Children's Hospital in Boise. The MCH program funds at least twenty four cardiac clinics, at least four pacemaker clinics, and at least four cranial facial clinics through a contract with Eastern Idaho Public Health District. Further, the MCH program uses funds to bring a metabolic specialist and registered dietitian from Oregon twice per year to host PKU clinics in northern and eastern Idaho. Across all clinics in 2014, there were a total of 1,611 patients seen, which includes patient encounters, not just unique patients.

Another way MCH serves the CYSHCN population is through the development and dissemination of transition-to-adulthood kits for CYSHCN to help empower them to take a primary role in their healthcare. Issues like health insurance, finding a doctor who takes care of adults, choosing a work or school setting, transportation and housing present new and sometimes overwhelming challenges and are covered in an interactive and step-by-step approach in the transition kits by providing information and guidance about a very important part of that process – gaining healthcare independence. Parents can learn how to support youth in taking charge of their health care, and youth, teens, and young adults can learn the skills that will prepare them for success. Youth with special health care needs may need more time and practice to reach that goal, so early adoption of these transition plans is one of the main focal points and tools for success. There are currently three versions of the kit available which target different age groups: 12-15, 15-18, and 18+. The Idaho MCH Program distributes approximately 1,250 kits annually free-of-charge to any individuals or organizations who request them. The kits are available in English and Spanish and are available online at CSHP.dhw.idaho.gov. The online versions can be saved and filled out electronically by CYSHCN and their families.

In 2013, the MCH program partnered with the Idaho Medicaid's Children's Healthcare Improvement Collaborative (CHIC) Project and two local public health

districts in eastern Idaho to implement a medical home demonstration for CYSHCN living in rural areas of Idaho. A medical home coordinator (MHC) works out of each health district to partner with up to three rural pediatric or primary clinics in the area to support transformation to a patient-centered medical home. The MHC helps with educating practices on continuity of care, identifying patient populations, developing care plans, health education, preventive health, and care coordination. The MHC facilitates positive relationships between families and practices by serving as a member of the practice team. On the patient and family side, the MHC helps guide patients and their families through barriers in the complex healthcare system by connecting them to community resources, referrals, care conferences, and family-centered care to help manage each child's condition in a patient-centered way. As of July 2014, the participating clinics have seen vast improvements in patient care and process improvement. The assignment of a MHC to these clinics has been a key component to their success. The clinics are continuing to work toward their goal of delivering a team-based, patient-centered model of care, facilitated through a partnership of the primary care provider, patient (family), and the MHC. Accomplishments of the MHCs include: Increased communication between providers and staff, increased representation of the local health districts in rural community organizations and committees, increased coordination of care for patients and families, and increased connection to community resources. The MCH program has a contract with the University of Utah to conduct an independent evaluation of the medical home demonstration to document successes, challenges, and lessons learned.

**State Action Plan Table**

**Cross-Cutting/Life Course**

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Decrease substance abuse among maternal and child health populations	Increase the percentage of women of reproductive age that have attempted to quit smoking in the past 12 months by July 2020.	Through CoIIN Infant Mortality efforts, increase referrals to smoking cessation services. Through CoIIN Infant Mortality efforts, promote the use of NRT for appropriate individuals enrolled in cessation services.	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births Percent of children in excellent or very good health	A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes		

Improve maternal and child health population access to medical homes	By July 2020, increase the number of women, children, and families who receive information about the importance of regular dental visits and oral health care.	Partner with primary care to develop education messages for women and children about oral health care.	Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months Percent of children in excellent or very good health	A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year		
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**Cross-Cutting/Life Course - Plan for the Application Year**

To address the priority need of decreasing substance abuse among MCH populations, the MCH program will leverage the work currently underway by the Infant Mortality CoIIN team to reduce smoking among pregnant women and women of reproductive age. Both the Title V MCH and CYSHCN directors lead the CoIIN team. To address smoking cessation, Idaho currently has pilot activities underway to increase tobacco cessation. In an effort to increase referrals to tobacco cessation programs and /or nicotine replacement therapies, a pilot of two healthcare provider clinics is assessing impact of electronic referrals vs. the paper fax method that has historically been in place. It is assumed that ease of referral using the electronic method will yield increased referrals to cessation services. By FY 2016, the CoIIN team will have been through an entire cycle and will have information about which smoking cessation activities were successful. The MCH program will use this information to determine the next population group and/or evidence-informed activities for targeted education and messaging.

To address the priority need to improve MCH population access to medical homes and linkage to dental care, the MCH program will support the development of educational message for pregnant women and children and families about the importance of oral health care. There is opportunity through the oral health program and the SHIP model-testing grant to integrate oral health into the patient-centered medical home (PCMH) environment in primary care. As SHIP activities ramp up, the MCH program will explore strategies to incorporate oral health care competencies into the PCMHs or identify ways to link pregnant women and children with dental homes.

The MCH block grant will continue to fund the Idaho Bureau of Epidemiology to support contracts with local public health districts for infectious or communicable disease investigation and reporting across the state. Communicable disease reporting and investigation is viewed as an essential public health service, and pregnant women, infants, and children are particularly vulnerable populations impacted by this service.

The MCH block grant will continue to fulfill its obligation to fund the Idaho CareLine per OBRA legislation. The MCH program will continue to fund the Idaho Poison Control Hotline as this is viewed as an essential public health service that significantly impacts MCH populations.

**Cross-Cutting/Life Course - Annual Report**

NPM 13 - A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

**Annual Objectives**

	2016	2017	2018	2019	2020
Annual Objective	61.2	61.4	61.6	61.7	61.8
Annual Objective	79.3	79.4	79.5	79.5	79.6

NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

**Annual Objectives**

	2016	2017	2018	2019	2020
Annual Objective	10.3	10.3	10.2	10.2	10.1
Annual Objective	20.2	20.1	20	20	19.9

FFY14 block grant funds helped support the Idaho Bureau of Epidemiology in a cross-cutting fashion across multiple population domains by providing funding for contracts with the Idaho local Public Health Districts (PHDs). These contracts dictate rigorous proficiency training of PHD staff, including epidemiologists, with emphasis placed on MCH topic areas and population domains. Specifically, funds were used in support of the Women/Maternal Health, Perinatal/Infant Health, Child Health, and Adolescent Health population domains by helping to fund Epidemiology’s efforts to inform and educate the public regarding the outbreaks of multiple viruses and bacteria in 2014. These included the Enterovirus D68 state-wide outbreak that affected mostly children, an outbreak of pertussis in southwest and central Idaho, the measles outbreak associated with Disneyland, and a mumps outbreak in schools located in northern, central, and eastern Idaho. The avenues Epidemiology utilized to inform and educate the public regarding these outbreaks consisted of Health Alert Network (HAN) messages and press releases, website updates, and community outreach on community-wide outbreaks. As situations dictate, these informational and educational efforts will continue in 2015, as well. The Cross-Cutting/Life Course domain was supported by Epidemiology’s infection control education of professionals within the healthcare community. In 2014, each of the seven PHDs attended either a monthly or quarterly infection control meetings of at least one hospital within their jurisdiction. These meetings provide updates on current outbreaks, updated treatment or prevention guidelines, public health law, and reporting. Many PHD epidemiologists attended/supported health fairs specific to MCH population domains in 2014, which provide information to the public and regular interactions with community partners and associations. The PHD epidemiologists also provided disease incidence trend data regularly to local schools and school districts. The Bureau of Epidemiology also carried out active surveillance projects and activities in 2014 to address issues of under-reporting of reportable diseases, including pertussis contact investigations, surveillance of non-reportable diseases, or in response to a new public health threat or outbreak.

FFY14 block grant funds were used in the Women/Maternal Health and Cross-Cutting/Life Course population domains by helping to fund the Idaho Oral Health Program (IOHP). During the prior year, the PEW Charitable Trusts assigned the state of Idaho an “A” grade for protecting children from tooth decay with the application of dental sealants. Idaho was one of only five states to receive this distinguished grade. The reason Idaho is top in the nation for protective sealants is due to many collaborative networks involving private and public entities. All seven Public Health Districts (PHDs) in Idaho provide dental sealants to elementary school children through School-Based/Linked Dental Sealant Clinics and Give Kids a Smile Day, two events focusing on the education and application of dental sealants. Along with providing dental sealants, the PHDs also provided oral health education, community-based oral health assessments, and health education

sealants. Along with providing dental sealants, the PHDs also provided oral health screenings or assessments, fluoride varnish applications, oral health education, and facilitated dental home referrals as needed. One of the major challenges for the IOHP is that, currently, there is not a systematic approach to ensure pregnant women receive dental care during pregnancy besides providing oral health education to both pregnant women and healthcare providers, and assisting with the facilitation of a dental home referral. An ongoing and improved collaboration with Women, Infants, and Children clinics and education surrounding the effects of poor oral health on pregnancy outcomes should help combat this challenge in the future. Also, the IOHP recently began the process of updating the 2015-2020 Idaho Oral Health Action Plan to be released later this year. The goals outlined in this plan, among others, will help ensure oral health professionals and settings in Idaho are working toward the same objectives and are able to reach more children and pregnant women.

For the Cross-Cutting/Life Course domain, the MCH program supported Project Filter and reducing the percentage of women who smoke in the last three months of pregnancy. One of the major aspects of Project Filter is the Idaho QuitLine, which is a multifaceted tool to aid in smoking cessation. Through the Idaho QuitLine, Project Filter provides a specific counseling protocol for pregnant women that inquire about smoking cessation information. Over the prior year, nearly 60 pregnant women have joined the Idaho QuitLine, proving this service is of value to the MCH population domain listed above.

The MCH Program supported a collaboration between the Idaho Lives Project (ILP), the Idaho State Department of Education (SDE), the Suicide Prevention Action Network of Idaho (SPAN Idaho), and their partners to reduce suicide in Idaho by targeting the Adolescent Health domain, which has suicide rates significantly higher than the national average. The ILP is a systematic and comprehensive approach using Sources of Strength (Sources), Shield of Care, community gatekeeper training and updated assessment and treatment training for health, mental health, and substance abuse professionals to foster resilience and connectedness through Idaho communities and prevent youth suicide. Sources is at the core of the ILP and is an ongoing, strength-based, comprehensive wellness program that focuses on youth suicide prevention, but also impacts other issues that affect additional population domains, such as the substance abuse aspect of the Cross-Cutting/Life Course domain, as well as, the Women/Maternal Health and Child Health domains by helping to reduce the occurrences of violence within those domains. Another core component of the ILP is to provide gatekeeper training to all staff of participating Sources schools and their surrounding community members, "Train the Trainer" models. Gatekeeper training presents the warning signs of a suicide crisis and how to respond by questioning an individual's intent regarding suicide, persuading an individual to seek help, and referring the individual to resources, which aid in preventing crises from occurring.

As mandated by OBRA legislation, the Title V MCH block grant fulfills its role of informing parents, families, and others of available services and providers in the state by the provision of funding to the Idaho 2-1-1 CareLine. The Idaho 2-1-1 CareLine provides information and referral services on a variety of MCH, CYSHCN, Infant Toddler Program, and Medicaid issues, thus serving segments of the MCH population. The CareLine is considered to be the state's clearinghouse for information and services provided by the Idaho Department of Health and Welfare. The CareLine is managed by the Division of Family and Community Services.

The MCH block grant funds the state's poison control hotline through contract with the Nebraska Poison Control Center. The contract is managed by the MCH Program. Program staff monitor the contract, conduct National Poison Prevention Week outreach activities, and release Idaho-specific public service announcements for various poison related issues.

## **Other Programmatic Activities**

FFY14 MCH Block Grant funds were used for additional activities not directly identified in the prior needs assessment completed in 2010. For the population domains Women/Maternal Health and Perinatal/Infant Health, funds were used to enhance the Women, Infants and Children (WIC) data system. Specifically, block grant funding allowed the state program to work with information technology staff within the department to build a breastfeeding peer-counseling platform into the existing data system. The value of this effort to the MCH population domains noted is the ability of WIC peer-counseling staff to enter contact information, counseling notes and identified needs of breastfeeding women/infants into a data system for seamless encouragement and follow-through of breastfeeding support by WIC staff. For these same domains, funds were used to support the Pregnancy Risk Assessment Tracking Survey (PRATS). This is an annual survey of new mothers in Idaho regarding maternal experiences and health behaviors before, during and after pregnancy. PRATS provide prevalence estimates of risk factors associated with poor pregnancy outcomes and infant health. Data from PRATS is one piece of the information used to inform MCH block grant priorities and activities.

Specific to Perinatal/Infant Health domain was the use of MCH block grant funds in FFY14 to support the enhancement of the Electronic Birth Certificate (EBC) data system to allow medical providers to send birth records electronically to Vital Records. The impact to the MCH population is a reduction in possible human error in recording of live births in Idaho, along with ease of use by the medical community. Another use of block grant funds for the Perinatal/Infant Health domain is in the area of Newborn Screening. Block grant funds are used to support staff in the administration of the newborns screening program, support of the Oregon State Public Health Laboratory which processes the test kits for Idaho and in the use of overnight courier service for test kits. The addition of block grant funds to add a courier service is in direct response to efforts to decrease transit time from the collection of the test kit to the delivery of the kit for processing. In Idaho, this noted improvement resulted in a decrease in transit time from approximately five (5) days to one (1) day turnaround.

FFY14 block grant funds were used in the Cross-Cutting/Life Course domain in the following ways: 1) funds were used to support MCH Epidemiology contracts with local public health districts through the Bureau of Communicable Disease Prevention. Typical communicable diseases that warrant investigation are flu outbreaks, West Nile virus, Respiratory Syncytial Virus (RSV), Waterborne illnesses, Methicillian-Resistant Staphylococcus aureus (MRSA), to name a few. Within this past year, investigations were also conducted on tuberculosis of an infant and in the refugee population, a food outbreak at a local establishment and a recent norovirus investigation that impacted hundreds of students in one school in Idaho. About 180 children stayed home or were sent home after reporting illness May 7th. The number of students out of class rose to 468; nearly 60 percent of the entire student body. Another use of block grant funds that fell under this domain was in the support for a Continuous Quality Improvement Manager position within the Division of Public Health. This position assisted the MCH programs specifically in looking at root cause analysis of issues around declining WIC caseload, decreased screening rates for breast and cervical cancer and general process improvement opportunities for programs that serve the entire population base. This was a limited support by the block grant funds. Value was seen by the Division and funding for this position going forward will come from other funds within the Division. The MCH program staff will still have ongoing access to this resource.

In the Child Health domain, FFY14 block grant funds were used to purchase BMI wheels for medical providers to use when assessing the health of their pediatric patient populations. This relates to the Child Health domain. The BMI wheels were customized with the Idaho Health and Wellness Collaborative for Children (IHAWCC) logo. IHAWCC aims to create a meaningful collaboration of stakeholders invested in child health care quality, with the common purpose of improving child health in Idaho.

To address Other Program Activities that do not directly align with the State priorities that were identified in the five year needs assessment, the MCH Director, CYSHCN Director and Division of Public Health assessed remaining needs of the MCH program area and identified key areas that MCH funds should support with FFY16 block grant funds. Two needs were identified in the Cross Cutting/Life Course domain: 1) MCH Epidemiology and 2) financial support for a

Physician Consultant to the MCH program. MCH Epidemiology and value was discussed previously. A family practice physician, Dr. Clay Roscoe, who works with the Family Medical Residency Program and has a background in Public Health is now a part-time state employee working solely in the Division of Public Health. The block grant will be funding approximately ten (10) hours per week of the physician time over the next year. Dr. Roscoe will be available to the MCH program to provide consultation where needed. The MCH program and population served have already benefitted from this relationship in the Division. In Idaho, the newborn screening program supports tests for forty (46) conditions. Dr. Roscoe was instrumental in assisting the program with assessing the addition of Severe Combined Immunodeficiency (SCID) to the newborn screening panel and in providing interface with the medical community. The on-going support for Newborn Screening will directly impact the Perinatal/Infant Health domain.

The Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality is another area of planned block grant funds support in FFY16. This is specific to Women/Maternal, Perinatal/Infant and Child Health domains. The MCH Director and CYSHCN Director are overseeing the CoIIN team efforts for Idaho. The two strategies that were selected to focus efforts toward on reducing infant mortality are smoking cessation among pregnant women and promoting safe sleep practices for infants. Funds will be used to support messaging efforts for these strategies. No final decisions have been made on the specifics of funds use, but Back to Sleep board books, sleep sacks and outreach on tobacco use have been explored. Sharing the domains of Women/Maternal Health and Perinatal/Infant Health is the planned use of FFY16 funds to continue the PRATS survey data collection of new mothers. Further, on-going support for the Cross Cutting /Life Course domain is planned through MCH Epidemiology efforts, discussed previously.

Lastly, while not supported by MCH block grant funds, it is worth noting that the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program is Title V funded and aligns with the Cross Cutting /Life Course domain. The investment in home visiting is seen as a best practice, evidence-based approach to ensure families with young children or those in pregnancy care for children, understand child development and care for his/herself as the parent of children. Home visiting is viewed as a critical partner to the MCH program, along with the WIC program. Already, Idaho has seen value in connecting WIC with Home Visiting. WIC is the biggest referral source to the home visiting program.



## II.F.2 MCH Workforce Development and Capacity

The administration of the Maternal and Child Health (MCH) Block Grant is under the MCH Director and CYSHCN Director in the State. Each of these positions has other duties that take a substantial amount of time. The MCH Director is also the Chief, Bureau of Clinical and Preventive Services (BOCAPS) which has thirty-four (34) FTE's under this bureau; the CYSHCN Director is the Manager for the Maternal and Child Health Programs which has 9.5 FTE's within the program area. Each director provides 0.5 FTE support of the grant along with 0.5 administrative staff support. This past year, BOCAPS restructured the bureau to move the Title X Family Planning Program under the MCH Program area. Because of this restructuring, the bureau was able to reclassify a support position to a Health Program Specialist dedicated to MCH programs. Further, the bureau was able to have two (2) FTE's dedicated to Title X Family Planning. While these are viewed as positive changes that impact the delivery of services to the MCH populations, due to the small capacity of the state staff, prioritization of needs and activities is inversely impacted.

In Idaho, the Department of Health and Welfare is allocated FTE's by the State Legislature. Therefore, even if funding is available to support additional staff, unless there is an available FTE, the programs must prioritize activities and work within the number of FTE's given. This can be challenging, especially when new initiatives arise that take additional staff time and effort. Furthermore, when new funding opportunities present, staff must first complete a request to apply form, describe impact to staffing allocation(s) and present an exit strategy should funding be received and then go away. This information must be shared with the Governor's office for approval prior to writing for funding opportunities. On occasion the approval may take up to one to two weeks, further impacting writing timelines for funding opportunities.

Training is on-going for the MCH staff supported by the Title V Block MCH Block Grant. The Department offers a variety of online training opportunities. The Division of Public Health is comprised of several bureaus that all collaborate on training for staff. For example, this past year, the Division offered training to staff on Public Health Accreditation processes, strategic planning and impact, sub grant writing, root cause analysis, using Stephanie Evergreen presentation guide for Power Point, displaying data in an easy to understand format, to name a few.

### II.F.3. Family Consumer Partnership

The Idaho MCH program understands the importance of family and consumer partnerships as a mechanism to strengthen MCH programming at the state and local levels. The Title V Block Grant defines family/consumer partnership as “the intentional practice of working with families for the ultimate goal of positive outcomes in all areas through the life course. Family engagement reflects a belief in the value of the family leadership at all levels from an individual, community and policy level.” While Idaho is limited by the number of full-time equivalent positions (FTEs) granted by the legislature and is therefore unable to hire a family representative as MCH staff, the program engages in ancillary methods of soliciting input from families and consumers, such as serving on advisory committees with family representatives, including family partners in needs assessment activities, and requesting public input on the annual grant application.

The Title V MCH and/or Title V CYSHCN directors serve on the Idaho Parents Unlimited (Family to Family Information Center) advisory committee, the Idaho Council on Developmental Disabilities, and the Early Childhood Coordinating Council (ECCS grant), among others. All of these councils include at least two or more representatives who are parents of CYSHCN. The Title V directors will often share major MCH activities with councils and solicit input for programmatic consideration. Each year, the MCH program reaches out to these councils during the public comment period and asks that a link to the Title V MCH block grant application be shared with their membership and/or listserv of contacts for feedback and comment on the block grant. For the 2015 five-year needs assessment, a broad group of stakeholders was convened to assist with assessing the state system’s capacity to fill the gaps in services for MCH populations and to select state priorities for the next five years. This was the first time in nearly a decade that a meeting of this kind was held for the MCH block grant. The MCH program intentionally recruited parents of CYSHCN to attend the meeting and ultimately had two parent partners in attendance.

While there are some efforts underway to engage family partners to inform Title V programming, leadership realizes there is opportunity to bolster engagement of representatives from all MCH populations and that these partnerships are beneficial to the program at the state and local levels. Over the next five years, Title V leadership will explore potential strategies to further involve families and consumers in developing MCH programs and services. Some potential strategies include the development of MCH advisory committee which would include representation from all MCH populations, financially supporting an AMCHP family delegate to attend the annual AMCHP conference, and intentionally including family partners and consumers in the grant review process and when developing policies.

#### II.F.4. Health Reform

In 2014 the Idaho Legislature did not authorize the state to expand Medicaid. In the 2015, the governor-appointed workgroup developed options for expansion to share with legislators. During the 2015 legislative session other competing priorities arose which did not allow for the continued discussion of whether or not to expand Medicaid. As a result, it is estimated that Idaho has approximately 78,000 persons who fall in the coverage 'gap'. In essence, those individuals do not qualify for Medicaid coverage or for subsidized private insurance. Of those in the coverage gap, many access care through hospital emergency rooms, county indigent services and the state Catastrophic Fund and charity. For those that do get health insurance, many have very high deductibles.

In November of 2014, Your Health Idaho began operating as Idaho's fully state-based health insurance marketplace. For the 2015 coverage year, eligibility and enrollment was conducted by Your Health Idaho and the Idaho Department of Health and Welfare (the state Medicaid/CHIP agency). For the 2014 coverage year, Idaho was third in the nation per capita for the number of residents who selected health insurance plans just behind Vermont and Florida (State of Idaho, Your Health Idaho). At the close of the second enrollment period that ended February, 2015, Idaho had more than 85,128 individuals enrolled in health insurance plans through YourHealthIdaho. Idaho ranked fourth in the nation, per capita for the number of residents who selected health insurance plans offered on the exchange. Florida, Maine and Georgia were ahead of Idaho.

Title V staff supported the efforts of enrollment into the state-based exchange by educating staff on the state based exchange. In February 2015, the Division of Public Health participated in a conference call with the Catalyst Center in cooperation with the Office of Assistant Secretary for Planning and Evaluation to assess early impact of the Affordable Care Act (ACA) in Idaho on the Title V MCH and Title X Family Planning programs. HIV Care was also a participant. The CYSHCN Director and MCH Director, along with the Deputy Division Administrator for Public Health responded to a variety of questions about program activities aimed at helping the MCH population with emphasis on the CYSHCN and women of reproductive age, and ACA. Following the initial call, a virtual site visit was held on April 27, 2015 with the Catalyst Center/National Opinion Research Center (NORC) staff to expand on content provided by Idaho. At this writing, a final report is pending summarizing the results from the eight participating states. In addition, HIV Care and Title X staff at the local sub recipient level participated in a technical assistance three (3) part webinar series on ACA which was a coordinated effort by BOCAPS and Cardea. Information on how to refer clients to the exchange was shared, along with ideas for billing using the new ICD10 codes. This technical assistance was in direct response to sub recipient's identified needs.

The Title V MCH Program continues to fill a valuable role in 'gap-filling' services for children via the Children's Special Health Program (CSHP). Children with qualifying medical conditions are most often referred to CSHP by hospitals and pediatricians or family physicians. The family must also have 'no credible insurance' to qualify for enrollment in CSHP. After insurance determination is made, the family is contacted by CSHP staff to explain program enrollment and/or to be referred to other providers/programs. The Program provides claims payment and medical formula support for PKU clients. Enrollment into the PKU program is not restricted by age or insurance status, though services are limited for adults over 18 years of age.

## II.F.5. Emerging Issues

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 applied for the Model Testing grant proposal (MTP). [Source: State of Idaho Website]

In December, 2014 Idaho was awarded \$39,683,813 million dollars to implement the SHIP strategies over a four-year model test period that began February, 2015 (Attachment A-SHIP Award). The SHIP indicators identified as focus areas of work are Tobacco Cessation, Obesity, and Diabetes. The MCH Director is an active participant on the SHIP Population Health Workgroup.

Another emerging issue is in the area of the Community Health Worker (CHW) in Idaho. The CYSHCN and MCH Director are part of a workgroup established to evaluate where Idaho is currently in utilizing CHW's. In November, 2014 a stakeholder group was convened by the workgroup to identify a common definition of CHW in Idaho and next steps toward establishing a CHW certification program in Idaho. As a result of that meeting, Idaho initiated a two-part survey of the CHW in Idaho. One group surveyed was the providers who already use CHW or someone in a related capacity; the other group surveyed was community partners who may have existing CHW programs in place. A meeting to discuss survey results and convene a panel of CHW-type individuals is slated for July, 2015.

The Division of Public health is working toward Public Health Accreditation to further support the national public health accreditation program goal of improving and protecting the health of the public by advancing the quality and performance of state, local, territorial and tribal health departments. In August 2014, the Division of Public Health completed the pre-application checklist and in August 2014. The goal is to submit the formal application July 2015. The MCH Director is co-leading the PHAB team 2 which is over domains 1, 5 and 9. Domain 1 is to conduct and disseminate assessments focused on population health status and public health issues facing the community, domain 5 is develop public health policies and domain 9 is evaluate and continuously improve health department processes, programs and interventions. The CYSHCN Director is an active participant on the PHAB team 2.

## II.F.6. Public Input

The MCH Director and CYSHCN Director strive to engage partners and the public in the awareness, reporting of and creation of the MCH Block Grant Annual Report and Application process. Throughout the year, the directors participate on various stakeholder groups where frequent MCH program updates are provided. For example, the MCH Director is on the governor-appointed Early Childhood Coordinating Council (EC3) which is comprised of parents of CYSHCN and other key stakeholders invested in early child health and wellness from across the state. The CYSHCN Director is part of Idaho Parents Unlimited advisory board which is equivalent to the Family-to-Family engagement councils in other states, is on the Idaho Perinatal Project advisory committee, Maternal Infant and Early Childhood Home Visiting steering committee, and often provided updates to the EC3 committee. The MCH Health Program Specialist is a part of the Idaho Sound Beginnings; a program that administers the Early Hearing and Detection and Intervention program in Idaho.

Engaging families has historically been a challenge in Idaho. This past year, during the five year needs assessment data collection and subsequent capacity assessment and prioritization partner meeting, diligence was applied to ensure that family participation occurred. During the data collection for the five year needs assessment, the CYSHCN and MCH Director provided links to the survey collection to partners and parents of CYSHCN, among several other partners. WIC clients and staff were also specifically engaged, along with tribal partners. Two family representatives traveled to Boise for the capacity assessment and prioritization meeting-a first! Idaho posts the completed annual report and grant application on the department website for public comment. Awareness of the documents is shared via an announcement in key newspapers across the state, along with outreach to specific stakeholders by the sharing of the link to the website and documents with partners. Last year, no comments were received by the public.

## II.F.7. Technical Assistance

For FY 2016 – FY 2020, the MCH program anticipates at least two potential technical assistance needs. First, the program would like to enhance family and consumer engagement in Title V MCH programming and services and would like technical assistance on where to start and how to do this given our state's FTE limitations and rural nature. Second, Idaho's Children's Special Health Program (CSHP) is a legislatively defined program that offers financial assistance to uninsured children who meet certain diagnostic, age, and residence criteria with a co-pay based on a sliding fee scale. The program pays eligible medical claims at the state's Medicaid rate and pays up to a cap amount each fiscal year depending upon the diagnosis type. There are currently about 130 children enrolled in the program with about \$175,000-\$200,000 in medical claims paid in recent years. Enrollment in the program is expected to diminish as more families seek health insurance through the state-based marketplace. Since this program is one of the ways Idaho meets the minimum of 30% of Title V funds spent on CYSHCN, Title V leadership would like technical assistance on ways to repurpose the program to better serve this population.

### III. Budget Narrative

	2012		2013		2014	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$3,203,380	\$2,785,566	\$3,203,380	\$2,926,860	\$3,203,380	\$3,246,758
<b>Unobligated Balance</b>	\$0	\$0	\$0	\$0	\$0	\$0
<b>State Funds</b>	\$2,402,535	\$2,089,174	\$2,402,535	\$2,195,146	\$2,402,535	\$2,435,068
<b>Local Funds</b>	\$0	\$0	\$0	\$0	\$0	\$0
<b>Other Funds</b>	\$0	\$0	\$0	\$0	\$0	\$0
<b>Program Funds</b>	\$0	\$0	\$0	\$0	\$0	\$0
<b>SubTotal</b>	\$5,605,915	\$38,400,114	\$5,605,915	\$38,262,321	\$5,605,915	\$5,681,826
<b>Other Federal Funds</b>	\$36,440,601	\$4,874,740	\$40,530,062	\$5,122,006	\$38,058,901	
<b>Total</b>	\$42,046,516	\$43,274,854	\$46,135,977	\$43,384,327	\$43,664,816	\$5,681,826

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$3,216,931		\$3,216,931	
<b>Unobligated Balance</b>	\$0		\$0	
<b>State Funds</b>	\$2,412,699		\$0	
<b>Local Funds</b>	\$0		\$2,412,699	
<b>Other Funds</b>	\$0		\$0	
<b>Program Funds</b>	\$0		\$0	
<b>SubTotal</b>	\$5,629,630		\$5,629,630	
<b>Other Federal Funds</b>	\$40,620,256		\$37,149,010	
<b>Total</b>	\$46,249,886		\$42,778,640	

### III.A. Expenditures

#### Annual Report for FFY14

The MCH Block Grant match (\$2,435,068) requirement was met by utilizing the state Idaho Immunization Assessment Fund. The Idaho Immunization Program (IIP) located in the Department of Health and Welfare's Division of Public Health, continues to provide childhood vaccine products for all children residing in Idaho, including those with private insurance coverage who are not eligible for federal Vaccines for Children (VFC) program vaccines. Since July 1, 2010, non-VFC vaccine products for insured children have been purchased with funds collected from statutory mandatory assessments from insurers. The intent of the legislation (Idaho Code Title 41 Chapter 60) is to provide funding for the Idaho Immunization Program to continue to provide vaccines for insured children living in Idaho. While the assessment fund helps ensure the health of Idaho children, the money cannot be used for any purpose other than the purchase of childhood vaccines. The assessment fund is managed by an immunization board responsible for determining the method of assessment, assessing carriers or establishing policies and procedures. The board consists of nine (9) appointed members and one (1) ex officio member. It should be noted that no state general funds are provided to support maternal and child health in Idaho. All funding for activities under the management of the MCH Director and CYSHCN Director related to this population come from federal funds.

FFY14 MCH Block Grant funds were spent in accordance with the 30%-30% requirements. In FFY14, 46.1 percent of funds (\$1,495,655) were spent on Preventive and Primary Care for Children and 34.5 percent of funds (\$1,119,614) were spent on Children and Youth with Special Health Care Needs. The total amount of funds spent on Administration was 5.1 percent (\$166,776).

The MCH block grant provided funding to the Idaho NBS Program to implement a next-business-day courier service which is free to first specimen providers in the state in an effort to reduce transit times to the Oregon State Public Health Laboratory. The courier service has reduced specimen transit times from four-five days to an average of one day.

The MCH block grant also supported the Idaho Family Planning Program to sub grants to the local public health districts to provide family planning services on a sliding-fee scale in accordance with Title X to women of reproductive age, as well as adolescents and men.

FFY14 block grant funds were used to fund the Idaho Oral Health Program (IOHP). During the prior year, the PEW Charitable Trusts assigned the state of Idaho an "A" grade for protecting children from tooth decay with the application of dental sealants. Idaho was one of only five states to receive this distinguished grade.

Funds helped enhance the Management Information System, WIC Information System Program (WISPr), to allow for better documentation of breastfeeding aid inventory and issuance and breastfeeding peer counseling

services in the prior year. These enhancements also streamlined paperwork, freeing clinicians' time to work with participants.

FFY14 MCH state match funds supported the activities of the Idaho Immunization Program (IIP). The IIP held three annual ShotSmart conferences around the state that focused on improving the immunization rates of the state. Immunization education was also offered in conjunction with the Idaho Immunization Coalition and the Centers for the Disease Control (CDC).

Funding also supplemented the immunization registry, multiple informational mailings, and upkeep and monitoring of an electronic health records system. In an effort to address the need for access to medical specialists, the MCH program funded specialty pediatric clinics for PKU, Cystic Fibrosis, and others throughout the state. Annually, the MCH program supports 32 pediatric genetic clinics, 12 pediatric metabolic and PKU clinics, and 13 pediatric cystic fibrosis clinics through contracts with St. Luke's Children's Hospital in Boise. The MCH program funded at least twenty four cardiac clinics, at least four pacer clinics, and at least four cranial facial clinics through a contract with Eastern Idaho Public Health District. Further, the MCH program used funds to bring a metabolic specialist and registered dietitian from Oregon twice per year to host PKU clinics in northern and eastern Idaho. Another way MCH served the CYSHCN population was through the development and dissemination of transition-to-adulthood kits for CYSHCN to help empower them to take a primary role in their healthcare.

The MCH program continued to partner with the Idaho Medicaid's Children's Healthcare Improvement Collaborative (CHIC) Project and two local public health districts in eastern Idaho to implement a medical home demonstration for CYSHCN living in rural areas of Idaho. A medical home coordinator (MHC) was funded by MCH block grant funds and worked out of each health district to partner with up to three rural pediatric or primary clinics in the area to support transformation to a patient-centered medical home.

FFY14 block grant funds helped support the Idaho Bureau of Epidemiology in a cross-cutting fashion across multiple population domains by providing funding for contracts with the Idaho local Public Health Districts (PHDs). These contracts dictated rigorous proficiency training of PHD staff, including epidemiologists, with emphasis placed on MCH topic areas and population domains. Specifically, funds were used in support of the Women/Maternal Health, Perinatal/Infant Health, Child Health, and Adolescent Health population domains by helping to fund Epidemiology's efforts to inform and educate the public regarding the outbreaks of multiple viruses and bacteria in 2014.

As mandated by OBRA legislation, the Title V MCH block grant fulfills its role of informing parents, families, and others of available services and providers in the state by the provision of funding to the Idaho 2-1-1 CareLine. The Idaho 2-1-1 CareLine provides information and referral services on a variety of MCH, CYSHCN, Infant Toddler Program, and Medicaid issues, thus serving segments of the MCH population. The CareLine is considered to be the state's clearinghouse for information and services provided by the Idaho Department of Health and Welfare. The CareLine is managed by the Division of Family and Community Services.

Health and Wellbeing. The CareLine is managed by the Division of Family and Community Services.

The MCH block grant funded the state's poison control hotline through contract with the Nebraska Poison Control Center. The contract is managed by the MCH Program. Program staff monitor the contract, conduct National Poison Prevention Week outreach activities, and release Idaho-specific public service announcements for various poison related issues.

FFY14 Block Grant funds were also used to support enhancement of the Electronic Birth Certificate (EBC) data system to allow medical providers to send birth records electronically to Vital Records.

Funds were used to support the Pregnancy Risk Assessment Tracking Survey (PRATS). This is an annual survey of new mothers in Idaho regarding maternal experiences and health behaviors before, during and after pregnancy. PRATS provide prevalence estimates of risk factors associated with poor pregnancy outcomes and infant health. Data from PRATS is one piece of the information used to inform MCH block grant priorities and activities.

FFY14 block grant funds were used to purchase BMI wheels for medical providers to use when assessing the health of their pediatric patient populations. This relates to the Child Health domain. The BMI wheels were customized with the Idaho Health and Wellness Collaborative for Children (IHAWCC) logo. IHAWCC aims to create a meaningful collaboration of stakeholders invested in child health care quality, with the common purpose of improving child health in Idaho.

*In Women/Maternal Health, (includes category for pregnant women)* Block Grant funds were used to support the MCH Reproductive Health program (\$121,051), MCH Sexually Transmitted Disease program (\$44,854), MCH Epidemiology (\$53,883), MCH Five Year Needs Assessment (\$13,632), WIC Breastfeeding Peer Counseling (\$8,599), Idaho Careline (\$8,110) and Administration (\$41,694).

*In Perinatal/Infant Health, (includes category for infants <1 year of age)* Block Grant funds were used to support MCH Epidemiology (\$53,883), MCH Five Year Needs Assessment (\$13,632), WIC Breastfeeding Peer Counseling (\$8,599), Idaho Careline (\$8,110), Immunizations (\$1,217,534) and Administration (\$41,694).

*In Child and Adolescent Health, (includes children 1 to 22 years of age)* Block Grant funds were used to support the Oral Health program (\$428,670), MCH Epidemiology (\$53,883), MCH Sexually Transmitted Disease program (\$33,641), MCH Five Year Needs Assessment (\$13,632), MCH Reproductive Health (\$242,102), Injury Prevention-Poison Control Hotline (\$286,154), Idaho Careline (\$8,110), Immunizations (\$1,217,534) and Administration (\$41,694).

*In Children and Youth with Special Health Care Needs (CYSHCN)* Block Grant funds were used to support MCH Epidemiology (\$53,885), MCH Five Year Needs Assessment (\$13,633), Idaho Careline (\$8,110),

Children's Special Health program (\$1,035,032) and Administration (\$41,694).

In *Cross-Cutting/Life Course (which includes Others)*, Block Grant funds were used for MCH Sexually Transmitted Disease program (\$33,641), MCH Reproductive Health (\$242,103), Behavioral Risk Factor Surveillance Survey (\$15,000), Vital Statistics Electronic Birth Certificate Project (\$43,991), Cancer Data Registry Contract (\$37,667) and Indirect support costs to the department (\$196,374).

### III.B. Budget

#### FFY16 Application

In order to meet the MCH Block Grant match requirement for FFY16 grant application, the state will be utilizing \$2,412,699 in state funds from the Idaho Immunization Assessment Fund.

In FFY16 MCH Block Grant, 37.2 percent of funds (\$1,195,537) are proposed for Preventive and Primary Care for Children and 35.2 percent of funds (\$1,132,641) for Children and Youth with Special Health Care Needs. The total amount of funds proposed for Administration is 5.9 percent (\$188,668).

MCH block grant funds will continue to support to the Idaho Careline (2-1-1) which is designed to refer individuals to a wide array of public services. In addition, support of injury prevention will be by funds dedicated to the Idaho Poison Control Hotline. This hotline is via a contract with Nebraska Poison Control Center and the contract administered by the MCH Program.

The MCH block grant will continue to support the Idaho Oral Health Program's efforts to provide oral health education to pregnant women and health care providers and assisting with dental home referral. Realizing the barrier of lacking a systematic approach to ensuring pregnant women receive dental care, MCH will support the collaboration between the Oral Health Program and WIC to identify strategies to link pregnant women with dental homes.

The MCH block grant will continue to fund Idaho Family Planning Program's sub grants to local public health districts to provide family planning services in accordance with Title X regulations. MCH funding is being allocated to support a physician consultant to MCH programs. Currently, Dr. Clay Roscoe, M.D. is available to the Division of Public Health as a part-time employee on-site. Providing MCH funding will ensure that programs within MCH, such as Newborn Screening, Children with Special Health, MIECHV, WIC, etc will benefit from physician input and liaison with the medical community.

To address the priority need to improve MCH population access to medical homes and linkage to dental care, the MCH program will support the development of educational message for pregnant women and children and

families about the importance of oral health care. There is opportunity through the oral health program and the SHIP model-testing grant to integrate oral health into the patient-centered medical home (PCMH) environment in primary care. As SHIP activities ramp up, the MCH program will explore strategies to incorporate oral health care competencies into the PCMHs or identify ways to link pregnant women and children with dental homes.

The Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality is another area of planned block grant funds support in FFY16. This is specific to Women/Maternal, Perinatal/Infant and Child Health domains. The MCH Director and CYSHCN Director are overseeing the CoIIN team efforts for Idaho. The two strategies that were selected to focus efforts toward on reducing infant mortality are smoking cessation among pregnant women and promoting safe sleep practices for infants. Funds will be used to support messaging efforts for these strategies. No final decisions have been made on the specifics of funds use, but Back to Sleep board books, sleep sacks and outreach on tobacco use have been explored.

The MCH block grant will continue to fund the Idaho Bureau of Epidemiology to support contracts with local public health districts for infectious or communicable disease investigation and reporting across the state. Communicable disease reporting and investigation is viewed as an essential public health service, and pregnant women, infants, and children are particularly vulnerable populations impacted by this service.

The MCH block grant will continue to fulfill its obligation to fund the Idaho CareLine per OBRA legislation. The MCH program will continue to fund the Idaho Poison Control Hotline as this is viewed as an essential public health service that significantly impacts MCH populations. Additional funding will support the Pregnancy Risk Assessment Tracking Survey (PRATS) data collection of new mothers. It should be noted that funding is now being broken out for the MCH Research Analyst position; historically this has been funded by MCH under Administration.

*In Women/Maternal Health, (includes category for pregnant women)* Block Grant funds are proposed to support the MCH Reproductive Health program (\$117,600), MCH Epidemiology (\$51,329), MCH Five Year Needs Assessment (\$15,000), Idaho Careline (\$11,250), Perinatal Assessment survey activities (\$60,000), Oral Health (\$15,000), MCH Physician Consultant (new-\$18,551), CoIIN activities (new-\$10,000), Pregnancy Education (new -\$10,000), MCH Research Analyst position (\$17,375) and Administration (\$42,097).

*In Perinatal/Infant Health, (includes category for infants >1 year of age)* Block Grant funds are proposed to support MCH Epidemiology (\$51,329), MCH Five Year Needs Assessment (\$15,000), Idaho Careline (\$11,250), MCH Physician Consultant (new-\$18,552), MCH Research Analyst position (\$17,375), Immunizations (\$1,206,349), Injury Prevention-Poison Control Hotline (\$135,720) and Administration (\$42,096).

*In Child and Adolescent Health, (includes children 1 to 22 years of age)* Block Grant are proposed to support the MCH Epidemiology (\$51,329), MCH Oral Health (\$15,000), MCH Five Year Needs Assessment (\$15,000), Idaho Careline (\$11,250), MCH Physician Consultant (new-\$18,552), MCH Research Analyst position (\$17,375), Immunizations (\$1,206,349), Injury Prevention-Poison Control Hotline (\$135,720) and Administration (\$42,096).

support the MCH Epidemiology (\$51,329), MCH Oral Health (\$189,900), MCH Five Year Needs Assessment (\$15,000), MCH Reproductive Health (\$235,200), Injury Prevention-Poison Control Hotline (\$135,720), Adolescent Health (new-\$10,000), Idaho Careline (\$11,250), MCH Physician Consultant (new-\$18,552), MCH Research Analyst position (\$17,375) Immunizations (\$1,206,350) and Administration (\$54,737).

In *Children and Youth with Special Health Care Needs (CYSHCN)* Block Grant funds are proposed to support MCH Epidemiology (\$51,329), MCH Five Year Needs Assessment (\$15,000), Idaho Careline (\$11,250), MCH Physician Consultant (new-\$18,552), MCH Research Analyst position (\$17,375), MCH Oral Health (\$189,900) Children's Special Health program (\$1,000,000) and Administration (\$49,738).

In *Cross-Cutting/Life Course (which includes Others)*, Block Grant funds are proposed to support MCH Reproductive Health (\$235,200) and Indirect support costs to the department (\$230,000).

#### **IV. Title V-Medicaid IAA/MOU**

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [Final MOU between Title V and Medicaid May 2015.pdf](#)

## **V. Supporting Documents**

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - [Attachments A-C.pdf](#)

Supporting Document #02 - [Organization Charts.pdf](#)

Supporting Document #03 - [Idaho MCH Needs Assessment Final Report.pdf](#)



**Form 2**  
**MCH Budget/Expenditure Details**  
**State: Idaho**

	<b>FY16 Application Budgeted</b>	<b>FY14 Annual Report Expended</b>
<b>1. FEDERAL ALLOCATION</b>		
(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$3,216,931	\$3,246,758
Of the Federal Allocation, the amount earmarked for:		
A. Preventive and Primary Care for Children	\$1,195,537	\$1,495,655
	(37.2%)	(46.1%)
B. Children with Special Health Care Needs	\$1,132,641	\$1,119,614
	(35.2%)	(34.5%)
C. Title V Administrative Costs	\$188,668	\$166,776
	(5.9%)	(5.1%)
<b>2. UNOBLIGATED BALANCE</b>	\$0	\$0
(Item 18b of SF-424)		
<b>3. STATE MCH FUNDS</b>	\$0	\$2,435,068
(Item 18c of SF-424)		
<b>4. LOCAL MCH FUNDS</b>	\$2,412,699	\$0
(Item 18d of SF-424)		
<b>5. OTHER FUNDS</b>	\$0	\$0
(Item 18e of SF-424)		
<b>6. PROGRAM INCOME</b>	\$0	\$0
(Item 18f of SF-424)		
<b>7. TOTAL STATE MATCH</b>	\$2,412,699	\$2,435,068
(Lines 3 through 6)		
A. Your State's FY 1989 Maintenance of Effort Amount	\$2,141,219	
<b>8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL</b>	\$5,629,630	\$5,681,826
(Same as item 18g of SF-424)		
<b>9. OTHER FEDERAL FUNDS</b>		
Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
<b>10. OTHER FEDERAL FUNDS</b>	\$37,149,010	
(Subtotal of all funds under item 9)		
<b>11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL</b>	\$42,778,640	\$5,681,826
(Partnership Subtotal + Other Federal MCH Funds Subtotal)		

## 9. OTHER FEDERAL FUNDS

<b>US Department of Agriculture (USDA) &gt; Food and Nutrition Services &gt; Women, Infants and Children (WIC)</b>	<b>\$27,082,111</b>
<b>Department of Health and Human Services (DHHS) &gt; Health Resources and Services Administration (HRSA) &gt; ACA Maternal, Infant and Early Childhood Home Visiting Program</b>	<b>\$1,002,467</b>
<b>Department of Health and Human Services (DHHS) &gt; Centers for Disease Control and Prevention (CDC) &gt; Sexually Transmitted Diseases (STD) Prevention</b>	<b>\$338,082</b>
<b>Department of Health and Human Services (DHHS) &gt; Centers for Disease Control and Prevention (CDC) &gt; Vaccines For Children/Immunizations</b>	<b>\$2,046,705</b>
<b>Department of Health and Human Services (DHHS) &gt; Health Resources and Services Administration (HRSA) &gt; Ryan White</b>	<b>\$1,480,458</b>
<b>Department of Health and Human Services (DHHS) &gt; Office of Population Affairs (OPA) &gt; Title X Family Planning</b>	<b>\$1,664,299</b>
<b>US Department of Agriculture (USDA) &gt; Food and Nutrition Services &gt; WIC Breastfeeding PC</b>	<b>\$288,178</b>
<b>Department of Health and Human Services (DHHS) &gt; Centers for Disease Control and Prevention (CDC) &gt; Viral Hepatitis</b>	<b>\$20,695</b>
<b>Department of Health and Human Services (DHHS) &gt; Centers for Disease Control and Prevention (CDC) &gt; HIV Prevention</b>	<b>\$802,951</b>
<b>Department of Health and Human Services (DHHS) &gt; Centers for Disease Control and Prevention (CDC) &gt; ADAP ERF</b>	<b>\$1,017,358</b>
<b>Department of Health and Human Services (DHHS) &gt; Centers for Disease Control and Prevention (CDC) &gt; Brst/Cer CA Screen</b>	<b>\$1,405,706</b>

**FY14 Annual Report Budgeted**

<b>1. FEDERAL ALLOCATION</b>	<b>\$3,203,380</b>
A. Preventive and Primary Care for Children	\$1,189,897
B. Children with Special Health Care Needs	\$1,137,226
C. Title V Administrative Costs	\$246,678
<b>2. UNOBLIGATED BALANCE</b>	<b>\$0</b>
<b>3. STATE MCH FUNDS</b>	<b>\$2,402,535</b>
<b>4. LOCAL MCH FUNDS</b>	<b>\$0</b>
<b>5. OTHER FUNDS</b>	<b>\$0</b>
<b>6. PROGRAM INCOME</b>	<b>\$0</b>
<b>7. TOTAL STATE MATCH</b>	<b>\$2,402,535</b>



**Form 3a**  
**Budget and Expenditure Details by Types of Individuals Served**  
**State: Idaho**

<b>I. TYPES OF INDIVIDUALS SERVED</b>	<b>FY16 Application Budgeted</b>	<b>FY14 Annual Report Expended</b>
<b>IA. Federal MCH Block Grant</b>		
1. Pregnant Women	\$368,202	\$291,824
2. Infants < 1 year	\$291,322	\$125,918
3. Children 1-22 years	\$739,063	\$1,107,886
4. CSHCN	\$1,353,144	\$1,152,354
5. All Others	\$235,200	\$290,744
<b>Federal Total of Individuals Served</b>	<b>\$2,986,931</b>	<b>\$2,968,726</b>
<b>IB. Non Federal MCH Block Grant</b>		
1. Pregnant Women	\$0	\$0
2. Infants < 1 year	\$1,206,349	\$1,217,534
3. Children 1-22 years	\$1,206,350	\$1,217,534
4. CSHCN	\$0	\$0
5. All Others	\$0	\$0
<b>Non Federal Total of Individuals Served</b>	<b>\$2,412,699</b>	<b>\$2,435,068</b>
<b>Federal State MCH Block Grant Partnership Total</b>	<b>\$5,399,630</b>	<b>\$5,403,794</b>

**Form Notes for Form 3a:**

None

**Field Level Notes for Form 3a:**

- 1. Field Name :** IA. Federal MCH Block Grant, 3. Children 1-22 years  
**Fiscal Year :** 2016  
**Column Name :** Application Budgeted  
**Field Note :**  
Difference is due to internal tracking of types of individuals served and direct services for the three legislatively defined categories.
- 2. Field Name :** IA. Federal MCH Block Grant, 4. CSHCN  
**Fiscal Year :** 2016  
**Column Name :** Application Budgeted  
**Field Note :**  
Difference is due to internal tracking of types of individuals served and direct services for the three legislatively defined categories.
- 3. Field Name :** IA. Federal MCH Block Grant, 3. Children 1-22 years  
**Fiscal Year :** 2014  
**Column Name :** Annual Report Expended  
**Field Note :**  
Difference is due to internal tracking of types of individuals served and direct services for the three legislatively defined categories.
- 4. Field Name :** IA. Federal MCH Block Grant, 4. CSHCN  
**Fiscal Year :** 2014  
**Column Name :** Annual Report Expended  
**Field Note :**  
Difference is due to internal tracking of types of individuals served and direct services for the three legislatively defined categories.

**Data Alert for Form 3a:**

None



**Form 3b**  
**Budget and Expenditure Details by Types of Services**  
**State: Idaho**

	<b>FY16 Application Budgeted</b>	<b>FY14 Annual Report Expended</b>
<b>I. TYPES OF SERVICES</b>		
<b>IIA. Federal MCH Block Grant</b>		
1. Direct Services	\$1,288,000	\$1,640,288
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$588,000	\$605,256
B. Preventive and Primary Care Services for Children	\$0	\$0
C. Services for CSHCN	\$700,000	\$1,035,032
2. Enabling Services	\$195,000	\$43,654
3. Public Health Services and Systems	\$1,733,931	\$1,562,816
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		
Physician/Office Services		
Hospital Charges (Includes Inpatient and Outpatient Services)		
Dental Care (Does Not Include Orthodontic Services)		
Durable Medical Equipment and Supplies		
Laboratory Services		
Other		
Repro health/clinics/claims/medical food		\$1,640,288
Direct Services Total		\$1,640,288
<b>Federal Total</b>	<b>\$3,216,931</b>	<b>\$3,246,758</b>

**FY16 Application  
Budgeted**

**FY14 Annual  
Report Expended**

**IIB. Non-Federal MCH Block Grant**

1. Direct Services	\$0	\$0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$0	\$0
B. Preventive and Primary Care Services for Children	\$0	\$0
C. Services for CSHCN	\$0	\$0
2. Enabling Services	\$0	\$0
3. Public Health Services and Systems	\$2,412,699	\$2,435,068
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$0
Physician/Office Services		\$0
Hospital Charges (Includes Inpatient and Outpatient Services)		\$0
Dental Care (Does Not Include Orthodontic Services)		\$0
Durable Medical Equipment and Supplies		\$0
Laboratory Services		\$0
Direct Services Total		\$0
<b>Non-Federal Total</b>	<b>\$2,412,699</b>	<b>\$2,435,068</b>

**Form Notes for Form 3b:**

None

**Field Level Notes for Form 3b:**

## Form 4

### Number and Percentage of Newborns and Others Screened, Cases Confirmed and Treated State: Idaho

**Total Births by Occurrence**

**22,495**

**1a. Core RUSP Conditions**

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Cystic fibrosis	22,263	136	7	7
Congenital adrenal hyperplasia	22,263	19	1	1
Primary congenital hypothyroidism	22,263	364	6	6
S,S disease (Sickle cell anemia)	22,263	276	1	1
Homocystinuria	22,263	42	0	0
Classic phenylketonuria	22,263	13	0	0
Tyrosinemia, type I	22,263	28	0	0
Carnitine uptake defect/carnitine transport defect	22,263	20	0	0
Medium-chain acyl-CoA dehydrogenase deficiency	22,263	7	2	0
Very long-chain acyl-CoA dehydrogenase deficiency	22,263	12	0	0
Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	22,263	1	0	0
β-Ketothiolase deficiency	22,263	1	0	0
Glutaric acidemia type I	22,263	6	0	0
Isovaleric acidemia	22,263	7	0	0

Maple syrup urine disease	22,263	13	0	0
Methylmalonic acidemia (methylmalonyl-CoA mutase)	22,263	0	0	0
Methylmalonic acidemia (cobalamin disorders)	22,263	0	0	0
Propionic acidemia	22,263	0	0	0
3-Hydroxy-3-methylglutaric aciduria	22,263	0	0	0
3-Methylcrotonyl-CoA carboxylase deficiency	22,263	6	1	1
Holocarboxylase synthase deficiency	22,263	0	0	0
Citrullinemia, type I	22,263	5	0	0
Biotinidase deficiency	22,263	10	0	0
Classic galactosemia	22,263	23	1	1

**1b. Secondary RUSP Conditions**

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
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**2. Other Newborn Screening Tests**

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	20,082	608	37	35

**3. Screening Programs for Older Children & Women**

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
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#### **4. Long-Term Follow-Up**

The Primary Care Provider (PCP) is notified by the appropriate specialist contracted with the Oregon State Public Health Laboratory (OSPHL), where our screenings are performed, when an abnormal result is found. He/she is involved with the child and family as further testing is ordered and performed. So, when a diagnosis is made, he/she is already part of the follow-up team. Once there is a diagnosis, the specialist at OSPHL will refer the PCP and family to the appropriate local/regional specialist and/or clinic for continued follow-up and treatment as indicated. Contact with OSPHL is then completed as they do short term follow-up only.

**Form Notes for Form 4:**

None

**Field Level Notes for Form 4:**

- Field Name :** Newborn Hearing - Receiving At Least One Screen

**Fiscal Year :** 2016

**Column Name :** Other Newborn

**Field Note :**

For newborn hearing screening: Idaho Sound Beginnings program records for 2014 show of 20131 births in hospitals that 19996 infants were screened prior to discharge for a rate of 99.3 percent.

**Form 5a**  
**Unduplicated Count of Individuals Served under Title V**  
**State: Idaho**

Reporting Year 2014

Types of Individuals Served	(A) Title V Total Served	Primary Source of Coverage				
		(B) Title XIX %	(C) Title XXI %	(D) Private/Other %	(E) None %	(F) Unknown %
1. Pregnant Women	1,165	7.1	0.5	16.9	72.2	3.3
2. Infants <1 year of Age	22,811	36.6	2.3	52.2	8.7	0.2
3. Children 1 to 22 Years of Age	202,964	9.3	0.6	28.9	59	2.2
4. Children with Special Health Care Needs	1,733	1.5	0.1	3.5	1.9	93
5. Others	55,258	0	0	0	0	100
<b>Total</b>	<b>283,931</b>					

**Form Notes for Form 5a:**

None

**Field Level Notes for Form 5a:**

- 1. Field Name :** Pregnant Women Total Served  
**Fiscal Year :** 2014  
**Column Name :**  
**Field Note :**  
Some programs that previously collected pregnancy status of clients no longer do so. Number of documentable pregnant women served is therefore lower than in previous years. Additionally issues involving family planning organization in one service district moved from our control further reducing reportable number of pregnant women served.
- 2. Field Name :** Child1To22Years\_TotalServed  
**Fiscal Year :** 2014  
**Column Name :**  
**Field Note :**  
Includes 184,000 child receiving immunizations funded as state match. Insurance coverage based on individuals participating in Family Planning and STD services.
- 3. Field Name :** ChildrenWithSpecialHealthcareNeeds\_TotalServed  
**Fiscal Year :** 2014  
**Column Name :**  
**Field Note :**  
The count includes children enrolled in our CSHP and those served by the clinics that MCH supports through contracts.
- 4. Field Name :** Others\_TotalServed  
**Fiscal Year :** 2014  
**Column Name :**  
**Field Note :**  
Majority of data associated with this category has no insurance coverage information collected.

**Form 5b**  
**Total Recipient Count of Individuals Served by Title V**  
**State: Idaho**

**Reporting Year 2014**

<b>Types Of Individuals Served</b>	<b>Total Served</b>
1. Pregnant Women	1,165
2. Infants < 1 Year of Age	22,811
3. Children 1 to 22 Years of Age	202,964
4. Children with Special Health Care Needs	1,733
5. Others	55,258
<b>Total</b>	283,931

**Form Notes for Form 5b:**

None

**Field Level Notes for Form 5b:**

1. **Field Name :** Infants Less Than One Year

**Fiscal Year :** 2014

**Column Name :**

**Field Note :**

Form 4 not completed when I entered this data (interesting no issue with 5A)  
value should be 22811

2. **Field Name :** Children With Special Health Care Needs

**Fiscal Year :** 2014

**Column Name :**

**Field Note :**

The count includes children enrolled in our CSHP and those served by the clinics that MCH supports through contracts.

## Form 6

# Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX State: Idaho

Reporting Year 2014

### I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	22,348	19,657	158	337	341	47	446	1,362
Title V Served	21,688	19,076	153	327	331	46	433	1,322
Eligible for Title XIX	8,666	7,227	98	221	90	22	235	773
2. Total Infants in State	22,089	19,715	218	474	346	51	1,285	0
Title V Served	21,436	19,132	212	460	336	49	1,247	0
Eligible for Title XIX	8,566	7,328	135	311	91	24	677	0

## II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	18,880	3,420	48	22,348
Title V Served	18,322	3,319	47	21,688
Eligible for Title XIX	6,764	1,884	18	8,666
2. Total Infants in State	18,025	4,064	0	22,089
Title V Served	17,492	3,944	0	21,436
Eligible for Title XIX	6,704	1,862	0	8,566

**Form Notes for Form 6:**

Data reflects 2013 births as 2014 data is not finalized as of entry date.

**Field Level Notes for Form 6:**

1. **Field Name :** 1. Eligible for Title XIX  
**Fiscal Year :** 2016  
**Column Name :** Total All Races  
**Field Note :**  
Based on birth certificate where Medicaid is listed as primary source of payment for delivery.

2. **Field Name :** 2. Total Infants in State  
**Fiscal Year :** 2016  
**Column Name :** Total All Races  
**Field Note :**  
Data source for this line is Census department population estimates and does not include unknown or other race.

**Form 7**  
**State MCH Toll-Free Telephone Line and Other Appropriate Methods Data**  
**State: Idaho**

	<b>Application Year 2016</b>	<b>Reporting Year 2014</b>
<b>A. State MCH Toll-Free Telephone Lines</b>		
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 296-2588	(800) 296-2588
2. State MCH Toll-Free "Hotline" Name	Idaho Careline	Idaho Careline
3. Name of Contact Person for State MCH "Hotline"	Donald Alveshere	Alex Zamora
4. Contact Person's Telephone Number	(208) 287-1030	(208) 287-1030
5. Number of Calls Received on the State MCH "Hotline"		40,799
<b>B. Other Appropriate Methods</b>		
1. Other Toll-Free "Hotline" Names	Poison Control Hotline	Poison Control Hotline
2. Number of Calls on Other Toll-Free "Hotlines"		15,329
3. State Title V Program Website Address		
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

**Form Notes for Form 7:**

The preferred number for in-state callers is 211, a special number established similar to 911 for emergencies. The form has no place to record this number.

The number of calls for 2-1-1 are for MCH specific issues and not reflecting total calls for 2-1-1 (140,056).

**Form 8**  
**State MCH and CSHCN Directors Contact Information**  
**State: Idaho**

**Application Year 2016**

**1. Title V Maternal and Child Health (MCH) Director**

Name	Kris Spain
Title	MCH Director/Bureau Chief
Address 1	450 W. State Str/4th PTC
Address 2	
City / State / Zip Code	Boise ID 83720
Telephone	(208) 334-6960
Email	spaink@dhw.idaho.gov

**2. Title V Children with Special Health Care Needs (CSHCN) Director**

Name	Jacquie Watson
Title	CYSHCN Director/MCH Program Manager
Address 1	450 W. State Str/4th PTC
Address 2	
City / State / Zip Code	Boise ID 83720
Telephone	(208) 334-5963
Email	WatsonJ1@dhw.idaho.gov

**3. State Family or Youth Leader (Optional)**

Name
Title
Address 1
Address 2
City / State / Zip Code
Telephone
Email

**Form Notes for Form 8:**

None

**Form 9**  
**List of MCH Priority Needs**  
**State: Idaho**

**Application Year 2016**

	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1 .	Increase percent of women accessing prenatal health care	New	
2 .	Improve breastfeeding rates	New	
3 .	Increase the number of families who practice safe and healthy parenting behaviors	New	
4 .	Decrease the prevalence of childhood overweight and obesity	Continued	
5 .	Improve childhood immunization rates	Continued	This priority need does not have a corresponding National Performance Measure. A corresponding State Performance Measure will be developed for the FY2017 Application.
6 .	Improve maternal and child health population access to medical homes	New	
7 .	Improve access to medical specialists for children and youth with special health care needs	Continued	
8 .	Decrease substance abuse among maternal and child health populations	New	

**Form Notes for Form 9:**

None

**Form 10a**  
**National Outcome Measures**  
**State: Idaho**

**Form Notes for Form 10a:**

None

**NOM-1 Percent of pregnant women who receive prenatal care beginning in the first trimester**

**NOM-1 Notes:**

None

**Data Alerts :**

None

**NOM-2 Rate of severe maternal morbidity per 10,000 delivery hospitalizations**

**NOM-2 Notes:**

No data source available and no projection when such data may be available.

**Data Alerts :**

- 1 . Data has not been entered for NOM #2. This outcome measure is linked to the selected NPM 1,14,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

**NOM-3 Maternal mortality rate per 100,000 live births**

**NOM-3 Notes:**

None

**Data Alerts :**

None

**NOM-4.1 Percent of low birth weight deliveries (<2,500 grams)**

**NOM-4.1 Notes:**

None

**Data Alerts :**

None

**NOM-4.2 Percent of very low birth weight deliveries (<1,500 grams)**

**NOM-4.2 Notes:**

None

**Data Alerts :**

None

**NOM-4.3 Percent of moderately low birth weight deliveries (1,500-2,499 grams)**

**NOM-4.3 Notes:**

None

**Data Alerts :**

None

**NOM-5.1 Percent of preterm births (<37 weeks)**

**NOM-5.1 Notes:**

None

**Data Alerts :**

None

**NOM-5.2 Percent of early preterm births (<34 weeks)**

**NOM-5.2 Notes:**

None

**Data Alerts :**

None

**NOM-5.3 Percent of late preterm births (34-36 weeks)**

**NOM-5.3 Notes:**

None

**Data Alerts :**

None

**NOM-6 Percent of early term births (37, 38 weeks)**

**NOM-6 Notes:**

None

**Data Alerts :**

None

**NOM-7 Percent of non-medically indicated early elective deliveries**

**NOM-7 Notes:**

None

**Data Alerts :**

None

**NOM-8 Perinatal mortality rate per 1,000 live births plus fetal deaths**

**NOM-8 Notes:**

None

**Data Alerts :**

None

**NOM-9.1 Infant mortality rate per 1,000 live births**

**NOM-9.1 Notes:**

None

**Data Alerts :**

None

**NOM-9.2 Neonatal mortality rate per 1,000 live births**

**NOM-9.2 Notes:**

None

**Data Alerts :**

None

**NOM-9.3 Post neonatal mortality rate per 1,000 live births**

**NOM-9.3 Notes:**

None

**Data Alerts :**

None

**NOM-9.4 Preterm-related mortality rate per 100,000 live births**

**NOM-9.4 Notes:**

None

**Data Alerts :**

None

**NOM-9.5 Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births**

**NOM-9.5 Notes:**

None

**Data Alerts :**

None

**NOM-10 The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy**

**NOM-10 Notes:**

None

**Data Alerts :**

None

**NOM-11 The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations**

**NOM-11 Notes:**

None

**Data Alerts :**

None

**NOM-12 Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)**

**Data Alerts :**

None

**NOM-13 Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)**

**Data Alerts :**

None

**NOM-14 Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months**

**NOM-14 Notes:**

None

**Data Alerts :**

None

**NOM-15 Child Mortality rate, ages 1 through 9 per 100,000**

**NOM-15 Notes:**

None

**Data Alerts :**

None

**NOM-16.1 Adolescent mortality rate ages 10 through 19 per 100,000**

**NOM-16.1 Notes:**

None

**Data Alerts :**

None

**NOM-16.2 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000**

**NOM-16.2 Notes:**

None

**Data Alerts :**

None

**NOM-16.3 Adolescent suicide rate, ages 15 through 19 per 100,000**

**NOM-16.3 Notes:**

None

**Data Alerts :**

None

**NOM-17.1 Percent of children with special health care needs**

**NOM-17.1 Notes:**

None

**Data Alerts :**

None

**NOM-17.2 Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system**

**NOM-17.2 Notes:**

None

**Data Alerts :**

None

**NOM-17.3 Percent of children diagnosed with an autism spectrum disorder**

**NOM-17.3 Notes:**

None

**Data Alerts :**

None

**NOM-17.4 Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)**

**NOM-17.4 Notes:**

None

**Data Alerts :**

None

**NOM-18 Percent of children with a mental/behavioral condition who receive treatment or counseling**

**NOM-18 Notes:**

None

**Data Alerts :**

None

**NOM-19 Percent of children in excellent or very good health**

**NOM-19 Notes:**

None

**Data Alerts :**

None

**NOM-20 Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)**

**NOM-20 Notes:**

None

**Data Alerts :**

None

**NOM-21 Percent of children without health insurance**

**NOM-21 Notes:**

None

**Data Alerts :**

None

**NOM-22.1 Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations**

**NOM-22.1 Notes:**

None

**Data Alerts :**

None

**NOM-22.2 Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza**

**NOM-22.2 Notes:**

None

**Data Alerts :**

None

**NOM-22.3 Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine**

**NOM-22.3 Notes:**

None

**Data Alerts :**

None

**NOM-22.4 Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine**

**NOM-22.4 Notes:**

None

**Data Alerts :**

None

**NOM-22.5 Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine**

**NOM-22.5 Notes:**

None

**Data Alerts :**

None

**Form 10a**  
**National Performance Measures**  
**State: Idaho**

**NPM 1-Percent of women with a past year preventive medical visit**

	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
<b>Annual Objective</b>	54.7	54.8	54.8	54.9	54.9

**NPM 4-A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months**

	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
<b>Annual Objective</b>	85	85.5	85.8	86	86.1
<b>Annual Objective</b>	25.3	25.7	25.8	25.9	26

**NPM 5-Percent of infants placed to sleep on their backs**

	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
<b>Annual Objective</b>	82	82.2	82.3	82.5	82.6

**NPM 8-Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day**

	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
<b>Annual Objective</b>	28	28.1	28.2	28.2	28.3

**NPM 10-Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
<b>Annual Objective</b>	66.2	66.3	66.4	66.5	66.6

**NPM 11-Percent of children with and without special health care needs having a medical home**

	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
<b>Annual Objective</b>	59.8	59.9	60	60.1	60.2

**NPM 13-A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year**

	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
<b>Annual Objective</b>	61.2	61.4	61.6	61.7	61.8
<b>Annual Objective</b>	79.3	79.4	79.5	79.5	79.6

**NPM 14-A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes**

	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
<b>Annual Objective</b>	10.3	10.3	10.2	10.2	10.1
<b>Annual Objective</b>	20.2	20.1	20	20	19.9

**Form 10b**  
**State Performance/Outcome Measure Detail Sheet**  
**State: Idaho**

States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.

**Form 10c**  
**Evidence-Based or Informed Strategy Measure Detail Sheet**  
**State: Idaho**

States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.

**Form 10d**  
**National Performance Measures (Reporting Year 2014 & 2015)**  
**State: Idaho**

**Form Notes for Form 10d:**

None

**NPM 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.**

	2011	2012	2013	2014	2015
<b>Annual Objective</b>	100.0	100.0	100.0	100.0	100.0
<b>Annual Indicator</b>	100.0	100.0	100.0	90.0	
<b>Numerator</b>	18	19	19	18	
<b>Denominator</b>	18	19	19	20	
<b>Data Source</b>	Idaho Newborn Screening Program				
<b>Provisional Or Final ?</b>				Final	

**Data Alerts:**

None

**NPM 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)**

	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Annual Objective</b>	53.0	73.0	75.0	75.0	75.0
<b>Annual Indicator</b>	72.4	72.4	72.4	72.4	
<b>Numerator</b>					
<b>Denominator</b>					
<b>Data Source</b>	National Survey of CSHCNs 2010				
<b>Provisional Or Final ?</b>				Final	

**Data Alerts:**

None

**NPM 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)**

	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Annual Objective</b>	52.0	43.0	45.0	45.0	45.0
<b>Annual Indicator</b>	42.9	42.9	42.9	42.9	
<b>Numerator</b>					
<b>Denominator</b>					
<b>Data Source</b>	National Survey of CSHCNs 2010				
<b>Provisional Or Final ?</b>				Final	

**Data Alerts:**

None

**NPM 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)**

	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Annual Objective</b>	60.0	60.0	60.0	60.0	60.0
<b>Annual Indicator</b>	55.2	55.2	55.2	55.2	
<b>Numerator</b>					
<b>Denominator</b>					
<b>Data Source</b>	National Survey of CSHCNs 2010				
<b>Provisional Or Final ?</b>				Final	

**Data Alerts:**

None

**NPM 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)**

	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Annual Objective</b>	86.0	65.0	65.0	67.0	67.0
<b>Annual Indicator</b>	64.6	64.6	64.6	64.6	
<b>Numerator</b>					
<b>Denominator</b>					
<b>Data Source</b>	National Survey of CSHCNs 2010				
<b>Provisional Or Final ?</b>				Final	

**Data Alerts:**

None

**NPM 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.**

	2011	2012	2013	2014	2015
<b>Annual Objective</b>	46.0	47.0	47.0	49.0	49.0
<b>Annual Indicator</b>	46.6	46.6	46.6	46.6	
<b>Numerator</b>					
<b>Denominator</b>					
<b>Data Source</b>	National Survey of CSHCNs 2010				
<b>Provisional Or Final ?</b>				Final	

**Data Alerts:**

None

**NPM 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.**

	2011	2012	2013	2014	2015
<b>Annual Objective</b>	75.0	75.0	75.0	75.0	75.0
<b>Annual Indicator</b>	68.8	64.5	64.5	70.2	
<b>Numerator</b>					
<b>Denominator</b>					
<b>Data Source</b>	NIS	NIS	NIS	NIS	
<b>Provisional Or Final ?</b>				Final	

**Data Alerts:**

None

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

	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Annual Objective</b>	16.0	15.0	15.0	13.7	13.3
<b>Annual Indicator</b>	11.5	11.7	9.5	9.5	
<b>Numerator</b>	385	391	322	322	
<b>Denominator</b>	33,425	33,513	33,906	33,906	
<b>Data Source</b>	Birth Certificate	Birth Certificate	Birth Certificate	Birth certificate	
<b>Provisional Or Final ?</b>				Provisional	

**Data Alerts:**

None

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

	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Annual Objective</b>	60.6	60.7	60.0	62.7	62.8
<b>Annual Indicator</b>	57.1	62.7	62.7	62.7	
<b>Numerator</b>					
<b>Denominator</b>					
<b>Data Source</b>	Smile Survey 2009	Smile Survey 2012	Smile Survey 2012	Smile Survey 2012	
<b>Provisional Or Final ?</b>				Final	

**Data Alerts:**

None

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

	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Annual Objective</b>	4.3	4.0	3.9	3.0	2.9
<b>Annual Indicator</b>	2.2	2.2	4.2	2.8	
<b>Numerator</b>	8	8	15	10	
<b>Denominator</b>	359,046	357,402	357,803	357,803	
<b>Data Source</b>	Death Certificate	Death Certificate	Death Certificate	Dept of Transportation	
<b>Provisional Or Final ?</b>				Provisional	

**Data Alerts:**

None

**NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.**

	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Annual Objective</b>	52.2	53.0	53.0	55.1	55.2
<b>Annual Indicator</b>	53.0	57.1	57.1	61.7	
<b>Numerator</b>					
<b>Denominator</b>					
<b>Data Source</b>	PRATS	PRATS	PRATS	PRATS	
<b>Provisional Or Final ?</b>				Provisional	

**Data Alerts:**

None

**NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.**

	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Annual Objective</b>	98.8	99.6	99.6	99.3	99.3
<b>Annual Indicator</b>	99.4	99.3	99.1	99.3	
<b>Numerator</b>	20,273	20,500	20,152		
<b>Denominator</b>	20,397	20,650	20,337		
<b>Data Source</b>	HiTrack	HiTrack	HiTrack	HiTrack	
<b>Provisional Or Final ?</b>				Final	

**Data Alerts:**

None

**NPM 13 - Percent of children without health insurance.**

	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Annual Objective</b>	10.0	9.0	9.0	9.0	9.0
<b>Annual Indicator</b>	9.0	11.3	10.0	10.8	
<b>Numerator</b>	37,721	48,315	45,859	48,213	
<b>Denominator</b>	417,962	427,360	456,430	448,259	
<b>Data Source</b>	Current Population Survey	Current Population Survey	Current Population Survey	Current Population Survey	
<b>Provisional Or Final ?</b>				Final	

**Data Alerts:**

None

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

	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Annual Objective</b>	29.5	29.4	28.9	28.8	28.8
<b>Annual Indicator</b>	29.4	28.9	28.1	28.4	
<b>Numerator</b>	7,012	6,555	5,639	5,342	
<b>Denominator</b>	23,828	22,716	20,060	18,843	
<b>Data Source</b>	State WIC Data	State WIC Data	State WIC Database	State WIC Database	
<b>Provisional Or Final ?</b>				Final	

**Data Alerts:**

None

**NPM 15 - Percentage of women who smoke in the last three months of pregnancy.**

	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Annual Objective</b>	8.4	8.3	8.3	8.0	8.0
<b>Annual Indicator</b>	8.1	8.0	8.1	8.1	
<b>Numerator</b>	1,804	1,838	1,812	1,812	
<b>Denominator</b>	22,277	22,916	22,323	22,323	
<b>Data Source</b>	Birth Certificate	Birth Certificate	Birth Certificate	Birth certificate	
<b>Provisional Or Final ?</b>				Provisional	

**Data Alerts:**

None

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

	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Annual Objective</b>	9.8	9.8	16.5	16.5	16.5
<b>Annual Indicator</b>	23.3	20.2	18.5	18.5	
<b>Numerator</b>	27	23	21	21	
<b>Denominator</b>	116,117	113,782	113,634	113,634	
<b>Data Source</b>	Death Certificates	Death Certificate	Death Certificate	Death Certificate	
<b>Provisional Or Final ?</b>				Provisional	

**Data Alerts:**

None

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

	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Annual Objective</b>	99.0	99.0	99.0	99.0	76.0
<b>Annual Indicator</b>	99.0	99.0	75.7	75.7	
<b>Numerator</b>			165	165	
<b>Denominator</b>			218	218	
<b>Data Source</b>	No reliable data source	No reliable data source	Birth Certificate	Birth certificate	
<b>Provisional Or Final ?</b>				Provisional	

**Data Alerts:**

None

**NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.**

	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Annual Objective</b>	73.2	73.6	75.0	75.0	75.0
<b>Annual Indicator</b>	74.4	73.9	73.3	73.3	
<b>Numerator</b>	16,529	16,884	16,309	16,309	
<b>Denominator</b>	22,206	22,841	22,242	22,242	
<b>Data Source</b>	Birth Certificate	Birth Certificate	Birth Certificate	Birth certificate	
<b>Provisional Or Final ?</b>				Provisional	

**Data Alerts:**

None

**Form 10d**  
**State Performance Measures (Reporting Year 2014 & 2015)**  
**State: Idaho**

**SPM 1 - Percent of 9th - 12th grade students that report having engaged in sexual intercourse.**

	2011	2012	2013	2014	2015
Annual Objective	39.0	39.0	39.0	39.0	38.0
Annual Indicator	40.0	40.0	38.5	38.5	
Numerator					
Denominator					
Data Source	YRBS	YRBS	YRBS	YRBS	
Provisional Or Final ?				Final	

**Data Alerts:**

None

**SPM 2 - Percent of pregnant women 18 and older who received dental care during pregnancy.**

	2011	2012	2013	2014	2015
Annual Objective	55.0	55.0	55.0	55.0	57.0
Annual Indicator	51.1	54.4	54.4	56.3	
Numerator					
Denominator					
Data Source	PRATS	PRATS	PRATS	PRATS	
Provisional Or Final ?				Provisional	

**Data Alerts:**

None

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

	2011	2012	2013	2014	2015
Annual Objective	18.0	18.0	18.0	18.0	18.0
Annual Indicator	22.6	22.6	25.3	25.3	
Numerator					
Denominator					
Data Source	YRBS	YRBS	YRBS	YRBS	
Provisional Or Final ?				Final	

**Data Alerts:**

None

**SPM 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.**

	2011	2012	2013	2014	2015
Annual Objective	59.0	59.0	59.0	51.0	53.2
Annual Indicator	49.7	48.9	53.0	53.0	
Numerator	10,890	11,019	11,676	11,676	
Denominator	21,909	22,538	22,020	22,020	
Data Source	Birth Certificate	Birth Certificate	Birth Certificate	Birth certificate	
Provisional Or Final ?				Provisional	

**Data Alerts:**

None

**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.**

	2011	2012	2013	2014	2015
Annual Objective	43.0	43.0	43.0	43.0	46.0
Annual Indicator	41.3	41.8	41.8	45.4	
Numerator					
Denominator					
Data Source	PRATS	PRATS	PRATS	PRATS	
Provisional Or Final ?				Provisional	

**Data Alerts:**

None

**SPM 6 - Percent of women 18 and older who gave birth and drank alcohol in the 3 months prior to pregnancy.**

	2011	2012	2013	2014	2015
Annual Objective	50.0	50.0	50.0	50.0	65.0
Annual Indicator	78.7	79.4	79.4	81.4	
Numerator					
Denominator					
Data Source	PRATS	PRATS	PRATS	PRATS	
Provisional Or Final ?				Provisional	

**Data Alerts:**

None

**SPM 7 - Percent of children at kindergarten enrollment who meet state immunization requirements.**

	2011	2012	2013	2014	2015
Annual Objective	90.0	90.0	91.0	91.1	93.5
Annual Indicator	86.4	91.1	92.0	93.2	
Numerator	19,675	21,761	22,016	21,412	
Denominator	22,762	23,888	23,934	22,968	
Data Source	SIR 2011	SIR 2012	SIR 2013	SIR 2014	
Provisional Or Final ?				Final	

**Data Alerts:**

None

**SPM 8 - Percent of children at seventh grade enrollment who meet state immunization requirements.**

	2011	2012	2013	2014	2015
Annual Objective	95.0	95.0	95.0	90.0	90.0
Annual Indicator	78.3	81.3	86.8	89.9	
Numerator	17,736	18,396	20,160	20,860	
Denominator	22,659	22,636	23,232	23,210	
Data Source	SIR 2011	SIR 2012	SIR 2013	SIR 2014	
Provisional Or Final ?				Final	

**Data Alerts:**

None

**Form 11**  
**Other State Data**  
**State: Idaho**

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the FY 2016 application and FY 2014 annual report.

## State Action Plan Table

### State: Idaho

Please click the link below to download a PDF of the State Action Plan Table.

[State Action Plan Table](#)