

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

Idaho

**FY 2017 Application/
FY 2015 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

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.

Women/Maternal Health

Increase percent of women accessing prenatal care. Accessing early prenatal care remains a challenge for Idaho women. In 2014, 74.2 percent of pregnant women accessed prenatal care in the first trimester. Progress to 'move the needle' is through collaboration with the Idaho WIC program, Maternal, Infant and Early Childhood Home Visiting (MIECHV) program and the Title X Family Planning program with emphasis on increased referrals of pregnant women to prenatal care.

Perinatal/Infant Health

Improve breastfeeding rates. Idaho is faring better than the national averages for breastfeeding. In 2014, a total of 90.9 percent of Idaho infants were breastfed at birth. Breastfeeding duration remains an on-going challenge. Efforts to 'move the needle' on breastfeeding has been through the Idaho WIC Peer Counseling program. All pregnant women in WIC attend a breastfeeding class. Following delivery, every breastfeeding woman is assigned a peer counselor. Collaboration with the Idaho Physical Activity and Nutrition (IPAN) program to increase the number of worksites who offer lactation rooms and breastfeeding support to breastfeeding women is ongoing.

Support services, programs and activities that promote safe and healthy family functioning. Idaho's objective is to reduce sleep-related infant deaths by improving safe sleep practices. In 2015, the Governor declared October as Safe Sleep Awareness Month. This effort was through a CoIIN partnership with Inland Northwest SIDS Foundation. In an effort to 'move the needle', 45 providers around the state have received the Cribs for Kids certification training from a CoIIN partner. In addition, the MCH program added a new objective to expand injury and disease prevention activities to reduce morbidity and mortality rates among pregnant women and young children. Block grant funds will support a portion of the Idaho Poison Control hotline. Block grant funds help 'move the needle' on MCH Epidemiology activities regarding disease risks to maternal and child health populations.

Child Health

Decrease the prevalence of childhood overweight and obesity. Based on the results of the 2011/2012 Idaho third

grade Body Mass Index (BMI) assessment and the 2011 Idaho Youth Risk Behavior Survey, there are an estimated 29 percent overweight or obese third grade students and 23 percent overweight or obese high school students living in Idaho. Efforts to 'move the needle' have been through on-going collaboration with IPAN to increase state activities focused on helping children achieve a healthy weight. Last year, IPAN conducted 14 Let's Move Child Care workshops across the state and reached 150 unique providers.

Improve childhood immunization rates. The estimated vaccination coverage among children aged 19-35 months in Idaho decreased from 70.2 percent in 2013 to 65.9 percent in 2014. MCH will support 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.

Adolescent Health

Improve maternal and child health population access to medical homes (this is cross-cutting/life course as well). In order to 'move the needle', collaboration with the Adolescent Pregnancy Prevention program is planned. Questions are being added to the Reducing the Risk curriculum to assess awareness of and the reasons why adolescents do not seek well-visits.

Children and Youth with Special Healthcare Needs (CYSHCN)

Improve Access to medical specialists for CYSHCN. Idaho MCH plans to continue to enhance services and activities focused on improving quality of care for CYSHCN. MCH block grant funds will continue to provide financial support for pediatric specialty clinics, support the Children's Special Health program to provide financial assistance to uninsured CYSHCN for payment of eligible medical claims and will partner with local public health districts and hospitals to identify specialist needs and recruit specialists. MCH will partner with Idaho Parents Unlimited (IPUL), the State's Family-to-Family Resource Center, to increase parent engagement and provide parent education about medical homes. MCH will use block grant funds to partner with the Children's Hospital on a pediatric and family practice learning collaborative focused on developmental screening that will be provided statewide to practitioners. For those clinics participating in the MCH medical home demonstration project, funds will be used to support quality improvement activities for enhanced depression screening among adolescents. MCH will continue to support the Idaho Newborn Screening program to detect certain genetic, endocrine and metabolic disorders that can affect a child's long-term health and survival.

Cross-Cutting/Life Course

Decrease substance abuse among maternal and child health populations. In Idaho, 10.6 percent of live births were to mothers who reported smoking any time during pregnancy. In an effort to 'move the needle', the Tobacco Cessation program, with MCH block grant support through CoIIN, implemented a 10-Call pregnancy program for pregnant and postpartum women which was added to the Idaho Quitline. The pregnancy program covers up to 10 calls during pregnancy and postpartum. These calls help the participant to develop skills to remain tobacco-free and to reduce the health risks to the infant from exposure to second-hand smoke. During 2015, 22 pregnant and breastfeeding women received telephone counseling and 52 utilized the self-guided web cessation program. The Tobacco Cessation program is also conducting targeted outreach to women of reproductive age by having informational materials printed and disseminated through providers, health fairs, etc. In addition, the Tobacco Cessation program also transitioned from a paper fax referral to an online, easy to use referral system for providers.

Improve maternal and child health population access to medical homes. In an effort to 'move the needle', MCH block grant funds will continue to be used to support the Oral Health program in the application of dental sealants in schools. A new collaboration with the Oral Health program will be to fund the Smile Survey which is designed to assess oral health care and barriers to care. The survey is given to all third grade students across the state. De-

identified data will be collected to capture the number of CYSHCN with an Individualized Education Program (IEP) that is written specific to each child based on needs and the approach the education system will take to meet those needs. This next year, MCH will use block grant funds to partner with the Children's Hospital on a pediatric and family practice learning collaborative focused on practice improvement and care delivery related to pediatric oral health.

Following is a description of MCH accomplishments and challenges. The information is not exhaustive and is intended to give an overview of MCH efforts in Idaho across the three legislatively defined areas. Additional detail can be found in the State Overview and Budget Narrative sections of the grant application.

Preventive and Primary Care services for pregnant women, mothers and infants: MCH block grant funds were used to support the on-going efforts of the Title X Family Planning program. 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.

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. The CollIN activities reside under the jurisdiction of the CYSHCN Director and the MCH Health Program Specialist. Idaho selected Tobacco Cessation and Safe Sleep as the two CollIN strategies.

Block grant funds helped support the Idaho Bureau of Epidemiology (EPI) in multiple population domains by providing funding for contracts with the Public Health Districts (PHDs), as well as staff support. Funds were used in support of the Women/Maternal Health and Perinatal/Infant Health population domains by helping to fund EPI efforts to inform and educate the public regarding the outbreaks of multiple viruses and bacteria, including Ebola and recent Zika virus updates.

Preventive and Primary Care services for children: Block grant funds helped support EPI in multiple population domains as noted above. MCH EPI created a Health Alert Network (HAN) to send messages directly to providers regarding the recent Zika virus outbreak and risks to pregnant women. This HAN also implemented a 'call for cases' to all public health districts, OB/GYN, pediatric and family practice providers. In addition, MCH EPI participate in the infection control meetings of at least one hospital within their respective jurisdiction on a monthly or quarterly basis, depending on the rules of the facility specific to infection control.

All seven 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. In 2015, a total of 193 third graders received sealants and 425 dental sealants were placed on permanent molar teeth. The PHDs also provided oral health screenings, fluoride varnish applications, oral health education, and facilitated dental home referrals as needed.

The Idaho WIC Program participated in the 2015 Idaho Hunger Summit, Idaho Hunger Relief Task Force, Childhood Hunger Coalition and in Healthy Eating Active Living (HEAL). HEAL focuses on developing and maintaining an active engaged network of partners who invest resources and expertise to create/support an active living, healthy eating population in Idaho with the aim towards reducing/preventing childhood obesity.

A contract with the Nebraska Regional Poison Center for the Poison Prevention hotline is administered within the MCH Program area. Poisoning is the third leading cause of unintentional injury deaths among all Idahoans, subsequent only to motor vehicle crashes and falls. In 2015, the Nebraska Regional Poison Center received 13,745 calls from Idaho residents; the majority of these calls were received from parents of children age 5 years and younger.

Services for CYSHCN: In 2015, the Title V MCH Program continued a partnership with Eastern Idaho Public Health District to address persistent health disparities among CYSHCN residing in rural Idaho communities. The goal of the collaboration was to expand the patient-centered medical home model to providers of pediatric and family care serving CYSHCN in rural parts of Idaho. 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, Patient Centered Medical Home (PCMH) transformation, and patient registry and workflow management.

The Idaho Maternal and Child Health Program utilized FFY15 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. The Idaho MCH Program releases around 1,250 kits annually to interested individuals and entities.

The Idaho Newborn Screening (NBS) Program added Severe Combined Immunodeficiency (SCID) to the panel of conditions screened in November 2015. The Idaho NBS Program also instituted a courier service through UPS, free to all birthing centers, which has reduced specimen transit times from three-four days to an average of one day. This courier service also reduced errors in screening, including lost to follow up claims. In order to make the newborn screening program self-sustaining, a fee increase for newborn screen kit costs was implemented January, 2016. This lessens the reliance on MCH block grant funds, allowing funds to be directed toward other activities.

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

The staff capacity to implement CoIIN strategies in large part fell on already very full workloads of the department team members. With the multitude of grant requirements and accreditation efforts going on in the Division of Public Health, the ability to sustain CoIIN activities has been challenging. The majority of CoIIN team members are within the department and competing priorities for time and effort make it difficult to keep this initiative a central focus. Funding for CoIIN activities falls on the MCH block grant, as there are no other dedicated funds to support this initiative.

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 (IPUL) 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. The MCH Program did successfully reclassify an existing position in order to have a concentrated focus of the position work effort on activities to support the CYSHCN population.

The Zika virus outbreak is continuing to evolve daily. As a result, it is challenging for our small MCH EPI staff and MCH directors to stay on top of the volume of related communication. The information from CDC around a Zika Pregnancy Registry has been limited and somewhat fragmented. Once all the details about participation and process become known, information will be provided that includes fact sheets, forms, processes and contact information.

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 39th of the 50 United States for total population and 14th for geographic size. The 2014 estimated population for Idaho was 1,634,464 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 44th 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 2014 were: (a) white, 93.5 percent; (b) black, 0.8 percent; (c) American Indian/Alaska Native, 1.7 percent; and (d) Asian or Pacific Islander, 1.6 percent. It is estimated that 2.3 percent of Idahoans identify as being of two or more races. Persons of Hispanic or Latino origin comprised 12.0 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 2014 American Community Survey, 14.8 percent of Idahoans were living below the poverty level; placing Idaho 26nd out of the 51 states and District of Columbia.

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 2014 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 (90.1 percent and 86.9 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 (25.0 percent) of Idahoans over the age of 25 hold a bachelor's degree or higher, compared with the national average of 30.1 percent.

To facilitate the availability of public health services, contiguous counties in Idaho have been aggregated into seven public health 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 2015, 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 2013, ranking 49th 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 2016, 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 277,567 participants per month in State Fiscal Year (SFY, July-June) 2015, an increase of 9.88 percent from 2014. The enrollment increase can be attributed primarily to the Affordable Care Act (ACA). 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). Medicaid has contracted with Blue Cross of Idaho/Dentaquest for the past five years to provide dental services for Medicaid participants. In SFY 2015, an average of 3,500 Medicaid participants received dental services each month. The state of Idaho, in partnership with the state of Utah, received a five-year Children's Health Insurance Program Reauthorization Act quality demonstration grant for over \$10 million dollars. This grant was extended through February, 2016. The project focused on improving health outcomes for children while lowering the impact to the overall health system. Nearly 75,000 Idaho children and 147 providers were reached. The Idaho Health and Wellness Collaborative for Children (IHAWCC), was formed to sustain the work of the grant. The IHAWCC is now housed in the St. Luke's Children's Hospital and has planned partnership with the Division of Public Health, Maternal and Child Health program to conduct two learning collaboratives in the upcoming year. The focus of the learning collaboratives is on developmental screening and oral health.

In 2015, Idaho was approved for a title IV-E waiver. This provides states with an opportunity to use federal funds to implement practices to assure child safety, help children in foster care move to safe, permanent homes more quickly and to improve on the well-being of any child entering the foster care system in Idaho. Whenever possible, children are placed with family members. Compared to other states, Idaho has approximately half the rate of children placed in non-family settings, such as group home settings. The need to recruit and retain resource families is critical. In SFY 2015, 2,434 children were placed in foster care in Idaho.

The Idaho 2-1-1 Careline is a statewide, bilingual, toll-free information and resource referral service linking Idaho citizens to health and human services. In SFY 2015, the Careline facilitated 132,063 information and referral contacts. Careline exceeded the federal government standard for answering 80 percent of calls within 60 seconds by attaining 84.2 percent.

Idaho opened the first Behavioral Health Crisis Center in December, 2014. In recognition of the on-going need to address serious mental health illness and substance use disorders, the 2015 legislature appropriated funds for a second crisis center to open in northern Idaho. In June of 2015, the federal court approved a settlement agreement in the 35-year-old Jeff D class action lawsuit concerning children's mental health services. The agreement targets the provision of community-based services rather than housing mentally ill children within the correction system without treatment.

In 2015, the Idaho Legislature did not authorize the state to expand Medicaid. In 2016, the governor announced a proposal to connect uninsured Idaho adults living in poverty with primary healthcare and preventive services. The

proposal was known as the Primary Care Access Program (PCAP). However, during the 2016 legislative session the proposal was not accepted. 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 2016, the Idaho Legislature approved and the Governor signed legislation around Abortion, Unborn Infants Dignity Act, Practice of Pharmacy and the creation of an Office of Suicide Prevention. Legislation amended the existing law to provide that the Idaho Department of Health and Welfare shall compile a list of providers, facilities and clinics that request to be included on a list the department maintains annually who offer free ultrasounds for a patient, prior to an abortion. The Maternal and Child Health program will be required to maintain this listing and updating the list, as part of the fetal development project information that is disseminated to providers on request. Legislation requires the state registrar, Bureau of Vital Records and Health Statistics, within the Division of Public Health to provide a certificate of miscarriage on request. In addition, there is an amendment to the existing law that allows pharmacists to administer immunizations to persons who are six years of age and older. Previously, the age limit was twelve years of age and older. There is concern that some immunizations will not be captured in the Idaho Immunization Registry, if a pharmacist does not access for data entry. The legislature appropriated funds for the creation of an Office of Suicide Prevention and Awareness, to be housed within the Division of Public Health, in the Department of Health and Welfare.

Idaho's suicide rate is one of the highest in the nation (19.1 suicide deaths per 100,000) ; 47 percent higher than the national rate of 13 per 100,000. Among Idaho's 10 to 44 year olds, suicide was the second leading cause of death in 2014, with 160 deaths in this age group. In calendar year 2014, 25 persons age 10 to 19 years completed suicide. In response, the 2016 Idaho legislature provided the Idaho Department of Health and Welfare with \$971,100 from general funds to establish and operate a Suicide Prevention and Awareness Program. Additional funds were appropriated to pay for immunizations for children covered by TRICARE (\$596,000) and to fund the Expanded Access Program that provides for treatment-resistant epilepsy in children (\$128,000).

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 2016 coverage year, Idaho ranked second in the nation for per capita enrollments; only Florida's per capita enrollment figures were higher. In 2016, 102,353 Idahoans enrolled in a Qualified Health Plan through the state-based exchange.

In December 2014, Idaho was awarded \$39,683,813 dollars to implement the Statewide Healthcare Innovation Plan (SHIP) strategies over a four-year model test period. The primary goals of SHIP are to transform primary care practices across the state into patient-centered medical homes, improve care coordination through the use of electronic health records and health data exchange, establish seven regional collaboratives to support the integration of each medical home with the broader community, improve rural patient access to care, build a statewide analytics system, align payment mechanisms across payers to transform payment methodology from volume to value and reduce healthcare costs overall. The SHIP indicators identified as focus areas of work are access to care, tobacco cessation, obesity, and diabetes. The first year of the award (February 2015-January 2016) was a pre-implementation year. [Source: State of Idaho Website]

The Division of Public Health is committed to being a positive influence in the changing health system in Idaho. Six top public health priorities were identified in 2014 with public health partners. These priorities are:

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

In July 2015, the Division of Public Health published the *Get Healthy Idaho: Measuring and Improving Population Health*. The *Get Healthy Idaho* plan will show progress, annually, on the objectives outlined to address four of the six priorities noted above. Strategies were created to address healthcare access, obesity, tobacco and diabetes. *Get Healthy Idaho* supports the Division of Public Health Strategic Plan central challenge - to advance public health's influence within the changing health system. It supports the identified priority areas of the Strategic Plan to define and promote the role of public health and achieve public health accreditation. Additionally, the SHIP Model Test grant requires the development and implementation of a population health improvement plan. *Get Healthy Idaho* serves dual roles to meet both the requirements of Public Health Accreditation Board (PHAB) and the SHIP Model Test grant. *Get Healthy Idaho* will be reviewed and updated annually from perspectives of both the data and the identified strategies and will transform as the SHIP transforms.

The priorities from SHIP align with the Leading Health Indicators for Idaho, the Get Healthy Idaho priorities identified through PHAB, Idaho Infant Mortality Collaborative Improvement and Innovation Network (ColIN) strategies for Idaho, as well as, the MCH Needs Assessment outcome priorities. Please refer to supporting document, *Get Healthy Idaho* for additional information.

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 2015, the Division of Public Health submitted the formal application to PHAB. The Division is on target to submit all documentation to PHAB August, 2016. 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 MCH Director, CYSHCN Director and MCH Health Program Specialist are involved with the ColIN efforts in Idaho. The identified ColIN 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 referral 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 ColIN 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 conducted 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

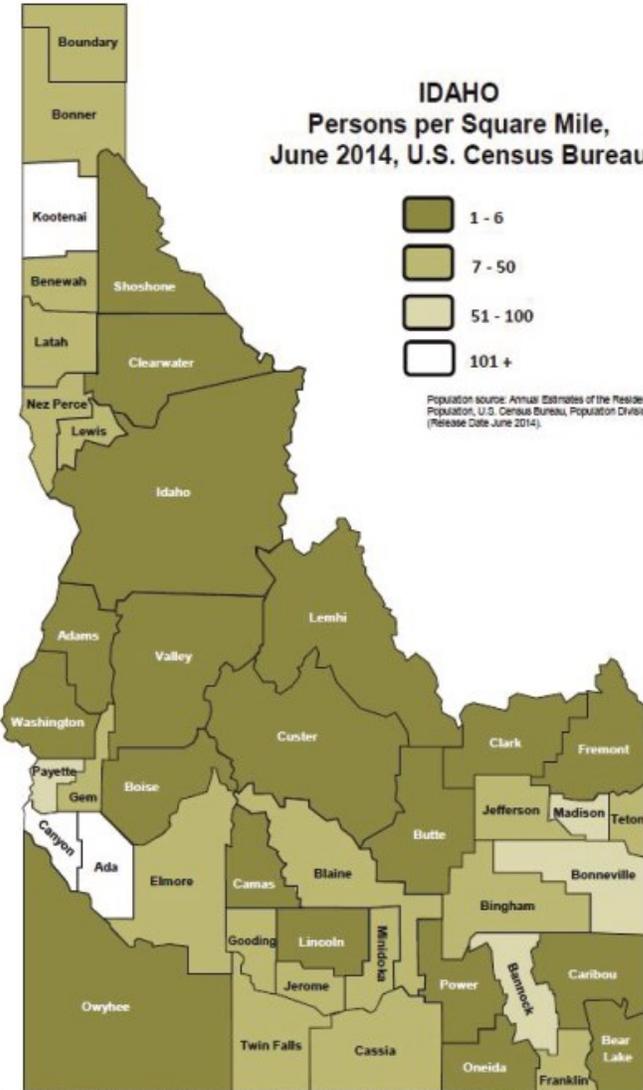
survey, respondents were provided a board book, "Sleep Baby, Safe and Snug", by Dr. John Hutton; illustrated by Leah Busch.

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 on an as needed basis 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 Title V MCH Director is part of the PHIT as well. The CYSCHN Director is on the Maternal, Infant and Early Childhood Home Visiting (MIECHV) steering committee, is on the Idaho Perinatal Project advisory committee, Idaho Parents Unlimited (IPUL) which is equivalent to the Family-to-Family engagement councils in other states and on the Developmental Disability Council. The MCH Health Program Specialist participates in the Idaho Sound Beginnings committee; overseen by the program that administers the Early Hearing and Intervention program in Idaho.

The Idaho Child Fatality Review Team (CFRT) was formed by the Governor's Task Force on Children at Risk, to review deaths to children under the age of 18 using a comprehensive and multidisciplinary process. In 2016, the Title V MCH Director became 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 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 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. Title V MCH block grant dollars will be used to support learning collaboratives in Idaho this next year.

IDAHO Persons per Square Mile, June 2014, U.S. Census Bureau



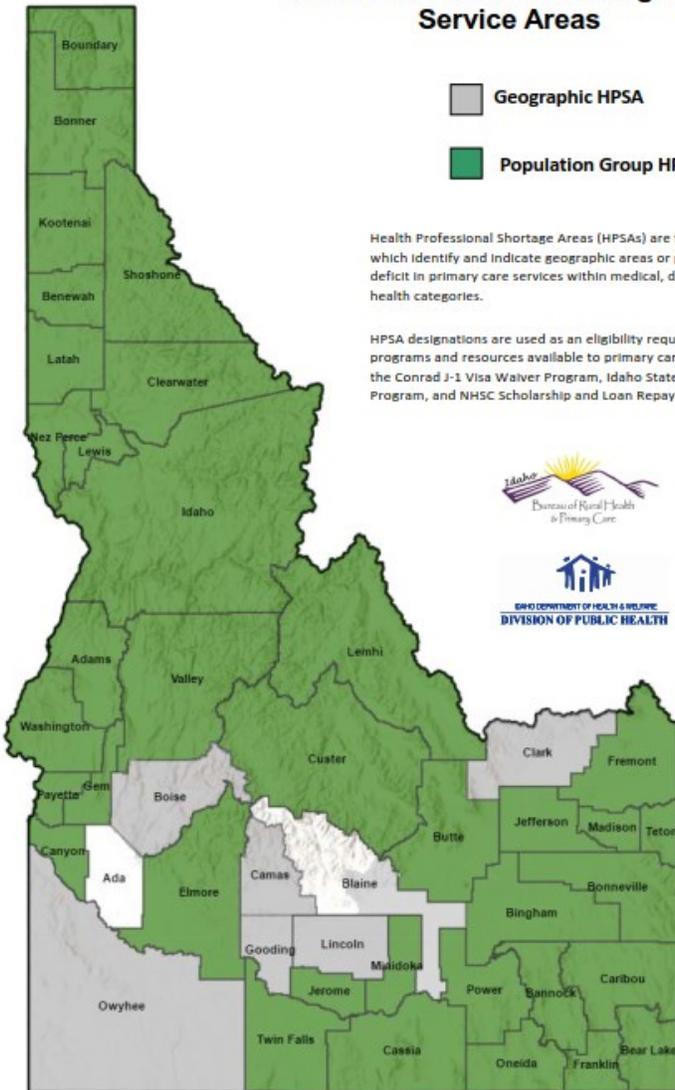
Bureau of Rural Health and Primary Care, Division of Public Health, Department of Health and Welfare, 1/15 – please contact (208) 334-5993 for updates

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH



Bureau of Rural Health
& Primary Care

Idaho Dental Health Professional Shortage Area Service Areas



- Geographic HPSA
- Population Group HPSA

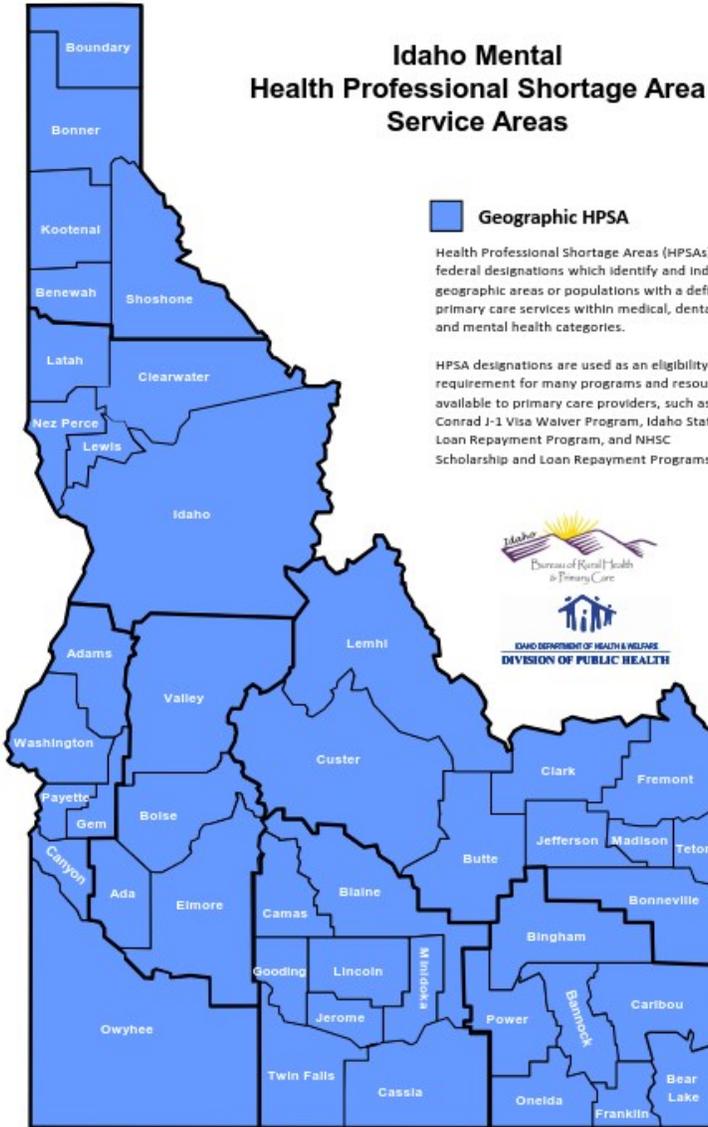
Health Professional Shortage Areas (HPSAs) are federal designations which identify and indicate geographic areas or populations with a deficit in primary care services within medical, dental, and mental health categories.

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



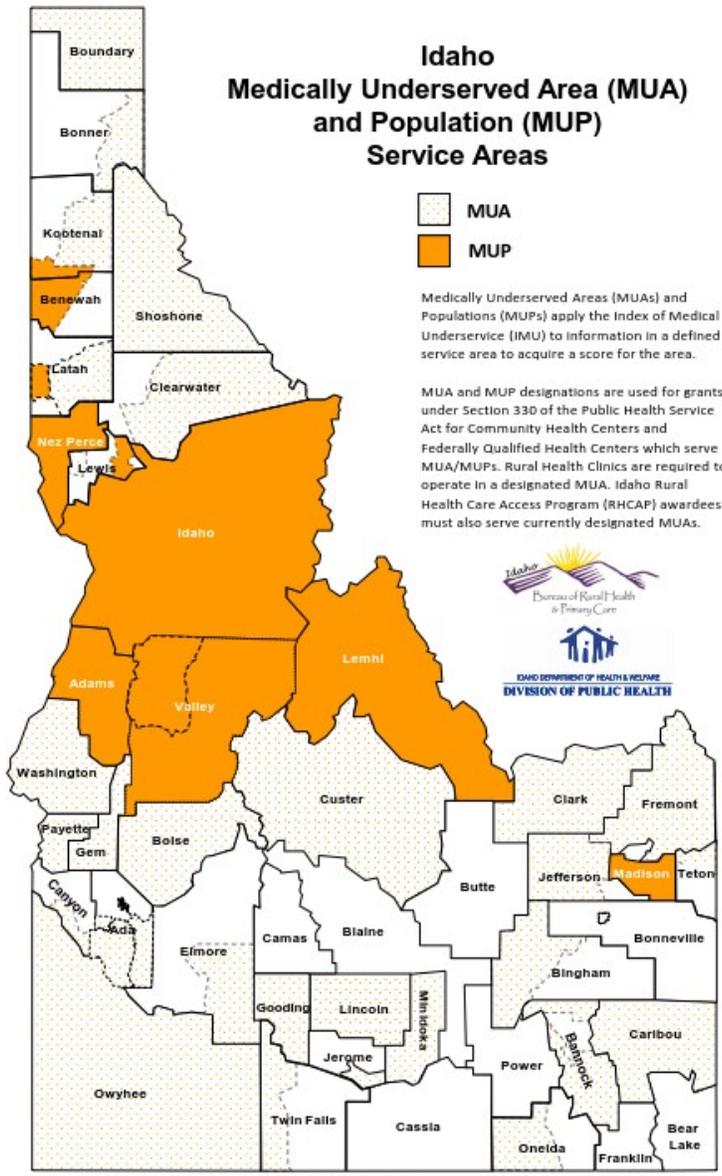
Bureau of Rural Health and Primary Care, Division of Public Health, Department of Health and Welfare, 7/15 – please contact (208) 334-5993 for updates

Idaho Medically Underserved Area (MUA) and Population (MUP) Service Areas

- MUA
- MUP

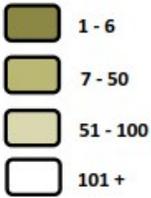
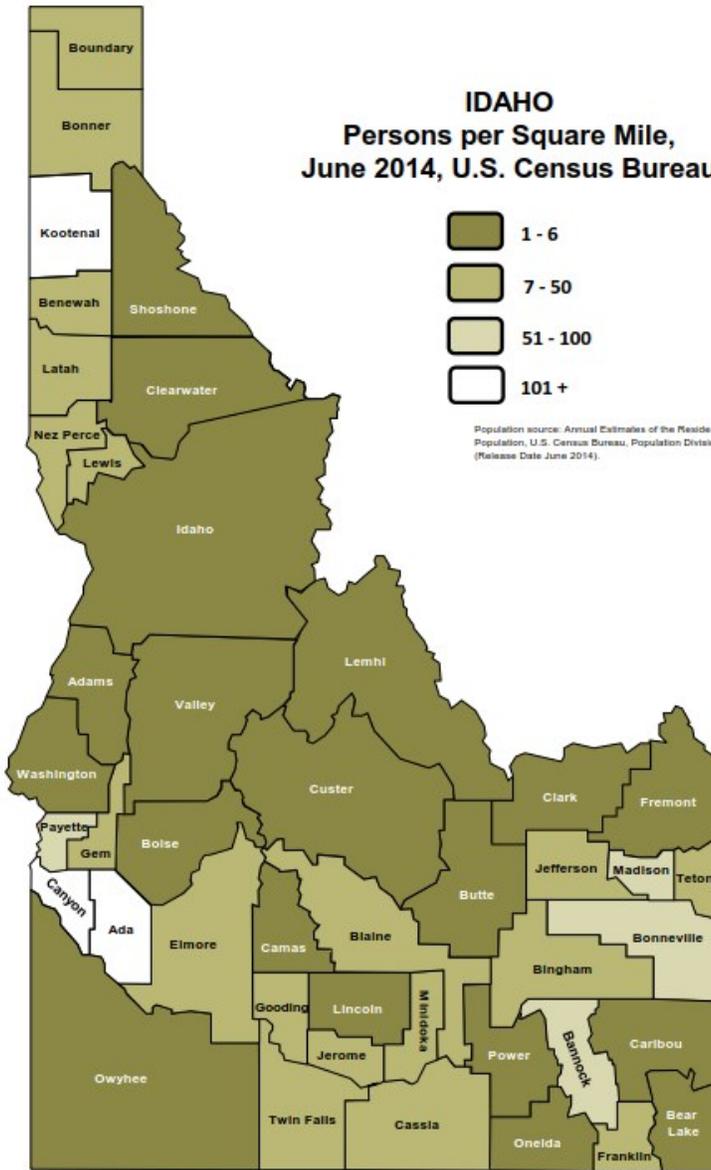
Medically Underserved Areas (MUAs) and Populations (MUPs) apply the Index of Medical Underservice (IMU) to information in a defined service area to acquire a score for the area.

MUA and MUP designations are used for grants under Section 330 of the Public Health Service Act for Community Health Centers and Federally Qualified Health Centers which serve MUA/MUPs. Rural Health Clinics are required to operate in a designated MUA. Idaho Rural Health Care Access Program (RHCAP) awardees must also serve currently designated MUAs.



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IDAHO
Persons per Square Mile,
June 2014, U.S. Census Bureau



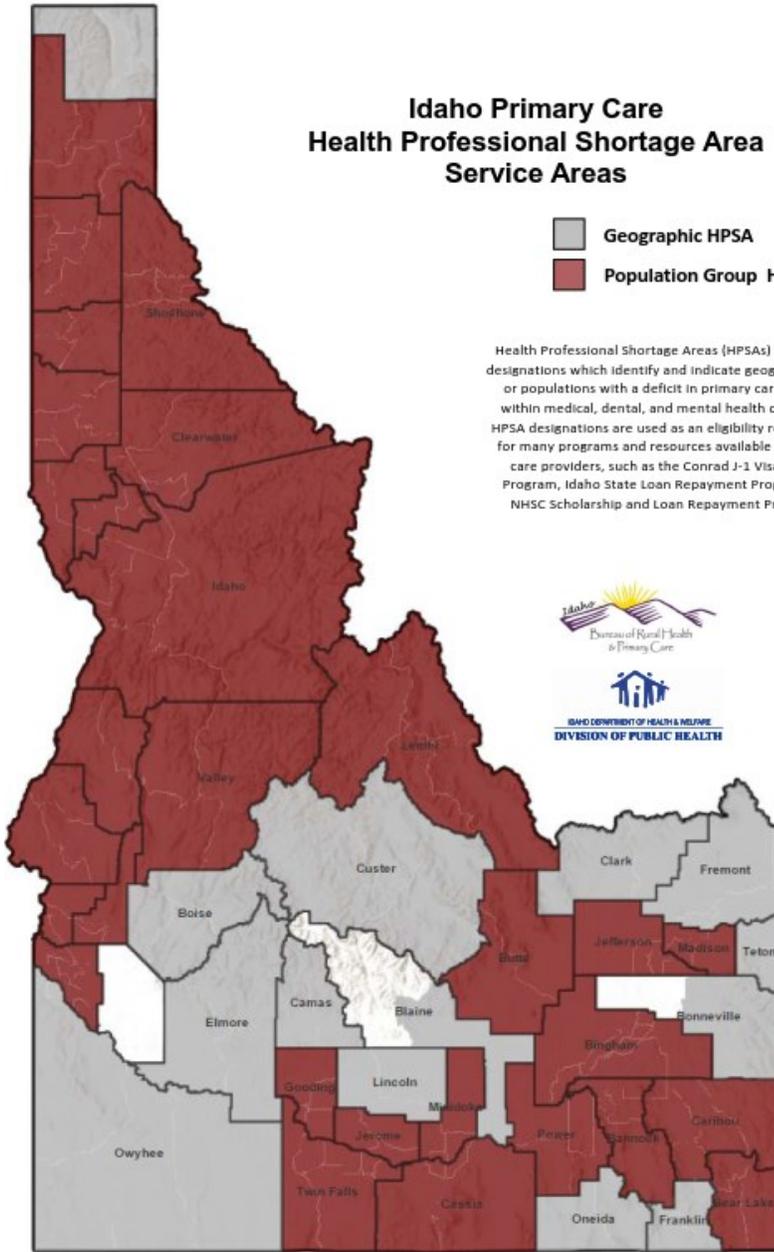
Population source: Annual Estimates of the Resident Population, U.S. Census Bureau, Population Division (Release Date June 2014)

Bureau of Rural Health and Primary Care, Division of Public Health, Department of Health and Welfare, 1/15 – please contact (208) 334-5993 for updates

Idaho Primary Care 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.



Bureau of Rural Health and Primary Care, Division of Public Health, Department of Health and Welfare, 5/16 – please contact (208) 334-5993 for updates

II.B. Five Year Needs Assessment Summary

2016 Five-Year Needs Assessment Summary

1. Process

The Idaho Maternal and Child Health (MCH) Program continued to partner with Boise State University's Center for Health Policy for a third year to continue evaluation and needs assessment efforts. The past year's on-going needs assessment involved various activities to continue the efforts made during the five-year comprehensive needs assessment, assess the current climate of Idaho's healthcare environment, and support the MCH Program's development of the State Action Plan.

The five-year needs assessment revealed a severe lack of access to pediatric specialists in the state. Through archival data collection, the needs assessment team took a deeper dive into the data to assess the specialist shortage. A dataset was obtained from the Idaho Medical Association (IMA) to assess current pediatric specialist access challenges. The data included physician specialists stratified by county of practice and specialist type. The needs assessment team retrieved information from the Association of Medical Colleges and U.S. Census Bureau to support specialist identification and to develop physician-to-population rates.

To continue to monitor the changing healthcare landscape in the state, the needs assessment partner followed the legislative session, monitored the development and initial implementation of the Statewide Healthcare Innovation Plan (SHIP), and kept apprised of the shortage levels of healthcare providers in both urban and rural areas of Idaho. The needs assessment partner also held monthly meetings with MCH program leadership to discuss progress made on the on-going needs assessment activities, development of the state action plan and Evidence-based Strategy Measures (ESMs), programmatic changes, and legislative impact to the Division of Public Health. The needs assessment team frequently interviewed the Title V MCH director and Children and Youth with Special Health Care Needs (CYSHCN) director, along with other Idaho Department of Health and Welfare (IDHW) personnel to identify sources of data, clarify information, and learn more about initiatives, strategies, and partnerships relevant to those receiving MCH services in Idaho. Despite Idaho's limited MCH staffing capacity, there are demonstrated strengths in building relationships and collaborating with others to leverage existing programs and activities in order to serve MCH populations.

The needs assessment partner was integral to developing the State Action Plan by conducting a comprehensive search of potential evidence-based strategies and ESMs, offering recommendations for ESMs, attending partner meetings for strategy development, and attending relevant webinars and national conferences. The needs assessment partner conducted an extensive literature review of strategies and provided a final report of recommended strategies and corresponding ESMs to the MCH Program. ESM development and selection was informed by Johns Hopkins environmental scans, Association of Maternal and Child Health Programs (AMCHP) webinar resources, AMCHP learning labs, AMCHP Innovation Station, the AMCHP national conference, technical assistance from HRSA, peer-reviewed journal, and state resources.

When developing the ESMs and State Performance Measures (SPMs), consideration was given to Idaho-specific activities and programs and how they could be leveraged, the state's strengths and challenges related to implementation of strategies, capacity to implement strategies, and MCH funding. ESM and SPM selection were chosen according to a variety of criteria:

- Ability to make a measurable impact in the short- and long-term
- Availability of data
- Feasibility of the evidence-based or -informed strategy
- Strategic collaboration and partnerships with interagency departments, local public health districts
- Practicality to implement
- State and local capacity
- Cost of potential strategies
- Alignment with existing programs and initiatives
- Alignment with NPMs
- Alignment with AMCHP resources from Johns Hopkins environmental scans, AMCHP Innovation Station, and

strategies identified as promising, emerging, or best practice

Ultimately, eleven ESMs and three SPMs were selected, representing each of the six population health domains (Women/Maternal Health, Perinatal/Infant Health, Child Health, Adolescent Health, Children and Youth with Special Healthcare Needs (CYSHCN), and Cross-Cutting/Life Course). Please see the State Action Plan narrative for further discussions about the Idaho MCH Program's goals, objectives, and selected ESMs and SPMs.

2. Findings

The key findings presented in the five-year needs assessment summary regarding Idaho's strengths, needs, program capacity, and partnerships/collaboration (FY 2016 Application / FY 2014 Annual Report) have not significantly changed. Below are the results, findings, and updates from on-going needs assessment activities over the past year.

2a. MCH Population Needs - Updates

Women/Maternal Health

- Idaho women initiated prenatal care during the first trimester at a similar rate as women nationally (74.2% compared with 73.7%, respectively).
- At 63.7%, Idaho women fell slightly short of the national rate of 65.2% of women who received a preventive visit in the past year.

Perinatal/Infant Health

- In 2014, Idaho had an 84.4% rate of ever breastfed indicating strong initiation of breastfeeding rates. However, duration of exclusive breastfeeding is 40.2% at three months and 24.8% at six months.

Child Health

- Unintentional injury was the leading cause of death for young children aged 1 to 4 years in the state in 2014.
- Idaho children fare better than children nationally for maintaining a healthy weight. About 28% of Idaho children were considered overweight or obese compared with 31% of children nationally.
- Only 65.9% of Idaho children aged 19-35 months had received the recommended vaccinations compared with 71.6% of children nationally. According to the Idaho Immunization Program, only 85.9% of children at kindergarten enrollment met state immunization requirements.

Adolescent Health

- Idaho children are lagging behind children nationally for receiving a preventive well-visit in the past year—only 73% of Idaho children had received a well-visit compared with 84% of children nationally.
- During the past decade there has been a steady decline in the annual teen pregnancy rate (from 45.2 per 1,000 in 2004 to 27.5 per 1,000 in 2014) among Idahoans aged 15 to 19.

CYSHCN

- Only 17 types of pediatric specialists practice in Idaho.

Physician and Pediatric Specialist Shortages

In 2015, Idaho ranked 49th in the United States in active physicians per 100,000 residents. Further, 96% of Idaho was designated as a primary care health professional area, 97% was a dental health professional shortage area, and 100% of Idaho was a mental health professional shortage area (Idaho Bureau of Rural Health and Primary Care, 2016).

Pediatric specialists are proportionally inaccessible or unavailable in the majority of counties in Idaho. A dataset was obtained from the IMA to specifically identify shortage areas for pediatric medical specialists. Only 17 of the 27 possible pediatric specialties are practiced in Idaho. Of the 17 specialties identified in Idaho, ten of them are only

offered in one county. These findings will help inform the MCH Program and efforts to recruit pediatric specialists to serve high-need communities. Below are some highlights regarding the pediatric specialist shortage in Idaho:

- Only 10 of 44 counties in Idaho have any pediatric specialists
- Only 17 of the 27 pediatric specialties are available anywhere in Idaho
- Of the 17 pediatric specialties offered in Idaho, 10 of them are only offered in one county in Idaho

Medicaid Expansion

Idaho is one of the states that chose to not expand Medicaid. The lack of Medicaid expansion has impacted individuals across the lifespan. Idaho Medicaid has experienced an 18% increase in enrollment from September 2013 to January 2016. Enrollment averaged 238,150 participants per month in the State Fiscal Year 2013 and reached 280,753 participants per month as of January 2016. Increased enrollment may be attributed to the Affordable Care Act individual mandate requiring people to obtain health insurance. In 2014-2016, the Idaho State Legislature voted against expanding Medicaid, leaving a coverage gap for approximately 78,000 Idaho residents who do not meet current Medicaid eligibility requirements or qualify for insurance coverage subsidies. A governor-appointed workgroup proposed an alternative to expanding Medicaid, which was called the Idaho Primary Care Access Program. This program would have provided primary care to those who fall in the coverage gap, however the bill did not leave the committee for a vote in the 2016 legislative session. As a result, Idaho residents (including members of MCH populations) who remain in the coverage gap will likely continue to access healthcare through other means, straining hospital emergency departments, county services, and the State Catastrophic Fund.

State Healthcare Innovation Plan

In December 2014, Idaho was awarded about \$40 million to implement the Statewide Healthcare Innovation Plan (SHIP) model test grant over a four-year period. The primary goal of the SHIP is to increase the number of Patient Centered Medical Homes across the state to improve healthcare delivery and coordinate care for more Idahoans, which in turn, should positively impact members of the MCH population. The SHIP identifies the following areas for targeted effort: access to care, tobacco cessation, obesity, and diabetes. These focus areas align well with Idaho's MCH Title V priorities, specifically health care access, obesity, and tobacco. The first year of the award (February 2015-January 2016) was a pre-implementation year. The SHIP implementation and data collection phase began in February 2016 and should serve as a good source of information for the MCH leadership team.

Your Health Idaho

Your Health Idaho (YHI) is the Idaho health insurance marketplace. YHI helps to provide insurance to members of populations who normally would not be covered or who would struggle to afford coverage (YHI, 2016). Eligible Idahoans can conveniently search for and purchase insurance either in person, online, or using the telephone. Eligible individuals include those who are not eligible for Medicaid, do not have coverage through their own or their spouse's employer, have pre-existing conditions, or own small businesses. From 2014 to 2015, enrollment in YHI increased from 78,000 to 86,000 participants. This put Idaho in the top four states in the entire country for per capital enrollments. In February of 2016, YHI reached a record enrollment of 102,353 Idahoans. In addition to increasing enrollees, YHI also increased the number of plan options available to Idahoans. As a part of this increase, adult dental service coverage was added for the first time as a potential service plan (YHI, 2016).

2b. Title V Program Capacity – Updates

Over the past year, the MCH Program has undergone a few changes. The program was able to reclassify a vacated Registered Nurse (RN) position and hired a new health program specialist to implement programs to serve Idaho's CYSHCN population, including the Newborn Screening Program. This position will oversee many of the strategies proposed for the CYSHCN health domain in the State Action Plan. The MCH Program houses the Family Planning Program which staffs a RN for clinical consultation. To maximize the RN position and cross-train on other MCH clinical components, the Family Planning RN's time was reallocated to partially support operations for the Children's Special Health and Newborn Screening Programs. The staffing coordination across programs has proven to be a success. As of July 2016, the Adolescent Pregnancy Prevention (APP) Program will be joining the MCH Program. The APP Program will join the Family Planning Program to create a Reproductive Health Unit, which includes the

addition of a health program manager who is also the state's Title V Adolescent Health Coordinator. The connection of APP with Family Planning was a strategic effort to align programs across the life course within MCH. Because of these changes, the MCH Program is better positioned to serve MCH populations in the state, with renewed focus on adolescents.

2c. Partnerships, Collaboration, and Coordination

Multiple meetings were conducted with MCH leadership and strategic partners to assess the feasibility of potential ESM development for the State Action Plan. Idaho is a state with limited staffing capacity, yet demonstrates many strengths in building relationships and collaborating with other organizations and agencies for a common goal. Leveraging and collaborating with other state agencies and strategic partners is critical to effectively serving MCH populations. Meetings and collaborations took place throughout the year with staff of the Idaho Physical Activity and Nutrition (IPAN) program, the Idaho Adolescent Pregnancy Prevention (APP) program, the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, the Idaho Women, Infants and Children (WIC) program, the Family Planning program, the Idaho Poison Control Center, the Newborn Screening program, the Idaho Immunization program, and the Children's Special Health program. These collaborations and meetings are an ongoing way to assess the needs of MCH populations and expand the reach and effectiveness of the state's Title V partnerships.

The MCH Program has strengthened collaboration with the Idaho Health and Wellness Collaborative for Children (IHAWCC). IHAWCC is housed at St. Luke's Children's Hospital and is part of the National Improvement Partnership Network (NIPN). IHAWCC is focused on collaborating with private and public partners to use quality improvement practices to improve pediatric care in the state. Over the next five years, the MCH program intends to partner with IHAWCC to host learning collaboratives focused on quality improvement of pediatric care in the state, including oral health care and developmental screening.

The Early Childhood Coordinating Council (EC3), which is funded by the state's Early Childhood Comprehensive Systems (ECCS) grant, will disband by fall 2016 due to lack of funding. Restructuring of the ECCS grant at the national level impacted the state's capacity to submit a successful application for funds. The Idaho Title V MCH Director served on the EC3 which helped inform MCH programming. The MCH program will seek other opportunities through the MIECHV program to engage in the early childhood systems-building efforts.

Five-Year Needs Assessment Summary (Submitted on July 15, 2015)

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 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 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 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.

Women/Maternal Health

- 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 "Sources of Strength" community program (fosters connectedness and resilience)

- 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 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
 - 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
 - Reportedly, 85,000 more Idahoans (including members of MCH populations) have been enrolled in health insurance due to the ACA
 - 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 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
- 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

No.	Priority Need
1	Increase percent of women accessing prenatal health care
2	Improve breastfeeding rates
3	Support services, programs, and activities that promote safe and healthy family functioning
4	Decrease the prevalence of childhood overweight and obesity
5	Improve childhood immunization rates
6	Improve maternal and child health population access to medical homes
7	Improve access to medical specialists for children and youth with special health care needs
8	Decrease substance abuse among maternal and child health populations

Update to the State Selected Priorities

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 MCH population domains.

For the current FY 2017 Application, Idaho made a wording change to one of the priorities. State Priority 3 “Increase the number of families who practice safe and healthy parenting behaviors” for the Perinatal/Infant Health Domain has been revised to “Support services, programs, and activities that promote safe and healthy family functioning”. This revision allows for more broad application to existing MCH programs and activities. For example, Idaho intends to reflect existing poison control and disease prevention activities under this priority area.

Idaho’s revised MCH Priority Needs are:

1. Increase percent of women accessing prenatal care (Women/Maternal Health)
2. Improve breastfeeding rates (Perinatal/Infant Health)
3. Support services, programs, and activities that promote safe and healthy family functioning (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)

Selection Process

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. 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. 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.

Priority needs were ranked by four collapsed population groups (groups were collapsed for ease of voting) and included 24 selections. These selections included the 16 National Performance Measures (NPMs) 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 NPMs
- 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 NPMs).

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. Based on the results from Phase 1 and Phase 2 of the prioritization process, leadership evaluated potential 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/initiatives
- Alignment with NPMs

Ultimately, leadership selected eight state priority needs, ensuring that needs of all the six MCH population domains were represented. 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
2. Perinatal Nutrition: Improve breastfeeding rates
3. Support services, programs, and activities that promote safe and healthy family functioning
4. Childhood Healthy Weight: Decrease the prevalence of childhood overweight and obesity
5. Childhood Immunizations: Improve childhood immunization rates
6. Access to Medical Specialists: Improve access to medical specialists for children and youth with special health care needs
7. Substance Abuse: Decrease substance abuse among maternal and child health populations
Medical Home Access: Improve maternal and child health population access to medical homes

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 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 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.

Domain	2010 Priority Need	2015 Priority Need	Status
Women/Maternal Health	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
Perinatal/Infant Health	Reduce premature births and low birth weight		Discontinued
		Improve breastfeeding rates	Added
	Reduce intentional injuries in children and youth	Support services, programs, and activities that promote safe and healthy family functioning	Replaced
Child Health	Decrease the prevalence of childhood overweight and obesity	Decrease the prevalence of childhood overweight and obesity	Continued
	Improve immunization rates	Improve immunization rates	Continued
Adolescent Health		Improve MCH population access to medical homes (cross-cutting)	Added
CYSHCN	Improve access to medical specialists for CSHCNs	Improve access to medical specialists for CYSHCNs	Continued
Cross-cutting/ Life Course		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 2014 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 CollIN 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 was a newly added category in the 2016 application, therefore both priority needs were 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
- NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
- NPM 5 - Percent of infants placed to sleep on their backs
- NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day
- NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
- NPM 11 - Percent of children with and without special health care needs having a medical home
- 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
- NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Idaho's eight identified priority needs helped inform the selection of eight of the 15 National Performance Measures (NPM) to be addressed over the next five years (FY 2016 – FY 2020) by Title V MCH 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.

For the current FY 2017 Application/FY 2015 Annual Report, Idaho made a wording change to one of the state priority needs. State Priority Need 3 "Increase the number of families who practice safe and healthy parenting behaviors" for the Perinatal/Infant Health Domain was revised to "Support services, programs, and activities that promote safe and healthy family functioning".

Domains	State Priority Needs	National Performance Measure (NPM)
Women/Maternal Health	Increase percent of women accessing prenatal care	NPM 1: Well-woman visits Percent of women with a past year preventive medical visit.
Perinatal/Infant Health	Improve breastfeeding rates	NPM 4: Breastfeeding A. Percent of infants who are ever breastfed. B. Percent of infants who are breastfed exclusively through 6 months.
	Support services, programs, and activities that promote safe and healthy family functioning	NPM 5: Safe Sleep Percent of infants placed to sleep on their backs.
Child Health	Decrease the prevalence of childhood overweight and obesity	NPM 8: Child Physical Activity 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

Adolescent Health	Improve maternal and child health population access to medical homes (Cross-Cutting/Life Course)	NPM 10: Adolescent Well-visit Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
CYSHCN	Improve access to medical specialists for children and youth with special health care needs	NPM 11: CYSHCN Medical Home Percent of children with and without special health care needs having a medical home.
Cross-Cutting/Life Course	Decrease substance abuse among maternal and child health populations	NPM 14: Smoking 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	NPM 13: Oral Health 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.

Below is a discussion of how Idaho’s priority needs are linked with the selected NPMs. Please see Section II.F.1 “State Action Plan and Strategies” for further discussion on the strategies and evidence-based/-informed measures that Idaho developed to address the NPMs.

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>). Because prenatal care is part of the package of routine care for women and because preconception care is associated with a healthy pregnancy, the state made the case for the linkage between the priority need for prenatal care and the NPM for well-care. Through this linkage, the Idaho MCH program will implement strategies to address routine preventive care and prenatal care for women. Idaho women initiated prenatal care during the first trimester at a similar rate as women nationally (74.2% compared with 73.7%, respectively) (2014 National Center for Health Statistics). At 63.7%, Idaho women fell slightly short of the national rate of 65.2% of women who received a preventive visit in the past year (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 issued 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. The state has developed a State Performance Measure to monitor this priority. 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.

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

- SPM 1 - Immunizations: Percent of children at kindergarten enrollment who are adequately immunized.
- SPM 2 - Medical Specialist Access: Percent of children with special health care needs who needed or received specialist care in the past 12 months, and experienced some problem accessing care.
- SPM 3 - Injury Prevention: Unintentional death rate to children under 5 years of age

In the FY 2016 Application/FY 2014 Annual Report, Idaho identified eight state MCH priorities for 2016 – 2020. These eight priority needs helped inform the selection of eight National Performance Measures (NPMs). Because these eight NPMs do not address all of the unique challenges faced by Idaho’s maternal and child health populations, the state developed three State Performance Measures (SPMs) to be addressed over the next five years for the FY 2017 Application/FY 2015 Annual Report. The table below identifies Idaho’s eight state priority needs and linked SPMs by the six MCH population domains.

Domains	State Priority Needs	State Performance Measure (SPM)
Women/Maternal Health	Increase percent of women accessing prenatal care	
Perinatal/Infant Health	Improve breastfeeding rates	
	Support services, programs, and activities that promote safe and healthy family functioning	SPM: Injury Prevention Unintentional death rate to children 0-4 years of age.
Child Health	Decrease the prevalence of childhood overweight and obesity	
	Improve childhood immunization rates	SPM: Immunizations Percent of children at kindergarten enrollment who meet state immunization requirements.
Adolescent Health	Improve maternal and child health population access to medical homes (Cross-Cutting/Life Course)	
CYSHCN	Improve access to medical specialists for children and youth with special health care needs	SPM: Specialist Access Percent of children with special health care needs who needed or received specialist care in the past 12 months, and experienced some problem accessing care.
Cross-Cutting/Life Course	Decrease substance abuse among maternal and child health populations	
	Improve maternal and child	

health population access to medical homes
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Idaho identified three SPM's across the perinatal and infant health, child health, and CYSHCN health domains.

For the perinatal and infant health domain, the needs assessment identified two priority needs: 1) perinatal nutrition, specifically breastfeeding, and 2) promoting safe and healthy family functioning, including injury prevention and healthy parenting practices. While the state selected "NPM 4: Breastfeeding" and "NPM 5: Safe Sleep" to address both priority areas, Idaho developed a SPM to further address the priority of promoting safe and healthy family functioning. During the needs assessment process, injury prevention was a reoccurring theme, which was ultimately combined with healthy parenting, to create the priority need of supporting services, programs, and activities that promote safe and healthy family functioning. In the FY 2016 Application/FY 2014 Annual Report, selection of "NPM 7: Injury Prevention" was considered but disregarded because Idaho does not have hospital admission/discharge data and is not included in the State Inpatient Databases, which is the national data source for the NPM. According to the Children's Safety Network National Injury and Violence Prevention Resource Center, unintentional injury was the leading cause of death for young children aged 1 to 4 years in 2014. The state did not want to abandon focus on injury prevention, so a SPM was developed to address injury prevention using fatality data. Specifically, the state will use the measure of the rate of fatalities due to unintentional injuries per 100,000 children under 5 years of age. The data source for the SPM will be Idaho Vital Records.

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. The state selected "NPM 8: Child Physical Activity" to continue focus on reducing childhood overweight and obesity, and developed an SPM to address immunization coverage. The 2014 National Immunization Survey revealed that only 65.9% of Idaho children aged 19-35 months had received the recommended vaccinations compared with 71.6% of children nationally (CDC, 2015). According to the Idaho Immunization Program, only 85.9% of children at kindergarten enrollment met state immunization requirements. For the Immunization SPM, Idaho will focus on the percent of children at kindergarten enrollment who are adequately immunized. The data source for the SPM will be the Idaho Immunization Program.

For the CYSHCN domain, the needs assessment revealed the priority need of improving access to medical specialists for CYSHCN. The state selected "NPM 11: CYSHCN Medical Home" as a method to ensure children receive coordinated, ongoing, comprehensive care within a medical home. 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. According to results from on-going needs assessment efforts:

- Only 10 of the 44 counties in Idaho have any pediatric specialists
- Only 17 of the 27 pediatric specialties are available in the state
- Of the 17 specialties that are practiced in the state, 10 of them are only offered in a single county

To focus on this priority, Idaho developed an SPM to address this lack of specialty care. Specifically, the state will use the measure of percent of children with special health care needs who needed or received specialist care in the past 12 months, and experienced some problem accessing care. The data source for the SPM will be the National Survey of Children's Health.

II.F. Five Year State Action Plan

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

Women/Maternal Health

State Action Plan Table

State Action Plan Table - Women/Maternal Health - Entry 1

Priority Need

Increase percent of women accessing prenatal health care

NPM

Percent of women with a past year preventive medical visit

Objectives

By July 2020, increase the number of women who are linked to routine well-woman care, including prenatal care during the first trimester.

Strategies

Through collaboration with the Idaho WIC program, MIECHV program, and the Family Planning program, increase referrals of pregnant women to prenatal care.

Host meetings with the Idaho WIC Program, MIECHV Program, and the Family Planning Program to raise awareness of, disseminate information about, encourage enhanced tracking of, and develop coordinated referral strategies related to prenatal care and well-women visits across programs.

ESMs

ESM 1.1 - Host meetings with the WIC Program, MIECHV Program, and the Family Planning Program to raise awareness of, disseminate information about, encourage enhanced tracking of, and develop coordinated referral strategies related to routine care for women

NOMs

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

Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	51.1	51.1	51.2	51.2	51.3	51.4

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	51.0 %	2.3 %	141,248	276,971
2013	54.6 %	2.2 %	150,860	276,258
2012	47.3 %	2.6 %	129,098	273,153
2011	51.6 %	2.2 %	141,466	274,166
2010	51.6 %	2.0 %	140,036	271,666
2009	53.5 %	2.2 %	145,781	272,674

Legends:

- 🚫 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 1.1 - Host meetings with the WIC Program, MIECHV Program, and the Family Planning Program to raise awareness of, disseminate information about, encourage enhanced tracking of, and develop coordinated referral strategies related to routine care for women

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	4.0	4.0	4.0	4.0	4.0

Women/Maternal Health - Plan for the Application Year

Plan for Application Year

For the women/maternal health domain, Idaho selected “NPM 1: Well-Women Visits” based on the results from the needs assessment indicating the need to focus on routine care for women, including prenatal care for pregnant women. By July 2020, the state aims to see an increase in the number of women who are linked to routine well-woman care, including prenatal care during the first trimester. Measurement of the objective will be based on data from the Pregnancy Risk Assessment Tracking System, birth record data, and programmatic data. Currently, Idaho’s Supplemental Nutrition Program for Women, Infants, and Children (WIC), Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, and the Family Planning Program provide some degree of education about and referral to well-woman care and prenatal care for pregnant women. However, these programs provide information, offer referrals, and collect data with varying consistency. Strategies to address this objective and NPM are discussed below.

Idaho received two competitive MIECHV expansion grants for FY 2014 and FY 2015, which allowed the program to

expand from four home visiting sites to 10 sites across the state. Through MIECHV funding, Idaho is supporting two Nurse-Family Partnership (NFP) programs, 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 of routine and prenatal care. Since the program's inception in 2012, there were 334 women who were pregnant at program enrollment. Approximately 93% indicated they had a primary care or prenatal care provider at intake. Of those who did not have a provider, only 68% 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.

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 Eastern Idaho Public Health District, 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 2015, the Idaho Title X Family Planning clinics had 12,764 unduplicated clients. Among these clients, 850 received positive pregnancy tests. An estimated 76% of women who received a positive pregnancy test were given a referral to prenatal care and approximately 2% were given a referral for high risk pregnancy care.

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.

According to the Association of Maternal and Child Health Programs' (AMCHP) Issue Brief "Opportunities and Strategies for Improving Preconception Health through Health Reform (2015)", building and strengthening partnerships between Title V MCH programs and other state and community-based agencies is one strategy that can be used to link women with comprehensive preconception, prenatal, and interconception care. In FY 2017, the Idaho MCH Program plans on hosting meetings with the WIC Program, MIECHV Program, and the Family Planning Program to raise awareness of, disseminate information about, encourage enhanced tracking of, and develop coordinated referral strategies related to prenatal and preventive well-woman care. To track this strategy, the state developed the evidence-informed strategy (ESM) measure of counting the number of meetings that will occur between the programs over the 12-month period. The MCH program aims to host at least four meetings between all of the programs. It is anticipated that the information gleaned from these meetings will help inform future MCH strategies to increase utilization of prenatal and preventive care for women, and these strategies will be implemented in coming years.

Women/Maternal Health - Annual Report

Annual Report

The MCH block grant provides funding to the Idaho Family Planning Program to support subgrants to six of the seven local public health districts, which 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 2015, the family planning programs served 12,764 unduplicated clients. Among these clients, 850 received positive pregnancy tests. 648, or 76%, of the women who received a positive pregnancy test were given a referral to prenatal care and 18 women, or 2%, were given a referral for high risk pregnancy care.

Idaho received two competitive MIECHV expansion grants for FY 2014 and FY 2015, which allowed the program to expand from four home visiting sites to 10 sites across the state. Through MIECHV funding, Idaho is supporting two Nurse-Family Partnership (NFP) programs, 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. Referrals are maintained in Idaho MIECHV's database. The new expansion sites began service delivery in June 2015. It is a part of MIECHV's required benchmarks to ensure programs provide enrolled pregnant women with information on the schedule of prenatal care, and if needed, provide referral to a provider. From when Idaho MIECHV began services, in 2012, through May 30, 2016, 93% of women who enrolled as pregnant had a provider at intake. Of those women, 68% were referred. Among the women who did not receive a referral, 25% remained in the program for six weeks or less and 13% were newly enrolled.

The Idaho Women, Infants, and Children (WIC) Program, which works to increase initiation and duration of breastfeeding by providing education and support to pregnant and postpartum women, used FFY15 block funds to support the Women/Maternal Health, Perinatal/Infant Health, and Child Health population domains. This year, Idaho WIC participated in a regional Maternal Child Health Nutrition Leadership Network Meeting, benefiting the aforementioned population domains. In August 2015, WIC sponsored a State breastfeeding conference titled "WIC: Making a Difference with Breastfeeding in Idaho". This was a two-day conference that included a variety of topics from latch, milk supply and breast pumps, to Peer Counseling best practices in local agencies. Peer Counseling management information system tools were refined and expanded to allow for paperless charting, which encourages a more streamlined experience for the patient and increases the amount of time and other resources that can be spent serving the participants of the stated population domain.

Perinatal/Infant Health

State Action Plan Table

State Action Plan Table - Perinatal/Infant Health - Entry 1

Priority Need

Improve breastfeeding rates

NPM

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

Objectives

By July 2020, increase the percentage of infants breastfeeding at 6 months of age.

Strategies

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.

Through collaboration with the MIECHV program and the WIC program, host a breastfeeding education and support training to home visitors across the state.

ESMs

ESM 4.1 - Through collaboration with the MIECHV program and the WIC program, host a breastfeeding education and support training to home visitors across the state.

NOMs

Post neonatal mortality rate per 1,000 live births

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

State Action Plan Table - Perinatal/Infant Health - Entry 2

Priority Need

Support services, programs, and activities that promote safe and healthy family functioning

NPM

Percent of infants placed to sleep on their backs

Objectives

By July 2020, reduce infant sleep-related deaths by improving safe sleep practices.

Strategies

Through CoIIN Infant Mortality efforts, provide safe sleep practice education to health care providers and support hospital certification through the Cribs for Kids Safe Sleep Hospital Certification Program.

Through CoIIN Infant Mortality efforts, increase safe sleep practices by new moms through the provision of sleep sacks and safe sleep education.

Participate in the Child Fatality Review Team to review child deaths and offer recommendations for prevention and education, including Sudden Unexpected Infant Death (SUID) cases.

ESMs

ESM 5.1 - Through CoIIN Infant Mortality efforts, provide safe sleep practice education to health care providers.

ESM 5.2 - Through CoIIN Infant Mortality efforts, support hospital certification through the Cribs for Kids Safe Sleep Hospital Certification Program

NOMs

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

State Action Plan Table - Perinatal/Infant Health - Entry 3

Priority Need

Support services, programs, and activities that promote safe and healthy family functioning

SPM

Injury Prevention: Unintentional death rate to children under 5 years of age

Objectives

By July 2020, fund injury and disease prevention activities to reduce morbidity and mortality rates among pregnant women and young children.

Strategies

Fund the Idaho Poison Control Center to provide statewide consultation on poison exposure, maintain the poison control hotline, and provide community education about poisoning prevention.

Fund the Bureau of Communicable Disease Prevention's Epidemiology Program to provide statewide education regarding disease risks to maternal and child health populations, including treatment and prevention recommendations, public health law, and outbreak reporting.

Participate in the Child Fatality Review Team to review child deaths and offer recommendations for prevention and education.

Measures

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	85.0	85.5	85.8	86.0	86.1	86.1

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	91.7 %	2.3 %	19,100	20,838
2011	84.4 %	3.2 %		
2010	90.6 %	2.4 %		
2009	90.7 %	2.4 %		
2008	83.1 %	2.7 %		
2007	86.4 %	2.4 %		

Legends:

-  Indicator has an unweighted denominator <50 and is not reportable
-  Indicator has a confidence interval width >20% and should be interpreted with caution

NPM-4 B) Percent of infants breastfed exclusively through 6 months

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	20.6	20.7	20.7	20.8	20.8	20.9

Data Source: National Immunization Survey (NIS)

Multi-Year Trend					
Year	Annual Indicator	Standard Error	Numerator	Denominator	
2012	20.2 %	3.3 %	4,040	20,018	
2011	24.8 %	3.4 %			
2010	20.1 %	3.0 %			
2009	25.4 %	3.4 %			
2008	21.9 %	2.4 %			
2007	21.3 %	2.8 %			

Legends:

- 🚫 Indicator has an unweighted denominator <50 and is not reportable
- ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 4.1 - Through collaboration with the MIECHV program and the WIC program, host a breastfeeding education and support training to home visitors across the state.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	25.0	25.0	25.0	25.0	25.0

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	82	82.2	82.3	82.5	82.6	82.6

FAD not available for this measure.

ESM 5.1 - Through COLIN Infant Mortality efforts, provide safe sleep practice education to health care providers.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	30.0	30.0	30.0	30.0	30.0

ESM 5.2 - Through COLIN Infant Mortality efforts, support hospital certification through the Cribs for Kids Safe Sleep Hospital Certification Program

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2.0	4.0	6.0	8.0	10.0

Perinatal/Infant Health - Plan for the Application Year

Plan for Application Year

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. The MCH program developed three objectives to address the state’s priority needs of improving breastfeeding rates and to support services, programs, and activities that promote safe and healthy family functioning. Strategies to address these objectives and NPMs are discussed below.

For the breastfeeding priority, the MCH program aims to increase the percentage of infants who are breastfeeding at 6 months of age. Measurement of the objective will be based on data from the Pregnancy Risk Assessment Tracking System, birth record data, and programmatic data. For strategies to increase breastfeeding initiation and duration rates, the AMCHP Issue Brief “State Opportunities and Strategies for Breastfeeding Promotion through the Affordable Care Act (2013)” discussed collaboration with the MIECHV program to provide training to home visitors about breastfeeding resources and provide information to mothers about breastfeeding. Research (Hannula et al., 2008 and Oliveira et al., 2001) shows that home visits during the postnatal period were effective for addressing mothers’ concerns about breastfeeding, providing education, linking them with community resources, and involving other family members. For FY 2017, the Idaho MCH program plans on collaborating with the MIECHV program to fund training for home visitors, which will be facilitated by WIC staff, on breastfeeding education, how to answer mother’s questions regarding breastfeeding, how to encourage fathers to support breastfeeding, and how to link families with community resources. The ESM to track this strategy will be a count of the home visitors who participate in the training and receive education about best-practices for supporting breastfeeding.

In the future, the MCH program intends on collaborating with the Idaho Physical Activity and Nutrition (IPAN) program to support their current efforts and increase the number of worksites who offer lactation and breastfeeding support to lactating employees. 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.

The MCH program will support the WIC program's peer counselors on educating new moms about baby behavior and feeding cues at three months and six months of age and use them as resource for families participating in the MIECHV 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 three target dates from birth of the baby to three months postpartum. The contacts will consist of an initial target contact within 72 hours postpartum, a four-six week postpartum contact, and a three 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. All Breastfeeding Peer Counselors in Idaho are required to complete the modules in order to provide education and support. With continuing education and refined management tools, Idaho Breastfeeding Peer Counselors are better equipped to efficiently provide breastfeeding support to WIC moms than ever before.

For the priority need to support services, programs, and activities that promote safe and healthy family functioning, the MCH program developed two objectives to monitor progress of strategies: 1) By July 2020, reduce sleep-related infant deaths by improving safe sleep practices, and 2) By July 2020, fund and participate in injury and disease prevention activities to reduce morbidity and mortality rates among pregnant women and young children. Measurement of the objective focused on sleep-related deaths will be based on vital record data. Measurement of the objective focused on injury and disease prevention will be based on fiscal support from the Title V MCH Block Grant, an inventory of activities in which the MCH program is involved, and vital record data.

For the state priority of supporting services, program, and activities that promote safe and healthy family functioning, "NPM 5: Safe Sleep" was selected to align with current activities in the state related to the Infant Mortality Collaborative Improvement and Innovation Network (CoIIN). According to AMCHP's Compendium "Forging a Comprehensive Initiative to Improve Birth Outcomes and Reduce Infant Mortality: Policy and Program Options for State Planning", successful strategies for supporting safe sleep campaigns included partnering with community-based agencies to conduct trainings about safe sleep practices that target health care professionals, including obstetric and pediatric nursing staff, and working with hospitals to create standard safe sleep policies and train staff on the American Academy of Pediatrics (AAP's) infant safe sleep guidelines. For FY 2017, the MCH program intends to leverage the work already conducted through the Infant Mortality CoIIN and to continue to partner with Inland Northwest SIDS Foundation to provide safe sleep education to health care providers and support hospital certification through the Cribs for Kids® National Safe Sleep Hospital Certification Program. Cribs for Kids® recognizes hospitals that demonstrate a commitment to best practices and education in infant sleep safety. At a minimum, a hospital must develop a safe sleep policy statement that incorporates the AAP's infant safe sleep guidelines, train staff on safe sleep guidelines, and educate parents on the importance of safe sleep practices and implement these practices in the hospital. To track the success of these strategies, the MCH program will use the following ESM's: the number of health care providers who participated in the safe sleep training and the number of birthing hospitals that were certified through the Cribs for Kids® National Safe Sleep Hospital Certification program.

In September 2015, an Idaho CoIIN team member from Inland Northwest SIDS/SUIDS Foundation partnered with Cribs for Kids® with the goal of certifying every birthing center in Idaho as a safe sleep birthing center. The certification process ensures that all aspects of the birthing center follow safe infant sleep practices and disseminate regular education to parents regarding the proper sleeping environments for babies. As of June 2016, two hospitals in Idaho have obtained safe sleep certification through Cribs for Kids® with multiple others in the process of attaining certification. The Idaho CoIIN team has also identified two pilot sites for gathering safe sleep data and conducting Plan Do Study Act (PDSA) cycles. The pilot sites are gathering data relating to several factors which can then be analyzed to improve safe sleep outcomes. Idaho specifically chose one pilot site that is already a safe sleep certified hospital through the Cribs for Kids certification process and one pilot site that is not currently certified. Idaho is very

interested in learning data patterns from each of these facilities to maximize where the most drastic and immediate impacts can be made to reduce infant mortality in Idaho.

In the future, the MCH program is considering other strategies such as funding the provision of “sleep sacks” to new moms in select birthing hospitals who earn a Safe Sleep Certification. Further, the MCH Director is a member of Idaho’s Child Fatality Review Team, which is tasked with identifying opportunities for increased awareness and education around sleep-related deaths. Each year, the team reviews sudden unexpected infant death (SUID) cases and offers recommendations for prevention and education in an annual report.

The second objective related to the healthy family functioning priority need was funding and participating in injury and disease prevention activities to reduce morbidity and mortality rates among pregnant women and young children by July 2020. The MCH program developed a State Performance Measure (SPM) related to Idaho’s unique needs related to injury prevention (please see “Section E. Linkage of State Selected Priorities with State Performance and Outcome Measure” for further explanation). The state will use the measure of the rate of fatalities due to unintentional injuries per 100,000 children under 5 years of age. According to the Children’s Safety Network National Injury and Violence Prevention Resource Center, unintentional injury was the leading cause of death for young children aged 1 to 4 years in the state from 2008-2012 (2015 Idaho State Fact Sheet). Strategies to address this objective and SPM are discussed below.

In 2014, unintentional poisoning was the 11th leading cause of unintentional injury to children 0 to 4 years of age in the United States (CDC, 2014). The Idaho MCH Program has a strong partnership with the Idaho Poison Control Center and provides 60% of the center’s funding. In 2015, about half (49%) of the calls made to the Idaho Poison Center were for children under 5 years of age and 59 calls were regarding pregnant women. It is estimated that for every one-dollar spent on the poison control hotline in Idaho, over seven dollars are saved on medical expenses (DHW, N.D.). Continuing the partnership with the Idaho Poison Control Center will help reduce poisoning injuries and fatalities and inform future education strategies regarding poison prevention. The Idaho Poison Control program will be attending Idaho’s annual Baby Palooza event in July 2016, which is a family-friendly event for new, expectant, and hopeful parents. In 2015, over 800 guests attended this event and organizers expect the event to attract over 1,200 this year. With 95% of attendees being pregnant or recently having a child, this event is a great platform for poison control education and can affect all MCH populations. In October 2016, the Idaho Poison Control program will be hosting a booth at the Idaho Kids Discovery Fair. This event focuses on children from newborn through 13 years old, which is the highest demographic affected by poisonings.

Further, the MCH program will continue to provide funding to the Idaho Bureau of Communicable Disease Prevention (Epidemiology program) to provide statewide education regarding disease risks to MCH populations, including treatment and prevention recommendations, public health policy, and disease/outbreak reporting. Communication has been sent to providers regarding the Zika Pregnancy Registry, although details are still changing. Information regarding the Zika Pregnancy Registry has been limited due to information from the CDC being sporadically disseminated. Once all details about the process have been determined, information will be provided that includes fact sheets, forms, processes, and contact information to all PHDs.

The MCH Director serves on the Idaho Child Fatality Review Team (CFRT). The CFRT 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 for the purpose of developing recommendations for prevention and education. The team utilizes information gathered by coroners, law enforcement, medical personnel and state government agencies in their reviews.

The MCH block grant will continue to provide funding for personnel and operations of the Idaho Newborn Screening (NBS) program as this is considered an essential population-based public health screening program. During the next year, the Idaho NBS program will be focusing efforts on educating health care providers including hospitals, clinics, and midwives. The NBS program will also increase outreach efforts to specific sects of providers such as OB/GYN and pediatrician practices. By educating these providers on a regular and consistent basis, the percent of infants screened at least once should increase and the number of unsatisfactory specimens submitted to the lab for processing should decrease. The Idaho NBS program has a goal set to increase the number of first specimens by 1% within the next two years.

Perinatal/Infant Health - Annual Report

Annual Report

Idaho received two competitive MIECHV expansion grants for FY 2014 and FY 2015, which allowed the program to expand from 4 home visiting sites to 10 sites across the state. Through MIECHV funding, Idaho is supporting 2 Nurse-Family Partnership (NFP) programs, 2 Early Head Start, Home-Based programs (EHS), and 6 Parents as Teachers (PAT) programs. At full capacity, the programs are expected to serve about 490 families combined. Improving breastfeeding initiation and duration rates is a goal of the MIECHV Program. From January 1, 2015 to March 31, 2016, 84% of women indicated that they had ever breastfed. Idaho MCH will work with MIECHV to determine if additional training or resources are needed for the local home visiting programs to supporting breastfeeding moms.

The Idaho Women, Infants, and Children (WIC) program, which works to increase initiation and duration of breastfeeding by providing education and support to pregnant and postpartum women, used FFY15 block funds to support the Women/Maternal Health, Perinatal/Infant Health, and Child Health population domains. This year, Idaho WIC participated in a regional Maternal Child Health Nutrition Leadership Network Meeting, benefiting the aforementioned population domains. In August 2015, WIC sponsored a State breastfeeding conference titled "WIC: Making a Difference with Breastfeeding in Idaho". This was a two-day conference that included a variety of topics from latch, milk supply and breast pumps, to Peer Counseling best practices in local agencies. Peer Counseling management information system tools were refined and expanded to allow for paperless charting, which encourages a more streamlined experience for the patient and increases the amount of time and other resources that can be spent serving participants. Funds also helped support the WIC program and mother-to-mother support through the WIC Breastfeeding Peer Counseling program, which trains Peer Counselors to gather information and educate the mother regarding baby cues and normal baby behavior in regard to breastfeeding. In December 2015, a new WIC Learning Management System was launched, which included Breastfeeding and Baby Behavior modules. All Breastfeeding Peer Counselors in Idaho are required to complete the modules in order to provide education and support. With continuing education and refined management tools, Idaho Breastfeeding Peer Counselors are better equipped to efficiently provide breastfeeding support to WIC moms than ever before.

FFY15 Block Grant funds supported Idaho's Collaborative Improvement and Innovation Network (CoIIN) initiatives, which strives to directly improve the Women/Maternal Health and Perinatal/Infant Health Domains. Idaho's CoIIN team is comprised of representation from various programs and organizations throughout Idaho, including the Inland Northwest SIDS/SUIDS Foundation, March of Dimes, numerous state agencies, and hospitals. Idaho is currently undertaking two CoIIN initiatives, Safe Sleep and Tobacco Cessation. The goal for the Safe Sleep initiative is to increase the amount of babies that are placed onto their backs for sleeping by providing education about best practices in safe sleep and facilitating certification to birthing centers in Idaho. The Tobacco Cessation initiative is aimed at assisting pregnant mothers to get and remain tobacco free during pregnancy, increasing the health of the mother and her children. In September 2015, an Idaho CoIIN team member from Inland Northwest SIDS/SUIDS

Foundation partnered with Cribs for Kids® to work with every birthing center in Idaho and get them certified as a safe sleep birthing center. The certification process ensures that all aspects of the birthing center follow safe infant sleep practices and disseminate regular education to parents regarding the proper sleeping environments for babies. To date, two hospitals in Idaho have obtained safe sleep certification through Cribs for Kids® with multiple others in the process of attaining certification. The Idaho COLLN team has also identified two pilot sites for gathering safe sleep data and conducting PDSA's. The pilot sites are to gather data relating to several factors which can then be analyzed to improve safe sleep outcomes. Idaho specifically chose one pilot site that is already a safe sleep certified hospital through the Cribs for Kids® certification process and one pilot site that is not currently certified. Idaho is very interested in learning data patterns from each of these facilities to maximize where the most drastic and immediate impacts can be made to reduce infant mortality in Idaho.

The Idaho Child Fatality Review Team (CFRT) was formed by the Governor's Task Force for Children at Risk, under an Executive Order to review deaths to children under the age of 18 using a comprehensive and multidisciplinary process. In 2016, the Title V MCH Director became a member of this team and 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 Child Fatality Review Team tasked with identifying opportunities for increased awareness and education around sleep-related deaths. This is on-going work. The FY2014 Annual Report from the team is pending finalization at this time.

FFY15 Block Grant funds were used by the Bureau of Communicable Disease Prevention (Epidemiology program) to support the Women/Maternal Health, Perinatal/Infant Health, and Child Health population domains. Zika has been at the forefront of public health recently and Idaho Epidemiology focused their efforts on education and prevention of this disease. Health Alert Network (HAN) messages were sent to providers regarding the Zika virus outbreak in South America and risks to pregnant women (all Idaho Public Health Departments (PHDs) have disseminated HAN messages about the Zika virus). There was a "call for cases" of microcephaly and HAN messages sent by all PHDs to OB/GYN, pediatric, and family practice physicians that outlined the process for reporting possible cases immediately to the State. Another important educational outlet has been the Department's social media campaigns, including websites, blogs, and radio, which included Zika Virus information for the public and healthcare providers that PHDs can link to and easily access. The Epidemiology program also collaborated with the Idaho Bureau of Laboratories (IBL), which has implemented a polymerase chain reaction (PCR) test, regarding testing capacity for Zika virus. Serologies will continue to be performed by the CDC laboratory. All PHDs attend the infection control meetings of at least one hospital within their jurisdiction on either a monthly or quarterly basis. During these meetings, staff have provided updates on current outbreaks, updated treatment or prevention guidelines, public health law, and reporting. During the Spring of 2016, many Idaho epidemiologists met with OB/GYNs regarding the Zika virus and the risk to pregnant women who traveled to areas where the virus is circulating. PHD epidemiologists also worked with pediatricians regarding microcephaly reporting and the risk of the Zika virus infection. Epidemiologists at every PHD traveled to one of the Immunization Shot Smarts conferences (3 throughout the state) to hear updates on the immunization program and participate in learning opportunities regarding how to ensure immunizations are up to date in children in their PHD clinics.

The Idaho Newborn Screening program (NBS) utilized FFY15 Block Grant funds to support the Women/Maternal Health and Perinatal/Infant Health population domains. Idaho is a two-screen state for NBS and for 2015, 97.4%, or 22,301, live births had at least one screen completed. A total of 28 NBS conditions were identified on these Idaho babies, potentially saving lives and financial resources for both affected families and the State of Idaho. The Idaho NBS team regularly attends meetings and conferences that have a focus on increasing the screening results and decreasing the number of conditions not caught on the screens. These include the Idaho Sound Beginnings Advisory Council, Northwest Regional Newborn Screening Meeting, Newborn Screening and Genetic Testing Symposium,

and the AMCHP annual conference. In January 2016, Idaho added severe combined immunodeficiency (SCID) to the Recommended Uniform Screening Panel (RUSP) and have had one case confirmed during this time. Adding SCID increased the cost of processing the kits through the Oregon State Public Health Laboratory and that cost was passed onto the providers in Idaho. The price of the NBS kit is now \$100 for a double kit, up from \$74 dollars last year. The Idaho NBS has been focusing recent efforts on education to providers and have initiated expanding our educational offerings to all providers dealing with the Women/Maternal Health and Perinatal/Infant Health population domains, including OB/GYN practices and pediatricians. In addition to offering free in-person education to any NBS provider, the NBS program has also created educational materials, including power point presentations and fact sheets that can be electronically sent to providers or obtained from the Department's websites that will help facilitate additional education for those staff that may not be able to attend an in-person meeting.

The MCH Block Grant funds Idaho's Poison Control work. Idaho contracts with the Nebraska Poison Center, which enables any person within the boundaries of Idaho to call a toll-free number and receive personalized, expert advice on any possible poisonings. For 2015, calls from Idaho resulted in 15,269 unique interactions to the poison center. The goal for the Nebraska Poison Center is to quickly and accurately handle all calls originating in Idaho. These services include pill identification, human or animal exposures, and chemical poisonings. Specifically relating to the Women/Maternal Health population domain, in 2015, the Nebraska poison center received 59 Idaho calls regarding pregnant women consisting of 69 exposures, as one caller could have been exposed to more than one toxin. Pesticides and household cleaning substances were the top two reasons for pregnant women to have called the poison center from Idaho last year. Regarding the Child Health population domain, about half (49%) of the calls made to the Idaho Poison Center were for children under five years of age. The Idaho Poison Control Program attended several educational events in the past year to help educate the public on poisonous materials and how to handle exposure or ingestion of toxins. During Poison Prevention Week of 2016, the Poison Control Program partnered with the Idaho State University pharmacy students and Idaho pharmacists to provide education to K-2nd grade classrooms resulting in 32 presentations in six Idaho elementary schools, send every 3rd grade teacher in Idaho information regarding Poison Prevention Week, and staff booths at several kids fairs.

Child Health

State Action Plan Table

State Action Plan Table - Child Health - Entry 1

Priority Need

Decrease the prevalence of childhood overweight and obesity

NPM

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

Objectives

By July 2020, help fund and support existing programs and initiatives to expand education and activities focused on physical activity and nutrition for children.

Strategies

Through collaboration with the Idaho Physical Activity and Nutrition Program, increase the number of child care providers trained on healthy behaviors for children.

For clinics participating in the shared medical home coordinator model, support quality improvement activities to address overweight and obesity among pediatric patients.

Partner with the Idaho Physical Activity and Nutrition Program to enhance current strategies focused on reducing overweight and obesity among children.

ESMs

ESM 8.1 - For clinics participating in the shared medical home coordinator model, support quality improvement activities to address overweight and obesity among pediatric patients.

NOMs

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)

State Action Plan Table - Child Health - Entry 2

Priority Need

Improve childhood immunization rates

SPM

Immunizations: Percent of children at kindergarten enrollment who are adequately immunized.

Objectives

By July 2020, collaborate with the Idaho Immunization Program to increase vaccination education and vaccine uptake among MCH populations.

Strategies

Through collaboration with the Idaho Immunization Program, support the purchase and distribution of vaccines for insured children through the Vaccine Assessment Fund.

Through collaboration with the Idaho Immunization Program, provide health care provider education about addressing vaccine hesitancy and improving clinic-level immunization rates.

Through collaboration with the Idaho Immunization Program, provide public education about the importance of vaccinations.

Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	28	28.1	28.2	28.2	28.3	28.3

Data Source: National Survey of Children's Health (NSCH) - CHILD

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	34.5 %	2.9 %	50,660	146,760
2007	31.8 %	2.6 %	41,610	130,906
2003	28.1 %	2.1 %	33,634	119,733

Legends:

-  Indicator has an unweighted denominator <30 and is not reportable
-  Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 8.1 - For clinics participating in the shared medical home coordinator model, support quality improvement activities to address overweight and obesity among pediatric patients.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	90.0	95.0	95.0	100.0	100.0

Child Health - Plan for the Application Year

Plan for Application Year

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.

The state selected “NPM 8: Child Physical Activity” to continue focus on reducing childhood overweight and obesity, and developed the objective of funding and participating in existing programs and initiatives to expand education and activities focused on physical activity and nutrition for children by July 2020. Measurement of the objective will be based on fiscal support from the Title V MCH Block Grant and an inventory of activities in which the MCH program is involved. Strategies to address this objective and NPM are discussed below.

Idaho's Physical Activity and Nutrition (IPAN) program is the leader in the public health arena for supporting communities with achieving and maintaining healthy weight and participating in regular physical activity. IPAN will continue to partner with the State Department of Education to provide statewide technical assistance to middle, junior, and high schools on Comprehensive School Physical Activity Program (CSPAP), healthy nutrition best practices, and Smart Snacks. IPAN is also planning, in collaboration with the State Department of Education, to deliver a presentation on CSPAP at the annual Idaho Association of Health, Physical Education, Recreation, and Dance Conference for school health professionals. In addition, IPAN will further the work with the school wellness councils to work on their action plans to improve wellness policy implementation within their school buildings and will work with student groups on Photovoice projects to document what wellness looks like to them in their schools, and present that information to adult stakeholder groups such as school boards, school administration, parent teacher associations and others. The Photovoice project allows children to learn from their peers and creates a positive learning atmosphere.

IPAN also focuses on healthy eating and physical activity during early childhood and provides training to 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 years of age attend child care while their parents work or attend school, 60% of which are enrolled full-time (NACCRRA, 2010). According to Let's Move, approximately 60% of children under 5 are in some form of child care and spend an average of 29 hours/week in that care. 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. Over the past six months, the MCH team has met with IPAN staff to discuss opportunities to collaborate on childhood obesity interventions. The discussion has been robust and many options are on the table. MCH will continue discussions with IPAN to determine an effective strategy and how to implement it in the child care setting.

According to 2011/2012 National Survey of Children's Health data, Idaho children fare better than children nationally for maintaining a healthy weight. About 28% of Idaho children were considered overweight or obese (based on BMI) compared with 31% of children nationally. For FY 2017, the MCH program intends to address overweight and obesity among children via the medical home demonstration for CYSHCN. A medical home coordinator (MHC) works out of the health district to partner with up to three pediatric or primary care 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, quality improvement, health education, and preventive health. 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. One of the medical clinics participating in the demonstration has elected to address obesity among all of their pediatric patients. The shared medical home coordinator will assist the clinic with quality improvement activities to address obesity and help ensure that families receive educational tools and counseling. The MCH team will monitor the success of this strategy using the ESM of the percentage of pediatric patients identified as being overweight or obese who received educational counseling on healthy eating and physical

activity. Through a learning collaborative that was held in the state in 2014/2015 by the Children's Healthcare Improvement Collaborative (CHIC) Project (now the Idaho Health and Wellness Collaborative for Children (IHAWCC)), there is evidence that suggests this is an effective strategy for assessing, treating, educating, and linking patients to resources. According to IHAWCC, a learning collaborative is "an opportunity for healthcare providers and practices to participate in a structured quality improvement process to raise the quality of care they deliver. Every learning collaborative includes a kick-off learning session to hear evidence behind best practices, coaching on how to implement process improvement in your practice, ongoing technical assistance, topic related conference calls from experts in the field, site visits from quality improvement coaches, a wrap-up session to review progress, and suggestions to create and implement a plan for sustainability." IHAWCC is part of the National Improvement Partnership Network (NIPN) and is focused on collaborating with private and public partners to use quality improvement practices to improve pediatric care in the state. Over the next five years, the MCH Program intends to partner with IHAWCC to host learning collaboratives focused on quality improvement of pediatric care in the state, including oral health care and developmental screening.

The MCH program will fund the Oral Health program to conduct the "Smile Survey" during the 2016/2017 school year, which is an oral health assessment conducted by registered dental hygienists (RDH) on a random sample of third grade students across the state every four years. Data collected includes demographic information, the number of decayed, missing and filled teeth, dental sealants, fluorosis, and treatment needs. A unique addition to this year's survey is the collection of height and weight to determine each child's BMI. This data will shed light on the current status of overweight and obesity among third-graders and help inform future strategies with IPAN.

To address the priority need for improving childhood immunization rates, the MCH program developed a SPM related to Idaho's unique needs related to immunizations (please see "Section E. Linkage of State Selected Priorities with State Performance and Outcome Measure" for further explanation). To support this SPM, the MCH team developed the objective of collaborating with the Idaho Immunization Program (IIP) to increase vaccination education and vaccine uptake among MCH populations. Measurement of the objective will be based on an inventory of programmatic activities related to immunizations and IIP data. Strategies to address this objective and SPM are discussed below.

One mechanism to help increase vaccine coverage in Idaho is the Vaccine Assessment Fund. The required state match for Idaho's Title V MCH Block Grant is achieved through this dedicated fund for state-supplied vaccines for privately insured children. Private insurance companies make a yearly payment into the Idaho Vaccine Assessment fund based on the number of insured children they cover and the vaccine assessment rate. This allows the IIP to purchase vaccines at the discounted federal rate. Idaho is a universal supply state, which means all children under 19 years of age are eligible for state-supplied vaccines regardless of insurance status. Medical providers place orders for vaccine through the IIP and are able to maintain a single stock of vaccines for their pediatric patients. The universal supply is supported by the Idaho Vaccine Assessment Fund, the Vaccines for Children (VFC) Program (covers children with Medicaid or who are uninsured, underinsured, American Indian and Alaska Natives), and the Separate Children's Health Insurance Program. Ultimately, insurance companies realize cost-savings through the assessment fund. The MCH program will continue to support the work of the IIP 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.

The IIP will continue to receive funding from the Centers for Disease Control and Prevention and from the State of Idaho to operate the state immunization program. Improving childhood immunization rates is a primary focus for the IIP. Immunization promotion activities will continue similar to previous years, including promotional billboards, provider education, and Assessment, Feedback, Incentive, and eXchange (AFIX) provider visits. After July 1, 2017, providers who are enrolled with the program will be able to generate immunization rates at any time through Idaho's

IRIS. In addition, the IIP plans to send immunization rates to all enrolled providers on a regular basis. The number of providers who receive an AFIX visit focused on improving immunization rates will be an area of focus for the IIP, also. IIP plans to continue to hold educational webinars for schools on how to improve school immunization rates in SFY 2017. Furthermore, IIP will record additional immunization registry tutorials to assist school staff with utilizing the immunization registry.

Child Health - Annual Report

Annual Report

The Idaho Physical Activity and Nutrition (IPAN) program has partnered with the Idaho State Department of Education to provide statewide technical assistance to middle, junior high, and high schools on Comprehensive School Physical Activity Programs (CSPAP), healthy nutrition best practices, and the Smart Snacks regulations. IPAN also worked with 7 pilot school district wellness councils throughout Idaho, representing several different demographics. In working with these wellness councils, IPAN has provided in-person training on physical activity and nutrition and supported them in assessing the implementation of their wellness policies within the school buildings. After the implementation assessments were completed, action plans for improvements were developed with a focus on increasing the wellness policy goals of the schools.

The Idaho WIC program participated in 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 and participated in the Creating Healthy Communities Summit, which has a purpose of developing and maintaining an active engaged network of partners working together, investing resources and expertise to create and support an active living, healthy eating population in Idaho with a focus of reducing and preventing childhood obesity. Additional WIC activities during the year included a wide range of nutrition education offerings for participants and promotion of food packages aligned with the Dietary Guidelines for Americans. Food package options were expanded to include 100% whole grain pasta and low-fat/nonfat yogurt. WIC will continue to participate in the coalitions and councils stated above.

In SFY 2015, the Idaho Immunization program (IIP) conducted live webinars for school staff on the Idaho school immunization requirements and the School Immunization Report. The webinars included information on immunization requirements for school entry, accessing and filling out the School Immunization Report, and how to use the Idaho Immunization Registry (IRIS). In addition, IIP recorded immunization registry tutorials to help school staff utilize functions of the immunization registry to keep track of student immunization records. IIP staff was able to secure 100% School Immunization Report completion by Idaho schools for the 2015 report. Three schools did not report in 2014. IIP staff also focused assistance on school staff that had difficulty completing the report in 2015. The IIP also released a new superhero themed immunization education campaign in 2015, encouraging parents to vaccinate their children. The campaign included educational brochures about the vaccines recommended for children and adolescents, statewide billboard advertisements, and signage at the Western Idaho Fair, at the Boise Towne Square Mall, and on Treasure Valley bus panels. These marketing efforts may have prompted parents to vaccinate their children or served as a reminder for parents to take their children in for recommended immunizations. Data from 2014 indicates 68.5% of Idaho children had their full series of vaccines at age-appropriate times.

Adolescent Health

State Action Plan Table

State Action Plan Table - Adolescent Health - Entry 1

Priority Need

Improve maternal and child health population access to medical homes

NPM

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

Objectives

By July 2020, increase the number of adolescents who receive information about the importance of regular well-visits.

Strategies

Through collaboration with the Adolescent Pregnancy Prevention Program (APP), implement strategies to increase awareness of the importance of adolescent well visits among teens and families.

Through collaboration with the Adolescent Pregnancy Prevention Program (APP), assess awareness of and the reasons why adolescents don't seek well-visit care.

ESMs

ESM 10.1 - Through collaboration with the Adolescent Pregnancy Prevention Program (APP), assess awareness of and the reasons why adolescents do not seek well-visit preventive care.

NOMs

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

Measures

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	2021
Annual Objective	66.2	66.3	66.4	66.5	66.6	66.6

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	65.7 %	3.1 %	87,555	133,352
2007	71.3 %	2.2 %	97,888	137,285
2003	55.5 %	2.2 %	69,226	124,647

Legends:

- 🚫 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 10.1 - Through collaboration with the Adolescent Pregnancy Prevention Program (APP), assess awareness of and the reasons why adolescents do not seek well-visit preventive care.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	No	No	No	No

Adolescent Health - Plan for the Application Year

Plan for Application Year

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. To assess progress of the proposed strategies, the MCH program developed the objective of increasing the number of adolescents who receive information about the importance of regular well-visits by July 2020. Measurement of the objective will be based on programmatic and evaluation data. Strategies to address this objective and NPM are discussed below.

According to 2011/2012 National Survey of Children’s Health data, Idaho children are lagging behind children nationally for receiving a preventive well-visit in the past year—only 73% of Idaho children had received a well-visit compared with 84% of children nationally. For FY 2017, the MCH program intends to use a two-pronged approach to increase education about and utilization of adolescent well-visits. To understand the barriers to seeking or receiving care among adolescents, the MCH program has collaborated with the state’s Title V Adolescent Health Coordinator and the Adolescent Pregnancy Prevention (APP) program to assess awareness of and the reasons why adolescents do or do not seek routine preventive care. 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. As part of the Reducing the Risk class, a participant entry and exit survey is administered at the beginning and end of the course. The MCH program will develop and add questions to the survey to assess awareness and barriers. The team will measure this strategy (ESM) by determining whether or not the assessment was conducted (yes/no measure). Based on the results of the survey, the MCH program will develop evidence-based strategies to address identified barriers and raise awareness for adolescent well-visits. According to the Centers for Medicare and Medicaid Services (2014), offering resources, training, and incentives to adolescents and families to encourage preventive care is a proven strategy for promoting adolescent well-visits. The MCH program will likely explore developing education, tool kits, or social media campaigns to raise awareness about the need for adolescent well visits.

Further, the APP will pilot the implementation of Draw the Line/Respect the Line during the 2016-2017 school year. Draw the Line/Respect the Line is a 3-year, evidence-based curriculum that promotes abstinence by providing students in grades 6, 7, and 8 with the knowledge and skills to prevent HIV, other STDs, and pregnancy. Using an interactive approach, the program shows students how to set personal limits and meet challenges to those limits. Lessons also include the importance of respecting others’ personal limits. During 2016-2017, the APP program will continue to research parent interventions that are focused on adolescent pregnancy prevention and sexual health.

In FY 2018/FY 2019, to address barriers from the provider’s perspective, the MCH program intends to partner with

IHAWCC to host a learning collaborative for pediatric and family practice providers focused on quality improvement related to adolescent well-visits. According to Elster & Levenberg (1997), there are 10 steps to successful integration of preventive care services in a clinical setting. The learning collaborative will use this as a framework for working with clinics.

Adolescent Health - Annual Report

Annual Report

The Idaho Adolescent Pregnancy Prevention (APP) program coordinates with local public health districts, educational organizations, and other partners across the state to provide adolescents with evidence-based curricula and resources to empower their reproductive health choices. The program currently supports three curricula in school and community settings: ¡Cuídate!, Reducing the Risk (RTR), and Wise Guys. ¡Cuídate!, which means, take care of yourself, is a cultural and theory-based pregnancy prevention and HIV sexual risk-reduction program designed specifically for Latino youth ages 13-18.

¡Cuídate! helps Latino youth develop the knowledge, attitudes, and skills to prevent unplanned pregnancy and reduce their risk for HIV. The program emphasizes risk reduction such as sexual abstinence and condom use through a variety of activities. ¡Cuídate! is unique because it addresses cultural beliefs related to sexual risk behaviors that are common among many Latino subgroups. Aspects of Latino culture, such as familialism and gender-role expectations, including machismo, are built into the program. ¡Cuídate! includes cultural beliefs related to abstinence and condom use in program activities, and shows these attitudes and beliefs in a positive way.

The RTR: Building Skills to Prevent Pregnancy, HIV, and STD is an evidence-based curriculum for students ages 12-18. RTR includes 16 lessons that emphasize refusal skills to increase students' ability to choose abstinence or to encourage protection from pregnancy and sexually transmitted infections. Activities include skill-building lessons in refusal skills, negotiation, and active communication. The goal of RTR is to prepare youth for their sexual future while reducing the incidence of unprotected sex.

Wise Guys: Male Responsibility Curriculum©, is an evidence-informed curriculum designed to engage males in the prevention of adolescent pregnancies. The 10-lesson curriculum was created by the Family Life Council of Greater Greensboro and was developed as a male involvement tool to engage young males, ages 10–24, in pregnancy prevention efforts. Additionally, the Wise Guys curriculum has been adapted to include the topic of statutory rape and include elements of Positive Youth Development (PYD). Contractors implement the curriculum as an after-school program, as part of a community-based program, in juvenile detention centers, vocational job trainings, and therapeutic programs for youth in crisis. Additionally, contractors implementing the Wise Guys curriculum conduct presentations to state and local law enforcement officials, individuals in the educational system, and relevant counseling services to provide education and training on statutory rape and sexual offenses against minors in Idaho.

Draw the Line/Respect the Line is a 3-year, evidence-based curriculum that promotes abstinence by providing students in grades 6, 7, and 8 with the knowledge and skills to prevent HIV, other STDs, and pregnancy. Using an interactive approach, the program shows students how to set personal limits and meet challenges to those limits. Lessons also include the importance of respecting others' personal limits.

Bridging the Gap community dinners provide an opportunity for parents and caregivers of middle-school aged children to visit with other adults during a catered dinner who are facing the challenges of raising children today. It is developed, promoted, and taught by high school-aged teens in their community. It provides them with an overview of adolescent pregnancy in Idaho, tips on how to discuss adolescent sexuality, and emphasizes how to keep the lines of

communication open with their children. Parents are a critical part of teen pregnancy prevention efforts. Teens consistently report that their parents are most influential when it comes to their decisions about sex, and often state that they wish they could talk more to their parents, particularly about topics such as relationships. Research suggests that parent-child communication is a protective factor that reduces engagement in risky sexual behavior. In particular, parent-child communication about sex can delay sexual initiation. As a result, many programs seek to engage parents in teen pregnancy prevention efforts and in recent years programs developed specifically for parents have been proven to change teens' behavior related to their risk of pregnancy.

Youth-Adult Partnership (YAP) groups are a Positive Youth Development (PYD) strategy focused on promoting the healthy development of all youth by creating learning experiences and providing access to adult mentors that enable youth to feel connected to others. It builds their capacity to meet personal and social needs, and enables youth to be engaged in meaningful activities. In YAP groups, youth and adults work together to accomplish common goals, with shared responsibilities, decision-making, and commitment. An essential principle of youth development/sexual health programming is that young people gain more from an experience when they are actively involved. Research also suggests that programs for youth which are developed through a partnership of youth and adults may be highly effective in building young people's skills and reducing their sexual risk-taking behaviors. Such programs benefit the youth who help to develop them and also have a greater impact on the young people served. The Idaho public health districts implement YAP groups as a youth development strategy to complement RTR implementation. YAP groups plan and implement activities that promote adolescent sexual health and healthy choices in their schools and communities.

The APP program runs public service announcements (PSAs) on teen pregnancy prevention and positive parent-child communication to increase participation in Bridging the Gap Community Dinners and ¡Cuidate! programming. These PSAs typically run statewide on English and Spanish-language radio stations, and occasionally on television (cable and local networks). Additionally, the APP program supports the Idaho Immunization program's efforts to increase awareness of HPV vaccination by contributing time and funds towards promotion of a statewide HPV vaccination day, as well as a radio campaign in English and Spanish. The APP program designs and purchases incentives, which are used by contractors to recruit and retain adolescents in pregnancy prevention programming, by YAP groups to promote APP messaging in their schools and communities, and at Bridging the Gap community dinners to direct parents to APP resources. The incentives change from year to year, but popular items include water bottles, pens, flash drives, and sunglasses. The incentives have the APP program's logo and website. The website has information on birth control methods, abstinence, and healthy relationships, and serves as a resource for adolescents and parents.

Children with Special Health Care Needs

State Action Plan Table

State Action Plan Table - Children with Special Health Care Needs - Entry 1

Priority Need

Improve access to medical specialists for children and youth with special health care needs

NPM

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

Objectives

By July 2020, fund and support services, programs, and activities focused on improving quality of care for CYSHCN.

Strategies

Develop and disseminate age-specific transition tool kits for youth with special health care needs to help empower teens and young adults to take a more active role in their health care.

Support the Idaho Children's Special Health Program to provide financial support to uninsured CYSHCN for payment of eligible medical claims.

Support shared medical home coordinator model at the local level to improve quality of care for CYSHCN in rural areas and supports clinic transition to the medical home model of care.

Partner with Idaho Parents Unlimited - IPUL (State's Family to Family Resource Center) to increase parent engagement and provide parent education about medical home.

ESMs

ESM 11.1 - Fund and support the shared medical home coordinator model at the local level to improve quality of care for CYSHCN in rural areas and support clinic transition to the medical home model of care.

NOMs

Percent of children with special health care needs (CSHCN) 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 completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

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

State Action Plan Table - Children with Special Health Care Needs - Entry 2

Priority Need

Improve access to medical specialists for children and youth with special health care needs

SPM

Medical Specialist Access: Percent of children with special health care needs who needed or received specialist care in the past 12 months, and experienced some problem accessing care.

Objectives

By July 2020, fund and support services, programs, and activities focused on screening, referral, and access to medical specialists.

Strategies

Fund pediatric specialty clinics across the state.

For clinics participating in the shared medical home coordinator model, support quality improvement activities to improve depression screening among adolescents and make appropriate referrals to mental health care providers.

Host a statewide learning collaborative for pediatric and family practice clinics focused on practice improvement and care delivery related to developmental screening and referral to appropriate specialists.

Support the Idaho Newborn Screening Program to detect certain genetic, endocrine, and metabolic disorders that can affect a child's long-term health and survival, and link children to appropriate specialist care.

Partner with hospitals and local public health districts to identify specialist needs and recruit medical specialists.

Measures

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	59.8	59.9	60	60.1	60.2	60.2

Data Source: National Survey of Children's Health (NSCH) - CSHCN

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	43.3 %	4.1 %	31,484	72,649
2007	44.1 %	3.7 %	27,687	62,750

Legends:

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH) - NONCSHCN

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	59.9 %	2.0 %	206,393	344,470
2007	58.4 %	1.7 %	190,568	326,138

Legends:

- 🚫 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 11.1 - Fund and support the shared medical home coordinator model at the local level to improve quality of care for CYSHCN in rural areas and support clinic transition to the medical home model of care.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	35.0	45.0	50.0	55.0	60.0

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

Plan for Application Year

For the CYSHCN health domain, “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. To monitor progress towards addressing this priority and NPM, Idaho developed the objective of funding and supporting services, programs, and activities focused on improving quality of care for CYSHCN by July 2020. Measurement of this objective will be based on fiscal support from the Title V MCH Block Grant and an inventory of activities in which the MCH program is involved. Strategies to address this objective and NPM are discussed below.

According to the 2009/2010 National Survey of Children with Special Health Care Needs, Idaho CYSHCN fared the same as their peers when it came to receiving care within a medical home (42.9% compared with 43.0%, respectively). To enhance quality of care for CYSHCN, the MCH program intends to leverage the success of the existing medical home demonstration for CYSHCN. The project was first launched in 2013 in partnership with the Idaho Medicaid’s Children’s Healthcare Improvement Collaborative (CHIC) Project, which was a Children’s Health Insurance Program Reauthorization Act (CHIPRA) quality demonstration grantee. In February 2016, the CHIPRA grant ended, but the demonstration has continued through coaching and training support through the local public health district. The model involves a shared medical home coordinator (MHC) approach. The MHC works out of the health district to partner with up to three pediatric or primary care clinics in the area to support transformation to a patient-centered medical home. The MHC helps with educating practices on quality improvement strategies, identifying patient populations, health education, community resources, and preventive health. 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, creating care plans, and conducting care conferences to help

manage each child's condition in a patient-centered way. The demonstration is underway in one health district in eastern Idaho. The MHC is working with two clinics—one with a large suburban pediatric population, and another with a small rural population. The clinics identify their CYSHCN patients using patient registries and implement quality improvement approaches with the help of the MHC to enhance their care quality. To measure the success of this strategy, the MCH program will be using the ESM of a count of the number of children on the clinic's registries identified as having special needs. According to the CHIPRA Quality Demonstration Grant Program - Evaluation Highlights (2014), utilizing a care coordinator resulted in increased patient-centered care, improved patient population management, and increased providers and family satisfaction. It's important to note that Idaho's medical home demonstration for CYSHCN was part of the CHIPRA evaluation and is reference in the Evaluation Highlights publication.

To further support high quality care for CYSHCN, the MCH program will continue to fund and operate the Children's Special Health program (CSHP), which 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 2015, there were a total of 107 unique pediatric patients enrolled in the CSHP across eight diagnostic areas. Additionally, CSHP pays for medical travel for enrolled children to access medical specialists not offered in the state.

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.

The MCH program intends to partner with Idaho Parents Unlimited (IPUL), the state's Family-to-Family Resource Center, to provide education about medical home and offer resources for navigating the health and education system to parents of CYSHCN. The MCH program will look to IPUL to assist with increasing family engagement in MCH programming. One possibility is hosting quarterly or bi-annual meetings with parents of CYSHCN to assess strengths, needs, and barriers to care in the state.

While the MCH program acknowledges that linkage to a medical home is critical for receipt of high quality care for CYSHCN, the state continues to struggle with lack of access to specialty and sub-specialty care providers, which

impacts the quality care for CYSHCN. To illuminate this unique need, the state developed a SPM focused on increasing access to medical specialists (please see “Section E. Linkage of State Selected Priorities with State Performance and Outcome Measure” for further explanation). To support this state priority and SPM, the MCH team developed the objective of funding and supporting services, programs, and activities focused on screening, referral, and access to medical specialists. Measurement of this objective will be based on fiscal support from the Title V MCH Block Grant and an inventory of activities in which the MCH program is involved. Strategies to address this objective and SPM are discussed below.

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 pacer clinics, and at least four cranial facial clinics through a contract with Eastern Idaho Public Health District. In 2015, the MCH program expanded funding to support two endocrinology clinics in eastern Idaho. 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. The MCH program will continue to fund these clinics and work with the local public health districts and hospitals to identify specialist needs.

The MCH program houses the state’s Newborn (Bloodspot) Screening (NBS) program and provides funding to staff and administer the program. The NBS program contracts with the Oregon State Public Health Laboratory to conduct the processing of the state’s bloodspots which allows the state to screen for 47 different conditions. Over the past year, the program has been working to bolster operations and improve processes to ensure that the state’s youngest and most vulnerable citizens are screened and receive medical treatment as soon as possible. The NBS program is afforded the opportunity to link newborns who receive a positive screen with medical specialists and subsequent follow-up care. The NBS program has contracted with local and out-of-state medical specialists to offer diagnosis and treatment when a positive screen occurs, and ensures that every positive case receives appropriate follow-up care.

Over the next five years, the MCH program intends to partner with IHAWCC to host a learning collaborative focused on practice improvement and care delivery related to developmental screening. Practices would be encouraged to follow Bright Futures/AAP recommendations, use a validated evidence-based screening tool during appointments with families, increase documentation in the electronic medical record (EMR) system, and make referrals and follow-up appointments when appropriate. In addition to quality improvement coaching and care coordination at no cost, one of the benefits to clinics participating in the medical home demonstration for CYSHCN is the ability to identify their unique special needs populations at the clinic level. This allows for tailored quality improvement activities and guidance from the medical home coordinator. For FY2016/2017, the MCH program identified depression among adolescents (aged 12-17) as a common diagnosis across the clinics. This was an effort to collect consistent data from the clinics and to identify any differences or challenges in screening and community connections for adolescent depression in the suburban versus rural clinic. Additionally, adolescent depression was the focus of a CHIC Project learning collaborative in 2013, which resulted in increased adolescent depression and substance use screening, increased documentation and creation of follow-up plans, and increased knowledge of community resources among 60 different providers. For the current demonstration, each clinic was able to identify two additional diagnoses among their pediatric populations. The suburban clinic identified autism and developmental delays and the rural clinic identified obesity and immunizations (children under 2 years of age) as conditions for inclusion in their population management activities. The MCH program will report the results of the demonstration in next year’s annual report.

Children with Special Health Care Needs - Annual Report

Annual Report

The MCH program continued to fund and operate the Children's Special Health program (CSHP), which 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 2015, there were a total of 107 unique pediatric patients enrolled in the CSHP across eight diagnostic areas. The estimated number of claims processed by the CSHP for 2015/2016 is 1,214 totaling an estimated \$172,500. Additionally, CSHP pays for medical travel for enrolled children to access medical specialists not offered in the state.

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 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 pacer clinics, and at least four cranial facial clinics through a contract with Eastern Idaho Public Health District. In 2015, the MCH program expanded funding to support two endocrinology clinics in eastern Idaho. 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 2015, there were a total of 1,554 patients seen, which includes patient encounters, not just unique patients. CYSHCN patients can attend these clinics and be seen at no charge to the patient, ensuring that anyone that needs care can access it for free.

The MCH program houses the state's Newborn (Bloodspot) Screening (NBS) program and provides funding to staff and administer the program. The NBS program contracts with the Oregon State Public Health Laboratory to conduct the processing of the state's bloodspots which allows the state to screen for 47 different conditions. The NBS program is afforded the opportunity to link newborns who receive a positive screen with medical specialists and subsequent follow-up care. The NBS program has contracted with local and out-of-state medical specialists to offer

diagnosis and treatment when a positive screen occurs, and ensures that every positive case receives appropriate follow-up care. Over the past year, the program has been working to bolster operations and improve processes to ensure that the state's youngest and most vulnerable citizens are screened and receive medical treatment as soon as possible. During 2015, the NBS program set the foundation for the addition of a new condition to the Idaho screening panel—Severe Combined Immunodeficiency (SCID), which became effective in Idaho in January 2016. The program partnered with two pediatric infectious disease physicians to provide technical assistance and follow-up when a positive SCID case is identified. Further, the NBS program continued to support next business day courier service for all first specimen providers at no cost. The courier service has drastically reduced transit time from an average of five business days to one, resulting in faster screening results and reduced delays in diagnosis and early treatment. In 2015, 22,301 babies received the first screen (97% of births) and, there were 28 confirmed cases that received follow-up and treatment.

The MCH program's original medical home demonstration for CYSHCN ended in December in 2015. The project was first launched in 2013 in partnership with the Idaho Medicaid's Children's Healthcare Improvement Collaborative (CHIC) Project, which was a Children's Health Insurance Program Reauthorization Act (CHIPRA) quality demonstration grantee. The demonstration used an innovative shared medical home coordinator (MHC) approach in two local public health districts. The MHC 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 and implement quality improvement activities to improve care for their identified CYSHCN population. Across the clinics that continued with the demonstration, the identified diagnoses were asthma, Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), and depression. The CHIC Project provided quality improvement training and coaching to the MHC and the local clinics. Anticipating the end of the CHIPRA funding for the CHIC Project in February 2016, the MCH program gave the two local public health districts the option to continue the project if they could sustain the coaching and training piece. In 2015, Southeastern Idaho Public Health district experienced staffing challenges and turnover in the MHC position and elected to end the project. Eastern Idaho Public Health district realized incredible success with their MHC and desired to continue the project. The district proposed promoting the existing MHC to support the regional SHIP work and the position would then provide training and oversight to the new MHC. Further, the district proposed the CYSHCN medical home demonstration would be used as a launching pad for clinics into the next cohort of clinics for SHIP medical home transformation efforts. The MCH program executed a new contract in January 2016 with Eastern Idaho Public Health district to support the renewed medical home demonstration. The district has hired a new MHC and is currently working with two clinics.

At the end of 2015, the MCH program and CHIC Project noted the following accomplishments of the medical home demonstration:

- Improved care coordination activities (care planning, pre visit contact, screenings), patient registries, population management, proactive healthcare
- Implementation of the Reach out and Read Program
- Southeastern Idaho Public Health district's MHC became a NCQA Certified Content Expert
- Eastern Idaho Public Health district's MHC became a Sources of Strength T4T Trainer
- Successful PHQ-9 implementation for adolescent depression screening, sustainability, connection to mental health resources
- Patient Portal implementation
- Both participating clinics completed a SHIP Application of Interest
- Implementation of patient satisfaction surveys
- Provision of public health materials and community resources in the clinics
- School district collaboration
- Collaboration with Idaho Parents Unlimited
- Community coalition involvement by the clinics, including mental health, youth development, bridging gaps in

community services, and quality improvement

In 2014/2015, the MCH program contact with the University of Utah to conduct an independent evaluation of the medical home demonstration to document successes, challenges, and lessons learned. Evaluators conducted a series of site visits to the local public health districts and clinics, conducted interviews with MHCs, providers, clinical staff, CHIC staff, and MCH program staff. Below are some highlights from the evaluation:

- MHCs must spend considerable time at a clinic to be integrated into a staffing role which may impact the number of clinics they can support
- Having the MHC dually assigned to the local health district and the clinic was positive because it brought outside resources to the clinic, patients, and families
- Rural environments rely on practitioners to fill multiple roles thus challenging them in their abilities to become patient-centered versus reactionary and traditional
- The project provided access to resources not usually identified by traditional clinic personnel
- Recommendation to train providers on the use of medical coding for care coordination activities, and advocate with local insurances and Medicaid to adopt care coordination billing codes
- A MHC who is a good fit with the clinic's model and is a self-starter can reduce physician workload, improve patient care, increase the patient's access to services, engage the practice in quality improvement, improve data management and EHR/HIT Meaningful Use, and increase overall practice efficiencies

Cross-Cutting/Life Course

State Action Plan Table

State Action Plan Table - Cross-Cutting/Life Course - Entry 1

Priority Need

Decrease substance abuse among maternal and child health populations

NPM

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

Objectives

By July 2020, increase the percentage of pregnant women and women of reproductive age that have attempted to quit smoking in the past 12 months.

Strategies

Through CoIIN Infant Mortality efforts, increase referrals to smoking cessation services for pregnant women and women of reproductive age.

Through CoIIN Infant Mortality efforts, promote the use of Nicotine-Replacement Therapy (NRT) for pregnant women and women of reproductive age enrolled in cessation services.

ESMs

ESM 14.1 - Through CoIIN Infant Mortality efforts, increase referrals to smoking cessation services for pregnant women.

ESM 14.2 - Through CoIIN Infant Mortality efforts, increase referrals to smoking cessation services for women of reproductive age.

NOMs

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

State Action Plan Table - Cross-Cutting/Life Course - Entry 2

Priority Need

Improve maternal and child health population access to medical homes

NPM

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

Objectives

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.

Strategies

Partner with primary care to develop education messages for women and children about oral health care.

Conduct the Smile Survey of all third grade students in the state of Idaho to assess the oral health status of children.

Fund the Oral Health Program to provide dental sealants, apply fluoride varnish, offer oral health education, and refer elementary school students to an dental homes.

Fund the Oral Health Program to provide oral health education to pregnant women.

Host a statewide learning collaborative for pediatric and family practice clinics focused on practice improvement and care delivery related to pediatric oral health.

Support the MIECHV program's tracking of dental homes for children and pregnant women.

ESMs

ESM 13.1 - Host a statewide learning collaborative for pediatric and family practice clinics focused on practice improvement and care delivery related to pediatric oral health.

ESM 13.2 - Fund the Idaho Oral Health Program to provide dental sealants, apply fluoride varnish, offer oral health education, and refer elementary school students to dental homes.

NOMs

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

Measures

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	57.2	57.4	57.6	57.7	57.8	57.8

FAD not available for this measure.

NPM-13 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	2021
Annual Objective	79.3	79.4	79.5	79.5	79.6	79.6

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	79.2 %	1.5 %	315,956	398,839
2007	76.6 %	1.4 %	296,409	387,165

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 13.1 - Host a statewide learning collaborative for pediatric and family practice clinics focused on practice improvement and care delivery related to pediatric oral health.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	30.0	0.0	0.0	0.0	0.0

ESM 13.2 - Fund the Idaho Oral Health Program to provide dental sealants, apply fluoride varnish, offer oral health education, and refer elementary school students to dental homes.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	3,500.0	3,525.0	3,550.0	3,575.0	3,600.0

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	10.3	10.3	10.2	10.2	10.1	10.1

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend					
Year	Annual Indicator	Standard Error	Numerator	Denominator	
2014	10.7 %	0.2 %	2,435	22,832	
2013	10.4 %	0.2 %	2,327	22,350	
2012	10.5 %	0.2 %	2,403	22,934	
2011	10.6 %	0.2 %	2,352	22,269	
2010	11.6 %	0.2 %	2,684	23,164	
2009	12.0 %	0.2 %	2,849	23,705	

Legends:
 Indicator has a numerator <10 and is not reportable
 Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	20.2	20.1	20.0	20.0	19.9	19.9

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	20.5 %	1.5 %	86,922	424,373
2007	21.5 %	1.3 %	88,003	409,285
2003	23.7 %	1.2 %	74,929	315,647

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 14.1 - Through ColIN Infant Mortality efforts, increase referrals to smoking cessation services for pregnant women.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	25.0	30.0	35.0	40.0	45.0

ESM 14.2 - Through ColIN Infant Mortality efforts, increase referrals to smoking cessation services for women of reproductive age.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	500.0	525.0	550.0	575.0	580.0

Cross-Cutting/Life Course - Plan for the Application Year

Plan for Application Year

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 and “NPM 13: Oral Health” aligns with the priority need to improve access to medical homes among MCH populations (including dental homes). To monitor progress towards addressing these priorities and NPMs, Idaho developed two objectives: 1) increasing the percentage of pregnant women and women of reproductive age that have attempted to quit smoking in the past 12 months, and 2) increase the number of women, children, and families who receive information about the importance of regular dental visits and oral health care by July 2020. Measurement of objective 1 will be based on data from the Idaho Quitline, the Behavioral Risk Factor Surveillance System (BRFSS), and PRATS. Measurement of objective 2 will be based on BRFSS data and programmatic data.

Strategies to address these objectives and NPMs are discussed below.

According to the Idaho PRATS, 5.5% of mothers who gave birth in 2014 smoked cigarettes during their last trimester of pregnancy. According to the Idaho BRFSS, 15% of Idaho women were smokers in 2013. To address the priority need of decreasing substance abuse, specifically tobacco use 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. Further, the Idaho Quitline is tracking calls for tobacco cessation counseling and referral for pregnant women and women aged 18 to 44. The Quitline promotes the use of nicotine replacement therapy (NRT) for these women, with a prescription from a doctor. Research (Dolan-Mullen, 1999; Crawford et al., 2008) showed that NRT was a promising smoking cessation strategy for pregnant women. Further, according to the Association of State and Territorial Health Officials (2013), offering pregnancy specific and postpartum Quitline services to women is a recommended strategy to improve smoking cessation. The Idaho Quitline has a 10-call program for pregnant women, which offers 10 intervention calls during the two-week period following a quit attempt, just before the due date, and within two months postpartum. To measure the success of this strategy, the MCH program will be using the ESM of the number of pregnant women and the number of women aged 18 to 44 who called the Idaho Quitline for cessation services. By FY 2017, 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 continue to fund the Idaho Oral Health program's contracts with the local public health districts for dental care among school-age children. In 2014, 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. According to the Centers for Disease Control and Prevention (2015), dental sealants are a critical preventive dental service and can reduce decay by 60 to 80 percent in two years after application. Further, school-based dental sealant programs are a great way to reach children and result in cost-savings for families. The reason Idaho is top in the nation for protective sealants is due to many collaborative networks involving private and public entities. Through the Oral Health program, all seven public health districts 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 public health districts also provided oral health screenings or assessments, fluoride varnish applications, oral health education, and facilitated dental home referrals as needed. To measure the success of this strategy, the MCH program will be using the ESM of a count of dental sealants provided to children.

The Idaho Oral Health program will continue to work with the Idaho Oral Health Alliance, Idaho Oral Health Network, and other community partners to identify opportunities for new oral health programs and policies focused on improving the oral health of children. 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. The Idaho Oral Health program released their 2015-2020 Idaho Oral Health Action Plan last 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 Idaho Oral Health program also began developing a statewide oral health network, called the Idaho Oral Health Network, consisting of oral health champions from across the state. Several of the regional oral health networks within the statewide network have developed objectives for 2016 specific to pregnant women and educating them on the importance of good oral health and increasing access to oral healthcare and will develop action plans to help accomplish their objectives.

The MCH program will fund the Oral Health program to conduct the “Smile Survey” during the 2016/2017 school year, which is an oral health assessment conducted by registered dental hygienists (RDH) on a random sample of third grade students across the state every four years. The survey for each child is approximately two minutes using a fiberoptic light, a sterile disposable mirror, and latex-free gloves. No treatment is provided. Data collected includes demographic information, the number of decayed, missing and filled teeth, dental sealants, fluorosis, and treatment needs. A survey report is sent home with each child, and in cases where a child has an urgent dental need, the RDH will work with the school nurse to ensure that the child is able to seek immediate care. To prepare for the administration of the survey, an epidemiologist from the Association of State and Territorial Dental Directors, will be delivering training to the RDHs.

In FY 2016/2017, the MCH program will partner with IHAWCC to host a learning collaborative focused on practice improvement and care delivery related to pediatric oral health care. According to IHAWCC, a learning collaborative is “an opportunity for healthcare providers and practices to participate in a structured quality improvement process to raise the quality of care they deliver. Every learning collaborative includes a kick-off learning session to hear evidence behind best practices, coaching on how to implement process improvement in your practice, ongoing technical assistance, topic related conference calls from experts in the field, site visits from quality improvement coaches, a wrap-up session to review progress, and suggestions to create and implement a plan for sustainability.” Qualis Health (2012) indicated that medical providers must understand the impact of poor oral health on overall health status, and ideally, primary care medical providers need to be trained to conduct oral health screenings, provide education, and apply fluoride varnish during well-visits. Practices participating in the learning collaborative would be encouraged to either provide fluoride varnish at well-child visits or conduct a brief screening and make a referral to a dental provider, increase documentation in the electronic medical record (EMR) system, and make and follow-up appointments when appropriate. It is anticipated that the MCH program will have data to report by August 2017. The ESM for this strategy is a count of the clinics that participated in the pediatric oral health learning collaborative.

Cross-Cutting/Life Course - Annual Report

Annual Report

Through the Infant Mortality CoIN efforts, the MCH program supported Project Filter and the Idaho QuitLine, which is a free phone based cessation program that offers free counseling to smokers in Idaho ready to quit. In 2015, the Idaho QuitLine implemented the 10-call pregnancy program to the list of services provided. The pregnancy program offers up to 10 calls during pregnancy and postpartum for women who want to quit smoking. This enhanced program includes several intervention calls in the two-week period following a quit attempt, one just before the due date and two calls within two months after the baby’s delivery. These calls help the participant to develop skills to remain tobacco free and to reduce the health risks to the baby from exposure to secondhand smoke. Pregnant women may request nicotine replacement therapy (NRT), however they must obtain approval from their primary care provider. Up to 8 weeks of free NRT is offered through the Idaho QuitLine, if approved through their primary care provider. Any pregnant or new mother that expresses interest in quitting tobacco through the QuitLine is automatically referred to the new 10-call pregnancy program. During 2015, the total number of pregnant and breastfeeding moms that received phone counseling was 22 and 52 pregnant and breastfeeding moms completed the self-guided web

cessation program.

The Idaho Oral Health program continued to provide oral health education and dental sealants in 2015 through all seven public health districts in Idaho. These services were provided to elementary school children either through School-Based/Linked Dental Sealant Clinics or Give Kids a Smile Day in partnership with the Idaho State Dental Association. In 2015, a total of 3,505 dental sealants were provided and a total of 10,394 fluoride varnish applications were administered. A total of 193 third graders received sealants and 425 dental sealants were placed on permanent molar teeth. As per the 2013 Idaho Smile Survey Report, “More than half (58%) of third-grade students had dental sealants on all teeth recommended for sealants, similar to previous surveys. 63% had sealants on at least one tooth recommended for sealants, a statistically larger rate than in any of the previous surveys”. In addition to the School-Based/Linked Dental Sealant Clinics provided by the public health districts, Delta Dental of Idaho, and the Miles for Smiles Mobile Dental Van continued to provide dental sealant clinics as well. Along with providing dental sealants and fluoride varnish applications, the public health districts also provided oral health screenings or assessments, oral health education, and facilitated dental home referrals as needed. In 2015, a total of 725 children were referred to a dental home because they were in need of dental care.

All seven public health districts in Idaho continued to provide oral health education and facilitated dental home referrals to pregnant women through Women, Infants, and Children (WIC) clinics, or worked on increasing the oral health knowledge of healthcare providers on the effects of poor oral health on pregnancy outcomes. According to the 2013 Pregnancy Risk Assessment Tracking System Survey, 56% of pregnant women received dental care during pregnancy. Last year, the Idaho Oral Health program released the 2015-2020 Idaho Oral Health Action Plan, which includes specific goals and strategies focused on improving the oral health of pregnant women and helping them to establish good oral health behaviors with their newborns. The Oral Health Action Plan also contains goals and strategies on educating healthcare providers on the importance of good oral health during pregnancy and on the safety of providing dental treatment to pregnant women. This past year the Idaho Oral Health program also released its first ever published report on the burden of oral disease in Idaho, which included data from Idaho’s Pregnancy Risk Assessment Tracking System Survey.

The development of evidence-based/-informed strategies and measures was informed by findings in peer-reviewed journals, recommendations from national agencies, and results from current programs and initiatives. Below is a list of references cited in the State Action Plan narrative.

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Other Programmatic Activities

In 2015, the MCH Block Grant provided funding to support the Behavioral Risk Factor Surveillance System. A question module was added to assess tobacco use among women of reproductive age. The data were used by the Idaho's National Breast and Cervical Cancer Early Detection Program, called Women's Health Check (WHC). WHC was interested in examining the linkage between tobacco use and cervical cancer and to increase referrals to tobacco cessation services for women eligible for the WHC Program. Support for the BRFSS question module is related to the Women/Maternal Health domain.

The MCH Block Grant funded the data collection contract for the Pregnancy Risk Assessment Tracking System (PRATS). The PRATS, which is similar to PRAMS in other states, is an annual survey of new mothers in Idaho conducted by the state's Bureau of Vital Records and Health Statistics. The PRATS is funded by Idaho's SSDI grant

(which is unable to pay for contractors for data collection). The PRATS is a population-based tracking system that collects information from new mothers regarding their experiences and health behaviors surrounding pregnancy which may affect pregnancy outcomes and infant health. The survey provides information on a variety of perinatal health topics, including unintended pregnancy, prenatal care, substance use, breastfeeding patterns, postpartum depression, and immunizations. The data are supplemental to vital record data and serve as the state's only perinatal data system. The PRATS is one of the major sources of information used for the MCH Block Grant and impacts the Women/Maternal Health and Perinatal/Infant Health domains.

Activities related to the Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality were funded by the MCH Block Grant. 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 on reducing infant mortality were smoking cessation among pregnant women and promoting safe sleep practices for infants. The MCH program has used funds to bring stakeholders together around both topic areas. The teams participated in learning sessions hosted through the CoIIN and have provided staff to support pilot sites and data collections. This is planned as a continued activity into FY 2017.

Through supporting a full-time equivalent (FTE) position for a principal research analyst, MCH Block Grant funds help support staff capacity for research and data analysis. The MCH principal research analyst is housed in the state's Bureau of Vital Records and Health Statistics, but is fully dedicated to providing data support to all of the MCH programs. In addition to providing regular data analysis to programs, the MCH principal research analyst is a key contributor to the block grant application and provides technical assistance to staff as needed. The analyst support is related to the Cross-Cutting/Life Course domain.

The MCH Block Grant funds are used to support a contract with Boise State University's Center for Health Policy to conduct evaluation and needs assessment work for the MCH program. The contract was established in 2014 to help drive the five-year needs assessment process, which impacts the Cross-Cutting/Life Course domain. The Boise State team was integral in developing data collection tools, administering surveys and conducting interviews, analyzing data, and providing results and recommendations regarding priority needs to MCH leadership. Once the five-year needs assessment activities concluded in 2015, the Boise State team began on-going needs assessment activities, including researching evidence-based or –informed strategy measures (ESMs), examining Idaho's pediatric specialist provider shortage, and attending meetings to develop strategies to support the state action plan. It is anticipated that the MCH Program will continue to partner with the Boise State team into 2017 to support on-going needs assessment activities and data collection and reporting for identified ESMs.

To enhance continuous quality improvement (CQI) support for MCH programs, MCH Block Grant funds were used to pay for a business analyst who was focused on CQI activities. This funding helped support efforts in the Cross-Cutting/Life Course domain. The business analyst provided CQI support to the MCH, WIC, WHC, MIECHV Programs. Activities included providing training and technical assistance on CQI to staff, flowcharting program processes, creating gantt charts, and walking staff through root cause analysis. Further, the CQI business analyst was integral to providing training to all Division of Public Health staff on Public Health Accreditation Board (PHAB) efforts. Support for this position was transitioned to a new funding source in 2016.

The MCH Block Grant supports the Idaho Newborn Screening (NBS) program by funding personnel and administrative costs of the program. Otherwise, the NBS program is a "self-funded" program in which the funds collected by birth facilities and providers through the purchase of NBS filter paper test kits are used to pay the contract with the Oregon State Public Health Laboratory (OSPHL) for processing of the kits. Historically, there has been a surplus of funds at the end of the state fiscal year. This surplus occurs because birthing facilities tend to purchase more kits than what are processed in a given year due to inventory management and the utilization rate of

the second screen is slightly lower than the first screen. The OSPHL typically increased the processing rates for the kits each year. Because of the funds surplus, the NBS program did not pass the cost increase onto facilities and providers for approximately five years. However in FY 2015, processing rates increased slightly and the cost differential between the purchase price for kits and the processing rate for OSPHL resulted in a deficit of funds to pay the OSPHL contract. MCH Block Grant funds were used to fill this “gap”. In January 2016, the NBS program raised the kit purchase price for facilities and providers to align with the OSPHL’s processing rate and to cover costs for the addition of a new condition to the Idaho NBS panel—Severe Combined Immunodeficiency (SCID). This funding supported the Perinatal/Infant Health domain.

In FY 2015, block grant funds were used to support the Cancer Data Registry of Idaho (CDRI). The Division of Public Health maintains a contract with CDRI to assess cancer data and inform cancer prevention and treatment programming. The CDRI is a population-based cancer registry that collects incidence and survival data on all cancer patients who reside in the state or are diagnosed and/or treated in the state. The CDRI aims to:

- Determine the incidence of cancer in the state with respect to geographic, demographic, and social characteristics
- Monitor trends and patterns of cancer incidence
- Identify high-risk populations
- Serve as a resource in conducting epidemiologic studies
- Provide data to assist relevant stakeholders to effectively plan services, prioritize health resource allocations, and develop and measure prevention and intervention strategies

Because cancer impacts individuals across the lifespan, including children, some block grant funds were used for gap-filling when funds for the contract fell short. This was a one-time contribution to the CDRI.

To support MCH priorities, financial support for a Physician Consultant was funded for the MCH program. 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 funds 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 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.

Lastly, while not supported directly 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 as 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 (30) 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. The MCH Director provides 0.5 FTE support to the grant and the CYSHCN Director provides 0.75 FTE support. There is also 0.5 administrative staff support. This past year, BOCAPS restructured the

bureau to move the National Breast and Cervical Cancer Early Detection program to another bureau in the Division. This move allowed for the creation of a new cancer section that will focus on multiple cancer areas. The Adolescent Pregnancy Prevention program, under the administration by the State's Title V Adolescent Health Coordinator, moved into the Bureau of Clinical and Preventive Services, within the Maternal and Child Health program. The bureau also added one FTE to the WIC program beginning July, 2016. This new staff will focus on overseeing the coordination of the various partners and staff needed to move the Idaho WIC program from paper to electronic benefits issuance. 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. The Division of Public Health is engaged in the Public Health Accreditation Bureau (PHAB) process. It is anticipated that all documents will be uploaded for PHAB review August, 2016. The MCH Director co-leads a PHAB domain team overseeing 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. In addition, the MCH Director is on the Workforce Development team which meets monthly and is tasked with developing a training policy and plan for the division staff. Currently, the team has identified three trainings for all staff to complete by December 2016.

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. For FY 2017, the MCH Program is going to explore the possibility of contracting with Idaho Parents Unlimited to provide medical home training and other education to parents of CYSHCN and to host quarterly meetings with parents of CYSHCN to inform MCH programming.

II.F.4. Health Reform

In 2015, the Idaho Legislature did not authorize the state to expand Medicaid. In 2016, the governor announced a proposal to connect uninsured Idaho adults living in poverty with primary healthcare and preventive services. The proposal was known as the Primary Care Access Program (PCAP). However, during the 2016 legislative session the proposal was not accepted. 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, 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 2016 coverage year, Idaho ranked second in the nation for per capita enrollments. Only Florida's per capita enrollment figures were higher. In 2016, 102,353 Idahoans enrolled in a Qualified Health Plan through the state-based exchange.

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. 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

Idaho is immersed in transforming healthcare for our citizens. In December, 2014 Idaho was awarded \$39,683,813 dollars to implement the Statewide Healthcare Innovation Plan (SHIP) strategies over a four-year model test period. The primary goals of SHIP are to transform primary care practices across the state into patient-centered medical homes, improve care coordination through the use of electronic health records and health data exchange, establish seven regional collaborative to support the integration of each medical home with the broader community, improve rural patient access to care, build a statewide analytics system, align payment mechanisms across payers to transform payment methodology from volume to value and reduce healthcare costs overall. The SHIP indicators identified as focus areas of work are access to care, tobacco cessation, obesity, and diabetes. The first fifty-five cohorts are identified and transformation work is underway.

The Division of Public Health is committed to being a positive influence in the changing health system in Idaho as well. Six top public health priorities were identified in 2014 with public health partners. These priorities are:

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

In July 2015, the Division of Public Health published *Get Healthy Idaho: Measuring and Improving Population Health*. The *Get Healthy Idaho* plan describes progress, annually, on the objectives outlined to address four of the six priorities noted above. Strategies were created to address healthcare access, obesity, tobacco and diabetes. *Get Healthy Idaho* supports the Division of Public Health Strategic Plan central challenge - to advance public health's influence within the changing health system. It supports the identified priority areas of the Strategic Plan to define and promote the role of public health and achieve public health accreditation. Additionally, the State Healthcare Innovation Plan (SHIP) Model Test Grant requires the development and implementation of a population health improvement plan. *Get Healthy Idaho* serves dual roles to meet both the requirements of PHAB and the SHIP Model Test Grant. *Get Healthy Idaho* is currently being updated to capture progress of both the data and the identified strategies and will transform as the SHIP transforms.

The priorities from SHIP align with the Leading Health Indicators for Idaho 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.

In November 2014, a stakeholder group was convened by the Division of Public Health to identify a common

definition of community health worker (CHW) in Idaho and next steps toward establishing a CHW certification program in Idaho. As a result of that meeting, and ongoing work in the division, the Idaho Department of Health and Welfare (IDHW) is establishing a contract with Idaho State University to deliver CHW training statewide. The course content is adopted from the State of Massachusetts program and adapted for Idaho. The core course includes 48 hours of instruction delivered live on-line with an additional 16 hours of project and homework assignments by students. IDHW is recruiting program instructors that will receive training from Massachusetts program experts in August 2016. Each course will be taught by a pair of instructors, including one with a public health or clinical background and the other a CHW. The first course begins on August 22.

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. The Division of Public Health is on target to submit all the required documents to PHAB by August, 2016. 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.

The Zika virus is an emerging issue that has long-term health impact and continues to evolve daily. As a result, it is challenging for our small MCH EPI staff and MCH directors to stay on top of the volume of related communication. The information from CDC around a Zika Pregnancy Registry has been limited and somewhat fragmented. Once all the details about participation and process become known, information will be provided that includes fact sheets, forms, processes and contact information.

An on-going issue in Idaho is around Medicaid expansion. In 2015, the Idaho Legislature did not authorize the state to expand Medicaid. In 2016, the governor announced a proposal to connect uninsured Idaho adults living in poverty with primary healthcare and preventive services. The proposal was known as the Primary Care Access Program (PCAP). However, during the 2016 legislative session the proposal was not accepted. 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 Idaho, there is strong support for the maternal and child health population, in terms of collaboration and referrals to existing programs and resources. However, no state funds are provided for specific maternal and child health programming, thus the Title V MCH block grant, WIC, MIECHV and various other grants remain the primary source of funding for MCH needs.

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. With the multitude of grant requirements and accreditation efforts going on in the Division of Public Health, the ability to sustain CoIIN activities has been challenging. The majority of CoIIN team members are within the department and competing priorities for time and effort make it difficult to keep this initiative a central focus. Funding for CoIIN activities falls on the MCH block grant, as there are no other dedicated funds to support this initiative.

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. The MCH Program did successfully reclassify an existing position in order to have a concentrated focus of the position work effort on activities to support the CYSHCN population.

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 and participates on the Idaho Child Fatality Review Team. 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. Participation in these various groups yields the MCH program with an opportunity to engage with families; specifically parents or caregivers of CYSHCN populations.

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 110 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

	2013		2014	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$3,203,380	\$2,926,860	\$3,203,380	\$3,246,758
Unobligated Balance	\$0	\$0	\$0	\$0
State Funds	\$2,402,535	\$2,195,146	\$2,402,535	\$2,435,069
Local Funds	\$0	\$0	\$0	\$0
Other Funds	\$0	\$0	\$0	\$0
Program Funds	\$0	\$0	\$0	\$0
SubTotal	\$5,605,915	\$5,122,006	\$5,605,915	\$5,681,827
Other Federal Funds	\$40,530,062	\$38,262,321	\$38,058,901	
Total	\$46,135,977	\$43,384,327	\$43,664,816	\$5,681,827

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$3,216,931	\$3,528,156	\$3,216,931	
Unobligated Balance	\$0	\$0	\$0	
State Funds	\$2,412,699	\$2,646,118	\$0	
Local Funds	\$0	\$0	\$2,412,699	
Other Funds	\$0	\$0	\$0	
Program Funds	\$0	\$0	\$0	
SubTotal	\$5,629,630	\$6,174,274	\$5,629,630	
Other Federal Funds	\$40,620,256	\$36,486,990	\$37,149,010	
Total	\$46,249,886	\$42,661,264	\$42,778,640	

	2017	
	Budgeted	Expended
Federal Allocation	\$3,273,054	
Unobligated Balance	\$0	
State Funds	\$0	
Local Funds	\$2,454,791	
Other Funds	\$0	
Program Funds	\$0	
SubTotal	\$5,727,845	
Other Federal Funds	\$46,596,490	
Total	\$52,324,335	

III.A. Expenditures

Budget Narrative for FFY15 Expended

The MCH Block Grant match (\$2,646,118) 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.

FFY15 MCH Block Grant funds were spent in accordance with the 30%-30% requirements. In FFY15, 39.4 percent of funds (\$1,391,453) were spent on Preventive and Primary Care for Children and 42.2 percent of funds (\$1,489,337) were spent on Children and Youth with Special Health Care Needs. The total amount of funds spent on Administration was 4.8 percent (\$171,825).

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 fund 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.

FFY15 block grant funds were used to fund the Idaho Oral Health program (IOHP). The Oral Health Program expended 10.8 percent of funds (\$381,096). 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.

FFY15 block grant funds helped support the Cancer Data Registry of Idaho (CDRI) to gap fill a contract for services. CDRI is a population-based cancer registry that collects incidence and survival data on all cancer patients who reside in the state or who are diagnosed and /or treated for cancer in the state. In FFY15, 1.1 percent of funds (\$37,666) were spent. CDRI support is a cross-cutting support.

FFY15 MCH state match funds supported the activities of the Idaho Immunization program (IIP). The IIP held 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 pacemaker 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.

FFY15 block grant funds helped support the Idaho Bureau of Communicable Disease Prevention (Epidemiology program) 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 2015. MCH EPI created a Health Alert Network (HAN) to send messages directly to providers regarding the Zika virus outbreak and risks to pregnant women. This HAN also implemented a 'call for cases' to all public health districts, OB/GYN, pediatric and family practice providers. In addition, MCH EPI participate in the infection control meetings of at least one hospital within their respective

jurisdiction on a monthly or quarterly basis, depending on the rules of the facility specific to infection control. 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 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.

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.

In Women/Maternal Health, (includes category for pregnant women) Block Grant funds were used to support the MCH Reproductive Health program (\$121,243), Pregnancy Risk Assessment Tracking Survey (PRATS) (\$59,435), MCH Epidemiology (\$56,426), MCH Sexually Transmitted Disease program (\$35,273) WIC Breastfeeding Peer Counseling electronic platform assistance (\$79), Idaho Careline (\$11,393) and Administration (\$42,956). Total funds expended for this category were \$326,805.

In Perinatal/Infant Health, (includes category for infants <1 year of age) Block Grant funds were used to support MCH Epidemiology (\$56,426), WIC Breastfeeding Peer Counseling electronic platform assistance (\$78), Idaho Careline (\$11,393), Immunizations (\$1,323,059), Newborn Metabolic Screening (\$32,956) and Administration (\$42,956). Total funds expended for this category were \$1,466,868.

In Child and Adolescent Health, (includes children 1 to 22 years of age) Block Grant funds were used to support the Oral Health program (\$381,096), MCH Epidemiology (\$56,426), MCH Sexually Transmitted Disease program (\$26,455), MCH Reproductive Health (\$242,486), Cancer Data Registry of Idaho (CDRI) (\$9,417), Injury Prevention-Poison Control Hotline (\$274,840), Idaho Careline (\$11,392), Immunizations (\$1,323,059) and Administration (\$42,956). Total funds expended for this category were \$2,368,127.

In Children and Youth with Special Health Care Needs (CYSHCN) Block Grant funds were used to support MCH Epidemiology (\$56,426), Idaho Careline (\$11,392), Children's Special Health program (\$1,416,872) and Administration (\$42,957). Total funds expended for this category were \$1,527,647.

In Cross-Cutting/Life Course (which includes Others), Block Grant funds were used for MCH Sexually Transmitted Disease program (\$26,455), MCH Reproductive Health (\$242,486), Cancer Data Registry Contract (\$28,249) and Indirect support costs to the department (\$187,637). Total funds expended for this category were \$484,827.

III.B. Budget

Budget Narrative for FFY17 Budget Projections

In order to meet the Maternal and Child Health (MCH) Block Grant match requirement for the FFY17 grant application, the state will be utilizing \$2,454,791 in local funds from the Idaho Immunization Assessment Fund. This is a dedicated fund for state-supplied vaccines for privately insured children to support the Idaho Immunization program (IIP). The IIP is located in the Department of Health and Welfare's Division of Public Health and continues to provide childhood vaccine products for all children residing in Idaho (universal supply state), including those with private insurance coverage who are not eligible for the federal Vaccines for Children (VFC) program. 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. Although the Immunization Assessment Fund is a state-managed fund, it is considered a local contribution as the funds are received from payers. All funding for activities under the management of the MCH Director and CYSHCN Director related to this population come from federal funds.

For the FFY17 MCH Block Grant, 36.3 percent of funds (\$1,187,097) are proposed for Preventive and Primary Care for Children and 36.5 percent of funds (\$1,194,100) are proposed for Children and Youth with Special Health Care Needs (CYSHCN). The total amount of funds proposed for Administration is 5.1 percent (\$168,000). It is important to note that Idaho made a change to the way administrative costs are defined for FFY17. Previously, administrative costs included personnel costs for half of the full-time equivalent (FTE) position for the Title V MCH Director and half of an FTE for an administrative assistant, plus operating costs for the MCH Director's position. For FFY17, administrative costs now include half of the FTE for the Title V MCH Director, half of the FTE for the Title V CYSHCN Director, and half the FTE for an administrative assistant. This change reflects actual personnel time spent on administering the MCH Block Grant Program, and operating costs have been spread across the Maternal and Infant Services, Preventive and Primary Care for Children, and CYSHCN categories.

The MCH block grant will continue to support the Idaho Oral Health program's efforts to provide oral health education, dental sealants, fluoride varnish, and referrals to a dental home for elementary school children. 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. Further, the MCH block grant will help fund the Smile Survey, which is an oral health assessment conducted on a random sample of third grade students across the state every four years. The survey provides a snapshot of the oral health status of children in the state, and will collect BMI status for the 2016/2017 school year. This will help inform work related to childhood obesity as well as oral health.

The MCH block grant will continue to fund Idaho Family Planning program's subgrants to six of the seven local public health districts to provide family planning services in accordance with Title X regulations. The MCH block grant funding for the Family Planning program is meant to complement Title X funding and expand services. The Family Planning clinics are a source of referral to well-woman and prenatal care and help ensure women across the life course have access to reproductive health services.

During FFY2017, the Idaho MCH program plans on collaborating with the MIECHV program to fund training for home visitors on breastfeeding education, how encourage breastfeeding among families, how to answer mother's questions regarding breastfeeding, how to encourage fathers to support breastfeeding, and how to link families with community resources.

The MCH block grant will continue to fund the Idaho Bureau of Communicable Disease Prevention (Epidemiology program) 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.

As mandated by OBRA legislation, the Title V MCH block grant will continue to fulfill 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 will continue to help fund the Idaho Poison Control Center. The Idaho Poison Control Center maintains a 24/7 hotline to provide medical consultation for poisoning calls and provides monthly public service announcements regarding poisoning risks relevant to Idaho. Approximately half the calls to the hotline are for children under the age of 5. The contract for the Idaho Poison Control Center with the Nebraska Poison Control center is directly managed by the MCH program.

The MCH block grant will continue to fund the data collection contract for 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.

The MCH program intends to continue the partnership with the Boise State University Center for Health Policy to continue evaluation and needs assessment activities for the MCH Program. The needs assessment partner will support data collection and reporting for the identified evidence-based strategy measures discussed in the State Action Plan along with on-going needs assessment efforts. Further, MCH block grant funds will continue to support a FTE for a research analyst that is dedicated to supporting MCH program's data needs.

The MCH program will continue to support the medical home demonstration for CYSHCN living in rural Idaho. Through a subgrant with the local public health district in eastern Idaho, a medical home coordinator partners with up to three rural pediatric or primary clinics in the area to support transformation to a patient-centered medical home and improve quality of care for CYSHCN.

In FFY17, the MCH program intends to partner with IHAWCC to host a learning collaborative focused on addressing pediatric oral health in the primary care setting. Practices participating in the learning collaborative would be encouraged to either provide fluoride varnish at well-child visits or conduct a brief screening and make a referral to a dental provider, increase documentation in the electronic medical record (EMR) system, and make and follow-up appointments when appropriate.

The MCH block grant will continue to fund and operate the Children's Special Health program (CSHP), which 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. This statewide program pays for direct medical services for children with significant health problems or chronic illnesses/conditions requiring long-term

medical treatment and rehabilitative measures.

In an effort to address the need for access to medical specialists, the MCH program will continue to fund 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 will continue to use funds to bring a metabolic specialist and registered dietitian from Oregon twice per year to host PKU clinics in northern and eastern Idaho. The MCH program will continue to use funds for 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 block grant will continue to provide funding for personnel and operations of the Idaho Newborn Screening (NBS) program as this is considered an essential population-based public health screening program. Operations include the next-business day courier service for first specimen providers and general office supplies and printing.

MCH Block Grant funds will continue to support Idaho's Infant Mortality Collaborative Improvement and Innovation Network (CoIIN) initiatives. Idaho's CoIIN team is comprised of representation from various programs and organizations throughout Idaho, including the Inland Northwest SIDS/SUIDS Foundation, March of Dimes, numerous state agencies, and hospitals. Idaho is currently undertaking two initiatives: Safe Sleep and Tobacco Cessation. The goal for the Safe Sleep initiative is to increase the education regarding safe sleep environments and facilitating certification to birthing centers in Idaho. The Tobacco Cessation initiative is aimed at assisting women of reproductive age and pregnant mothers to get and remain tobacco free during pregnancy, increasing the health of the mother and her children.

Below is a breakdown of how MCH block grant funds will be spent across the types of individuals served. For FFY17, it is important to note that MCH leadership refined the way certain activities were split across the categories, so some costs per category will differ from previous years. For instance, Administration, MCH Epidemiology, and Poison Control are now split across all of the categories of individuals served, and Perinatal Assessment is split across the Pregnant Women and Infant categories. Further, MCH leadership restructured some programmatic operations which resulted in the creation of new categories: MCH Program Personnel and MCH Program Operating. These new categories reflect the staff time and operational costs to support the Children's Special Health Program, Newborn Screening Program, activities for CYSHCN, and other MCH initiatives and projects.

In Women/Maternal Health (includes category for pregnant women), Block Grant funds are proposed to support the MCH Reproductive Health program (\$108,800), MCH Epidemiology (\$41,063), MCH Needs Assessment (\$12,000), Idaho CareLine (\$9,000), Perinatal Assessment Survey Support (\$30,000), Pregnancy/Perinatal Education (\$12,750), Poison Control (\$54,280), CoIIN Activities (\$2,500), MCH Research Analyst position (\$19,575), MCH Program Personnel (\$45,000), MCH Program Operations (\$65,300), Administration (\$33,600), and Indirect Costs (\$42,000). Total Block Grant funds projected to be expended are \$475,868.

In Perinatal/Infant Health (includes category for infants >1 year of age), Block Grant funds are proposed to support MCH Epidemiology (\$41,063), Perinatal Assessment Survey Support (\$30,000), MCH Needs Assessment (\$12,000), Idaho CareLine (\$9,000), MCH Research Analyst position (\$19,575), CoIIN Activities (\$2,500), Poison Control Hotline (\$54,280), MCH Program Personnel (\$45,000), Home Visitor Breastfeeding Training (new - \$12,750), MCH Program Operations (\$65,300), Administration (\$33,600), and Indirect Costs (\$42,000). Total Block Grant funds projected to be expended are \$367,068. With the Immunization Match (\$1,227,395), total funds projected to be expended are \$1,594,463.

In *Child and Adolescent Health (includes children 1 to 22 years of age)*, Block Grant are proposed to support the MCH Epidemiology (\$41,063), MCH Oral Health (\$303,840), MCH Needs Assessment (\$12,000), MCH Reproductive Health (\$217,600), Poison Control Hotline (\$54,280), Adolescent Health Activities (new - \$12,750), Idaho CareLine (\$9,000), MCH Research Analyst (\$19,575), MCH Program Personnel (\$45,000), MCH Program Operations (\$65,300), Administration (\$33,600), and Indirect Costs (\$42,000). Total Block Grant funds projected to be expended are \$856,008. With the Immunization Match (\$1,227,396), total funds projected to be expended are \$2,083,404.

In *Children and Youth with Special Health Care Needs (CYSHCN)*, Block Grant funds are proposed to support MCH Epidemiology (\$41,063), MCH Needs Assessment (\$12,000), Idaho CareLine (\$9,000), Learning Collaborative (new-\$12,750), Poison Control Hotline (\$54,280), MCH Research Analyst (\$19,575), Children's Special Health Services (\$740,000), MCH Program Personnel (\$135,000), MCH Program Operations (\$65,300), Administration (\$33,600), and Indirect Costs (\$42,000). Total Block Grant funds projected to be expended are \$1,164,568.

In *Cross-Cutting/Life Course (which includes Others)*, Block Grant funds are proposed to support MCH Reproductive Health (\$217,600), MCH Epidemiology (\$41,063), MCH Needs Assessment (\$12,000), Idaho Careline (\$9,000), Poison Control Hotline (\$54,280), Administration (\$33,600), and Indirect Costs (\$42,000). Total Block Grant funds projected to be expended are \$409,543.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [Medicaid_Welfare_Public Health MOU.pdf](#)

V. Supporting Documents

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

Supporting Document #01 - [Get Healthy Idaho Final.pdf](#)

Supporting Document #02 - [CAP and Indirect Costs.pdf](#)

Supporting Document #03 - [MCH State Action Plan Table - 2017 Plan - FINAL.pdf](#)

Supporting Document #04 - [Org Charts - MCH Block Grant.pdf](#)

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Idaho

	FY17 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 3,273,054	
A. Preventive and Primary Care for Children	\$ 1,187,097	(36.3%)
B. Children with Special Health Care Needs	\$ 1,194,100	(36.5%)
C. Title V Administrative Costs	\$ 168,000	(5.1%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	\$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 0	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 2,454,791	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 2,454,791	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 2,141,219		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	\$ 5,727,845	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	\$ 46,596,490	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 52,324,335	

OTHER FEDERAL FUNDS	FY17 Application Budgeted
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 30,812,561
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	\$ 342,473
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	\$ 3,652,362
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sexually Transmitted Diseases (STD) Prevention	\$ 334,985
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	\$ 2,046,705
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Ryan White	\$ 5,044,235
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 1,533,096
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	\$ 400,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 279,742
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Comprehensive HIV Prevention Programs for Health Departments	\$ 833,217
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Viral Hepatitis	\$ 30,273
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > ADAP ERF	\$ 757,200
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Ryan White Part B - Supplemental	\$ 529,641

	FY15 Application Budgeted		FY15 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 3,216,931		\$ 3,528,156	
A. Preventive and Primary Care for Children	\$ 1,190,428	(37%)	\$ 1,391,453	(39.4%)
B. Children with Special Health Care Needs	\$ 1,232,689	(38.3%)	\$ 1,489,337	(42.2%)
C. Title V Administrative Costs	\$ 165,923	(5.2%)	\$ 171,825	(4.9%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	\$ 0		\$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 2,412,699		\$ 2,646,118	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0		\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0		\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0		\$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 2,412,699		\$ 2,646,118	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 2,141,219				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	\$ 5,629,630		\$ 6,174,274	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	\$ 40,620,256		\$ 36,486,990	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 46,249,886		\$ 42,661,264	

OTHER FEDERAL FUNDS	FY15 Annual Report Expended
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 26,311,820
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	\$ 2,355,157
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sexually Transmitted Diseases (STD) Prevention	\$ 417,126
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	\$ 1,900,752
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Ryan White	\$ 966,819
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 1,514,496
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	\$ 327,181
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	\$ 1,243,336
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Comprehensive HIV Prevention Programs for Health Departments	\$ 797,026
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Viral Hepatitis	\$ 20,933
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > ADAP ERF	\$ 632,344

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	Field Name:	Federal Allocation, A. Preventive and Primary Care for Children:
	Fiscal Year:	2015
	Column Name:	Annual Report Expended
	Field Note:	This value represents more was expended in this category than was projected.
2.	Field Name:	Federal Allocation, B. Children with Special Health Care Needs:
	Fiscal Year:	2015
	Column Name:	Annual Report Expended
	Field Note:	This value represents more was expended in this category than was projected.

Data Alerts:

None

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

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	\$ 475,868	\$ 326,805
2. Infants < 1 year	\$ 367,068	\$ 143,809
3. Children 1-22 years	\$ 856,008	\$ 1,045,068
4. CSHCN	\$ 1,164,567	\$ 1,527,646
5. All Others	\$ 409,542	\$ 484,827
Federal Total of Individuals Served	\$ 3,273,053	\$ 3,528,155

IB. Non Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	\$ 0	\$ 0
2. Infants < 1 year	\$ 1,227,395	\$ 1,323,059
3. Children 1-22 years	\$ 1,227,396	\$ 1,323,059
4. CSHCN	\$ 0	\$ 0
5. All Others	\$ 0	\$ 0
Non Federal Total of Individuals Served	\$ 2,454,791	\$ 2,646,118
Federal State MCH Block Grant Partnership Total	\$ 5,727,844	\$ 6,174,273

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:	2017
	Column Name:	Application Budgeted
	Field Note:	Due to difference in internally tracking, amounts are different across the three legislatively defined categories.
2.	Field Name:	IA. Federal MCH Block Grant, 4. CSHCN
	Fiscal Year:	2017
	Column Name:	Application Budgeted
	Field Note:	Difference of \$1 due to validation error where budgeted value must be less than Form 2 Line 1
3.	Field Name:	IA. Federal MCH Block Grant, 3. Children 1-22 years
	Fiscal Year:	2015
	Column Name:	Annual Report Expended
	Field Note:	Due to difference in internally tracking, amounts are different across the three legislatively defined categories.
4.	Field Name:	IA. Federal MCH Block Grant, 4. CSHCN
	Fiscal Year:	2015
	Column Name:	Annual Report Expended
	Field Note:	Difference of \$1 due to validation error where expended value must be less than Form 2 Line 1

Data Alerts:

None

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

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	\$ 1,020,920	\$ 2,023,087
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 544,000	\$ 606,215
B. Preventive and Primary Care Services for Children	\$ 151,920	\$ 0
C. Services for CSHCN	\$ 325,000	\$ 1,416,872
2. Enabling Services	\$ 860,470	\$ 54,388
3. Public Health Services and Systems	\$ 1,391,664	\$ 1,450,681
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
Other		
CSHP CLINICS/CLAIMS/MEDICAL FOOD/FAMILY PLANNING		\$ 2,023,087
Direct Services Line 4 Expended Total		\$ 2,023,087
Federal Total	\$ 3,273,054	\$ 3,528,156

IIB. Non-Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
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	\$ 2,454,791	\$ 2,646,118
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 Line 4 Expended Total		\$ 0
Non-Federal Total	\$ 2,454,791	\$ 2,646,118

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated
State: Idaho

Total Births by Occurrence: 22,888

1. 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
Core RUSP Conditions	22,301 (97.4%)	984	28	28 (100.0%)

Program Name(s)				
Cystic fibrosis	Congenital adrenal hyperplasia	Primary congenital hypothyroidism	S,S disease (Sickle cell anemia)	Homocystinuria
Classic phenylketonuria	Tyrosinemia, type I	Carnitine uptake defect/carnitine transport defect	Medium-chain acyl-CoA dehydrogenase deficiency	Very long-chain acyl-CoA dehydrogenase deficiency
Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	β-Ketothiolase deficiency	Glutaric acidemia type I	Isovaleric acidemia	Maple syrup urine disease
Methylmalonic acidemia (methylmalonyl-CoA mutase)	Methylmalonic acidemia (cobalamin disorders)	Propionic acidemia	3-Hydroxy-3-methylglutaric aciduria	3-Methylcrotonyl-CoA carboxylase deficiency
Holocarboxylase synthase deficiency	Citrullinemia, type I	Biotinidase deficiency	Classic galactosemia	Severe combined immunodeficiencies
Trifunctional protein deficiency	Argininosuccinic aciduria	S, β-thalassemia	S,C disease	

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
Methylmalonic acidemia with homocystinuria	22,301 (97.4%)	0	0	0 (0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Malonic acidemia	22,301 (97.4%)	24	0	0 (0%)
Isobutyrylglycinuria	22,301 (97.4%)	12	0	0 (0%)
2-Methylbutyrylglycinuria	22,301 (97.4%)	0	0	0 (0%)
3-Methylbutyrylglycinuria	22,301 (97.4%)	6	0	0 (0%)
2-Methyl-3-hydroxybutyric aciduria	22,301 (97.4%)	0	0	0 (0%)
Short-chain acyl-CoA dehydrogenase deficiency	22,301 (97.4%)	8	0	0 (0%)
Glutaric acidemia type II	22,301 (97.4%)	0	0	0 (0%)
Carnitine palmitoyltransferase type I deficiency	22,301 (97.4%)	0	0	0 (0%)
Carnitine palmitoyltransferase type II deficiency	22,301 (97.4%)	0	0	0 (0%)
Carnitine acylcarnitine translocase deficiency	22,301 (97.4%)	0	0	0 (0%)
Argininemia	22,301 (97.4%)	0	0	0 (0%)
Citrullinemia, type II	22,301 (97.4%)	0	0	0 (0%)
Hypermethioninemia	22,301 (97.4%)	0	0	0 (0%)
Benign hyperphenylalaninemia	22,301 (97.4%)	0	0	0 (0%)
Tyrosinemia, type II	22,301 (97.4%)	0	0	0 (0%)
Various other hemoglobinopathies	22,301 (97.4%)	0	0	0 (0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Idaho does not conduct long-term follow-up. The process in Idaho ends once the case is confirmed positive and referred for treatment.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

None

Data Alerts:

None

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

State: Idaho

Reporting Year 2015

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	886	5.8	0.4	12.9	77.9	3.0
2. Infants < 1 Year of Age	21,687	37.1	2.4	53.6	6.7	0.2
3. Children 1 to 22 Years of Age	160,269	9.4	0.6	31.2	56.7	2.1
4. Children with Special Health Care Needs	1,554	2.3	0.0	3.4	0.7	93.6
5. Others	50,101	0.0	0.0	0.0	0.0	100.0
Total	234,497					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

1.	Field Name:	Pregnant Women Total Served
	Fiscal Year:	2015
	Field Note:	Technical issues related to changed Electronic Medical Record Systems report fewer than are actually likely served.

2.	Field Name:	Children 1 to 22 Years of Age
	Fiscal Year:	2015
	Field Note:	Health Insurance status/ information not available in most of the data sources for this population

3.	Field Name:	Others
	Fiscal Year:	2015
	Field Note:	Data sources for majority of this category have no health insurance information available.

Form 5b
Total Recipient Count of Individuals Served by Title V

State: Idaho

Reporting Year 2015

Types Of Individuals Served	Total Served
1. Pregnant Women	886
2. Infants < 1 Year of Age	21,687
3. Children 1 to 22 Years of Age	160,269
4. Children with Special Health Care Needs	1,554
5. Others	50,101
Total	234,497

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Idaho

Reporting Year 2015

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	22,888	20,008	176	332	349	53	554	1,416
Title V Served	22,759	19,895	175	330	347	53	551	1,408
Eligible for Title XIX	9,052	7,483	116	226	84	27	297	819
2. Total Infants in State	22,805	20,297	218	507	353	61	1,369	0
Title V Served	22,676	20,182	217	504	351	61	1,361	0
Eligible for Title XIX	9,019	7,680	144	345	85	31	734	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	19,181	3,652	55	22,888
Title V Served	19,073	3,631	55	22,759
Eligible for Title XIX	6,951	2,077	24	9,052
2. Total Infants in State	18,613	4,192	0	22,805
Title V Served	18,508	4,168	0	22,676
Eligible for Title XIX	6,635	2,384	0	9,019

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	Field Name:	2. Total Infants in State
	Fiscal Year:	2014
	Column Name:	Total All Races

Field Note:

Census department data used for this line does not include an "other or unknown" category.

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

State: Idaho

A. State MCH Toll-Free Telephone Lines	2017 Application Year	2015 Reporting Year
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"	Charles A Beal	Donald Alveshere
4. Contact Person's Telephone Number	(208) 287-1030	(208) 287-2030
5. Number of Calls Received on the State MCH "Hotline"		41,039

B. Other Appropriate Methods	2017 Application Year	2015 Reporting Year
1. Other Toll-Free "Hotline" Names	Poison Control Hotline	Poison Control Hotline
2. Number of Calls on Other Toll-Free "Hotlines"		15,269
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:

Idaho CareLine may also be accessed in state by dialing 211.

It services more than the MCH population. The number of calls reflects the numbers of calls related to MCH population interests.

Form 8
State MCH and CSHCN Directors Contact Information

State: Idaho

1. Title V Maternal and Child Health (MCH) Director	
Name	Kris Spain, MS, RD, LD
Title	Chief, Bureau of Clinical and Preventive Services
Address 1	450 West State Street, 4th Floor
Address 2	PO Box 83720
City/State/Zip	Boise / ID / 83720
Telephone	(208) 334-5930
Extension	
Email	spaink@dhw.idaho.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Jacque Watson, MHS
Title	Manager, Maternal and Child Health Programs
Address 1	450 West State Street, 4th Floor
Address 2	PO Box 83720
City/State/Zip	Boise / ID / 83720
Telephone	(208) 334-5962
Extension	
Email	watsonj1@dhw.idaho.gov

3. State Family or Youth Leader (Optional)

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

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Idaho

Application Year 2017

No.	Priority Need
1.	Increase percent of women accessing prenatal health care
2.	Improve breastfeeding rates
3.	Support services, programs, and activities that promote safe and healthy family functioning
4.	Decrease the prevalence of childhood overweight and obesity
5.	Improve childhood immunization rates
6.	Improve maternal and child health population access to medical homes
7.	Improve access to medical specialists for children and youth with special health care needs
8.	Decrease substance abuse among maternal and child health populations

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	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

Field Level Notes for Form 9:

None

**Form 10a
National Outcome Measures (NOMs)**

State: Idaho

Form Notes for Form 10a NPMs, NOMs, SPMs, SOMs, and ESMs.

For ESM 5.1, at this time, it is difficult to project how many health care providers will be trained over the next five years. The number of trainings will be based on Inland Northwest SIDS Foundation's capacity and staff availability. A value of 30 will be entered and will be adjusted next year based on the actual value.

For ESM 10.1, the MCH Program anticipates conducting the assessment of adolescents a single time in 2017. Based on the results of the assessment, the MCH Program will develop and implement evidence-based strategies to increase awareness and utilization of adolescent well-visits.

For ESM 13.1, the MCH Program will be hosting the oral health learning collaborative in 2017. For future years, learning collaboratives will focus on other topics.

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	75.6 %	0.3 %	17,239	22,818
2013	73.4 %	0.3 %	16,329	22,248
2012	73.8 %	0.3 %	16,857	22,840
2011	74.3 %	0.3 %	16,482	22,185
2010	73.5 %	0.3 %	16,968	23,088
2009	71.6 %	0.3 %	16,907	23,606

Legends:
 Indicator has a numerator <10 and is not reportable
 Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

State Provided Data	
	2014
Annual Indicator	74.2
Numerator	16,907
Denominator	22,784
Data Source	Birth Certificate
Data Source Year	2014

NOM 1 - Notes:

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

Due to out-of-state birth certificates not received as of date of entry, 2014 values are used as estimate.

Data Alerts:

None

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

FAD Not Available for this measure.

NOM 2 - Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2010_2014	20.2	4.2 %	23	113,725
2009_2013	19.2	4.1 %	22	114,586
2008_2012	17.0	3.8 %	20	117,352
2007_2011	19.3	4.0 %	23	119,408
2006_2010	19.8	4.0 %	24	121,287
2005_2009	19.8	4.0 %	24	121,151

Legends:
🚩 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.4 %	0.2 %	1,471	22,869
2013	6.9 %	0.2 %	1,545	22,364
2012	6.4 %	0.2 %	1,477	22,952
2011	6.1 %	0.2 %	1,352	22,298
2010	6.8 %	0.2 %	1,573	23,184
2009	6.5 %	0.2 %	1,541	23,717

Legends:
🚩 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.1 - Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	1.0 %	0.1 %	227	22,869
2013	1.1 %	0.1 %	243	22,364
2012	1.0 %	0.1 %	217	22,952
2011	1.0 %	0.1 %	215	22,298
2010	1.0 %	0.1 %	241	23,184
2009	1.1 %	0.1 %	248	23,717

Legends:
🚩 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.2 - Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	5.4 %	0.2 %	1,244	22,869
2013	5.8 %	0.2 %	1,302	22,364
2012	5.5 %	0.2 %	1,260	22,952
2011	5.1 %	0.2 %	1,137	22,298
2010	5.8 %	0.2 %	1,332	23,184
2009	5.5 %	0.2 %	1,293	23,717

Legends:
🚩 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.3 - Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	8.2 %	0.2 %	1,863	22,870
2013	9.0 %	0.2 %	2,019	22,329
2012	8.5 %	0.2 %	1,947	22,913
2011	8.1 %	0.2 %	1,799	22,265
2010	8.9 %	0.2 %	2,061	23,147
2009	9.0 %	0.2 %	2,132	23,661

Legends:
🚩 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.1 - Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	2.0 %	0.1 %	453	22,870
2013	2.6 %	0.1 %	569	22,329
2012	2.1 %	0.1 %	470	22,913
2011	1.9 %	0.1 %	429	22,265
2010	2.2 %	0.1 %	510	23,147
2009	2.3 %	0.1 %	550	23,661

Legends:
🚩 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.2 - Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.2 %	0.2 %	1,410	22,870
2013	6.5 %	0.2 %	1,450	22,329
2012	6.5 %	0.2 %	1,477	22,913
2011	6.2 %	0.2 %	1,370	22,265
2010	6.7 %	0.2 %	1,551	23,147
2009	6.7 %	0.2 %	1,582	23,661

Legends:
🚩 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.3 - Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	23.3 %	0.3 %	5,337	22,870
2013	23.2 %	0.3 %	5,184	22,329
2012	24.8 %	0.3 %	5,686	22,913
2011	24.0 %	0.3 %	5,338	22,265
2010	25.4 %	0.3 %	5,867	23,147
2009	26.3 %	0.3 %	6,221	23,661

Legends:
🚩 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts:

None

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

Data Source: CMS Hospital Compare

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014/Q2-2015/Q1	10.0 %			
2014/Q1-2014/Q4	9.0 %			
2013/Q4-2014/Q3	8.0 %			
2013/Q3-2014/Q2	6.0 %			
2013/Q2-2014/Q1	5.0 %			

Legends:
📅 Indicator results were based on a shorter time period than required for reporting

NOM 7 - Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.5	0.5 %	146	22,453
2012	6.0	0.5 %	137	23,024
2011	5.9	0.5 %	132	22,381
2010	5.1	0.5 %	119	23,266
2009	5.6	0.5 %	133	23,804

Legends:
🚩 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.6	0.5 %	126	22,383
2012	5.4	0.5 %	125	22,963
2011	5.1	0.5 %	113	22,305
2010	4.8	0.5 %	111	23,198
2009	5.5	0.5 %	130	23,737

Legends:
🚩 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	3.6	0.4 %	81	22,383
2012	3.7	0.4 %	85	22,963
2011	3.1	0.4 %	68	22,305
2010	2.8	0.4 %	64	23,198
2009	3.5	0.4 %	82	23,737

Legends:
🚩 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	2.0	0.3 %	45	22,383
2012	1.7	0.3 %	40	22,963
2011	2.0	0.3 %	45	22,305
2010	2.0	0.3 %	47	23,198
2009	2.0	0.3 %	48	23,737

Legends:
🚩 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	183.2	28.6 %	41	22,383
2012	148.1	25.4 %	34	22,963
2011	148.0	25.8 %	33	22,305
2010	90.5	19.8 %	21	23,198
2009	130.6	23.5 %	31	23,737

Legends:
🚩 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	102.8	21.4 %	23	22,383
2012	78.4 ⚡	18.5 % ⚡	18 ⚡	22,963 ⚡
2011	112.1	22.4 %	25	22,305
2010	103.5	21.1 %	24	23,198
2009	80.0 ⚡	18.4 % ⚡	19 ⚡	23,737 ⚡

Legends:
 🚩 Indicator has a numerator <10 and is not reportable
 ⚡ Indicator has a numerator <20 and should be interpreted with caution

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

FAD Not Available for this measure.

NOM 10 - Notes:

None

Data Alerts:

None

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

FAD Not Available for this measure.

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)

FAD Not Available for this measure.

NOM 12 - Notes:

None

Data Alerts:

None

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

FAD Not Available for this measure.

NOM 13 - Notes:

None

Data Alerts:

None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	18.4 %	1.4 %	73,618	399,342

Legends:
🚫 Indicator has an unweighted denominator <30 and is not reportable
⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	18.2	2.9 %	39	214,780
2013	18.6	3.0 %	40	214,535
2012	12.5	2.4 %	27	215,985
2011	20.2	3.1 %	44	217,796
2010	21.0	3.1 %	46	219,357
2009	16.5	2.8 %	36	217,622

Legends:
🚩 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	35.4	3.9 %	84	237,209
2013	29.4	3.5 %	69	234,813
2012	37.8	4.0 %	88	233,009
2011	43.1	4.3 %	101	234,606
2010	34.9	3.9 %	81	232,314
2009	33.7	3.8 %	78	231,407

Legends:
 Indicator has a numerator <10 and is not reportable
 Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2014	12.9	1.9 %	44	342,139
2011_2013	17.8	2.3 %	61	343,533
2010_2012	19.4	2.4 %	67	345,258
2009_2011	20.4	2.4 %	71	347,441
2008_2010	21.3	2.5 %	74	347,787
2007_2009	24.1	2.6 %	84	347,916

Legends:
🚩 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2014	17.5	2.3 %	60	342,139
2011_2013	20.7	2.5 %	71	343,533
2010_2012	20.0	2.4 %	69	345,258
2009_2011	16.1	2.2 %	56	347,441
2008_2010	13.2	2.0 %	46	347,787
2007_2009	13.8	2.0 %	48	347,916

Legends:
🚩 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts:

None

NOM 17.1 - Percent of children with special health care needs

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	17.2 %	1.3 %	73,477	427,810
2007	15.9 %	1.1 %	65,292	411,741
2003	15.0 %	1.0 %	55,671	370,344

Legends:
🚩 Indicator has an unweighted denominator <30 and is not reportable
⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

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

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	14.0 %	1.5 %	6,831	48,857

Legends:
🚩 Indicator has an unweighted denominator <30 and is not reportable
⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts:

None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	2.0 %	0.5 %	7,237	359,409
2007	1.2 %	0.3 %	4,141	338,063

Legends:
🚩 Indicator has an unweighted denominator <30 and is not reportable
⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

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)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	6.4 %	0.9 %	22,904	357,574
2007	6.2 %	0.8 %	20,957	337,860

Legends:
🚩 Indicator has an unweighted denominator <30 and is not reportable
⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts:

None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	56.3 % ⚡	6.5 % ⚡	18,379 ⚡	32,637 ⚡
2007	64.3 % ⚡	5.7 % ⚡	18,080 ⚡	28,131 ⚡
2003	58.3 % ⚡	5.3 % ⚡	14,226 ⚡	24,414 ⚡

Legends:
 🚩 Indicator has an unweighted denominator <30 and is not reportable
 ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts:

None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	87.8 %	1.2 %	375,691	427,810
2007	86.1 %	1.1 %	354,123	411,222
2003	87.1 %	0.9 %	322,512	370,187

Legends:
🚩 Indicator has an unweighted denominator <30 and is not reportable
⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

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)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	27.8 %	2.6 %	49,365	177,746
2007	27.5 %	2.0 %	47,613	172,867
2003	25.6 %	1.7 %	40,882	159,714

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	26.8 %	0.3 %	4,626	17,278

Legends:
 Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	25.3 %	0.9 %	19,430	76,830
2011	22.7 %	1.2 %	17,661	77,981
2009	20.5 %	1.1 %	16,363	79,868
2007	22.5 %	1.6 %	17,501	77,708
2005	20.8 %	1.5 %	14,430	69,274

Legends:
🚩 Indicator has an unweighted denominator <100 and is not reportable
⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts:

None

NOM 21 - Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	7.2 %	0.7 %	31,036	431,337
2013	8.3 %	0.7 %	35,334	426,677
2012	7.5 %	0.7 %	32,005	424,523
2011	8.5 %	0.8 %	36,523	428,105
2010	10.6 %	0.8 %	45,450	428,897
2009	10.7 %	0.7 %	44,661	418,801

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts:

None

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	65.9 %	4.1 %	20,373	30,921
2013	70.2 %	3.5 %	22,515	32,071
2012	63.0 %	4.2 %	21,155	33,582
2011	58.1 %	4.3 %	20,417	35,170
2010	42.6 %	3.5 %	15,565	36,540
2009	33.6 %	3.7 %	11,722	34,919

Legends:

- 🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

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

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2015	50.3 %	2.1 %	203,378	404,491
2013_2014	45.5 %	2.2 %	183,115	402,849
2012_2013	44.0 %	2.3 %	175,493	398,775
2011_2012	42.4 %	2.5 %	160,916	379,777
2010_2011	43.1 %	4.0 %	170,451	395,479
2009_2010	31.6 %	2.9 %	128,147	405,527

Legends:

-  Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
-  Estimates with 95% confidence interval half-widths > 10 might not be reliable

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

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	59.4 % ⚡	5.2 % ⚡	34,571 ⚡	58,200 ⚡
2013	55.0 % ⚡	5.4 % ⚡	31,404 ⚡	57,132 ⚡
2012	51.4 %	4.8 %	28,939	56,356
2011	45.5 % ⚡	5.4 % ⚡	25,652 ⚡	56,376 ⚡
2010	28.8 %	4.0 %	15,866	55,035
2009	30.2 % ⚡	5.3 % ⚡	16,190 ⚡	53,565 ⚡

Legends:
 🚩 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
 ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	32.0 %	4.4 %	19,641	61,345
2013	34.5 % ⚡	5.2 % ⚡	20,905 ⚡	60,642 ⚡
2012	16.2 %	3.9 %	9,706	59,976
2011	NR 🚩	NR 🚩	NR 🚩	NR 🚩

Legends:
 🚩 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
 ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

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

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	70.8 %	3.3 %	84,629	119,545
2013	74.6 %	3.4 %	87,819	117,774
2012	64.5 %	3.1 %	75,046	116,332
2011	58.3 %	3.6 %	67,822	116,381
2010	49.2 %	3.2 %	55,716	113,354
2009	38.6 %	3.8 %	42,752	110,748

Legends:

-  Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
-  Estimates with 95% confidence interval half-widths > 10 might not be reliable

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

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	78.1 %	3.0 %	93,322	119,545
2013	71.6 %	3.6 %	84,277	117,774
2012	63.2 %	3.2 %	73,559	116,332
2011	50.5 %	3.7 %	58,734	116,381
2010	40.8 %	3.1 %	46,293	113,354
2009	34.2 %	3.7 %	37,837	110,748

Legends:

- 🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.5 - Notes:

None

Data Alerts:

None

**Form 10a
National Performance Measures (NPMs)**

State: Idaho

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	51.1	51.1	51.2	51.2	51.3	51.4

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend					
Year	Annual Indicator	Standard Error	Numerator	Denominator	
2014	51.0 %	2.3 %	141,248	276,971	
2013	54.6 %	2.2 %	150,860	276,258	
2012	47.3 %	2.6 %	129,098	273,153	
2011	51.6 %	2.2 %	141,466	274,166	
2010	51.6 %	2.0 %	140,036	271,666	
2009	53.5 %	2.2 %	145,781	272,674	

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 4 - A) Percent of infants who are ever breastfed

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	85.0	85.5	85.8	86.0	86.1	86.1

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	91.7 %	2.3 %	19,100	20,838
2011	84.4 %	3.2 %		
2010	90.6 %	2.4 %		
2009	90.7 %	2.4 %		
2008	83.1 %	2.7 %		
2007	86.4 %	2.4 %		

Legends:
 Indicator has an unweighted denominator <50 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 4 - B) Percent of infants breastfed exclusively through 6 months

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	20.6	20.7	20.7	20.8	20.8	20.9

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	20.2 %	3.3 %	4,040	20,018
2011	24.8 %	3.4 %		
2010	20.1 %	3.0 %		
2009	25.4 %	3.4 %		
2008	21.9 %	2.4 %		
2007	21.3 %	2.8 %		

Legends:
 Indicator has an unweighted denominator <50 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	82.0	82.2	82.3	82.5	82.6	82.6

FAD not available for this measure.

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	28.0	28.1	28.2	28.2	28.3	28.3

Data Source: National Survey of Children's Health (NSCH) - CHILD

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	34.5 %	2.9 %	50,660	146,760
2007	31.8 %	2.6 %	41,610	130,906
2003	28.1 %	2.1 %	33,634	119,733

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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	2021
Annual Objective	66.2	66.3	66.4	66.5	66.6	66.6

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	65.7 %	3.1 %	87,555	133,352
2007	71.3 %	2.2 %	97,888	137,285
2003	55.5 %	2.2 %	69,226	124,647

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	59.8	59.9	60.0	60.1	60.2	60.2

Data Source: National Survey of Children's Health (NSCH) - CSHCN

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	43.3 %	4.1 %	31,484	72,649
2007	44.1 %	3.7 %	27,687	62,750

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH) - NONCSHCN

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	59.9 %	2.0 %	206,393	344,470
2007	58.4 %	1.7 %	190,568	326,138

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 13 - A) Percent of women who had a dental visit during pregnancy

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	57.2	57.4	57.6	57.7	57.8	57.8

FAD not available for this measure.

Field Level Notes for Form 10a NPMs:

None

NPM 13 - 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	2021
Annual Objective	79.3	79.4	79.5	79.5	79.6	79.6

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	79.2 %	1.5 %	315,956	398,839
2007	76.6 %	1.4 %	296,409	387,165

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 14 - A) Percent of women who smoke during pregnancy

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	10.3	10.3	10.2	10.2	10.1	10.1

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	10.7 %	0.2 %	2,435	22,832
2013	10.4 %	0.2 %	2,327	22,350
2012	10.5 %	0.2 %	2,403	22,934
2011	10.6 %	0.2 %	2,352	22,269
2010	11.6 %	0.2 %	2,684	23,164
2009	12.0 %	0.2 %	2,849	23,705

Legends:
 Indicator has a numerator <10 and is not reportable
 Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 14 - B) Percent of children who live in households where someone smokes

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	20.2	20.1	20.0	20.0	19.9	19.9

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	20.5 %	1.5 %	86,922	424,373
2007	21.5 %	1.3 %	88,003	409,285
2003	23.7 %	1.2 %	74,929	315,647

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

Form 10a
State Performance Measures (SPMs)
State: Idaho

SPM 1 - Immunizations: Percent of children at kindergarten enrollment who are adequately immunized.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	85.6	85.7	85.7	85.7	85.8

Field Level Notes for Form 10a SPMs:

None

SPM 2 - Medical Specialist Access: Percent of children with special health care needs who needed or received specialist care in the past 12 months, and experienced some problem accessing care.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	15.4	15.4	15.3	15.3	15.2

Field Level Notes for Form 10a SPMs:

None

SPM 3 - Injury Prevention: Unintentional death rate to children under 5 years of age

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	13.2	13.0	12.8	12.6	12.4

Field Level Notes for Form 10a SPMs:

1. **Field Name:** 2017
Field Note:
Annual objective reflects a the average rate of the previous 3 years per 100,000 children as the annual values can be very volatile due to relatively small population of Idaho.

2. **Field Name:** 2021
Field Note:
Annual objective reflects a the average rate of the previous 3 years per 100,000 children as the annual values can be very volatile due to relatively small population of Idaho.

Form 10a
Evidence-Based or-Informed Strategy Measures (ESMs)

State: Idaho

ESM 1.1 - Host meetings with the WIC Program, MIECHV Program, and the Family Planning Program to raise awareness of, disseminate information about, encourage enhanced tracking of, and develop coordinated referral strategies related to routine care for women

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	4.0	4.0	4.0	4.0	4.0

Field Level Notes for Form 10a ESMs:

None

ESM 4.1 - Through collaboration with the MIECHV program and the WIC program, host a breastfeeding education and support training to home visitors across the state.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	25.0	25.0	25.0	25.0	25.0

Field Level Notes for Form 10a ESMs:

None

ESM 5.1 - Through CoIIN Infant Mortality efforts, provide safe sleep practice education to health care providers.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	30.0	30.0	30.0	30.0	30.0

Field Level Notes for Form 10a ESMs:

None

ESM 5.2 - Through CoIIN Infant Mortality efforts, support hospital certification through the Cribs for Kids Safe Sleep Hospital Certification Program

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2.0	4.0	6.0	8.0	10.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.1 - For clinics participating in the shared medical home coordinator model, support quality improvement activities to address overweight and obesity among pediatric patients.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	90.0	95.0	95.0	100.0	100.0

Field Level Notes for Form 10a ESMs:

None

ESM 10.1 - Through collaboration with the Adolescent Pregnancy Prevention Program (APP), assess awareness of and the reasons why adolescents do not seek well-visit preventive care.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	No	No	No	No

Field Level Notes for Form 10a ESMs:

None

ESM 11.1 - Fund and support the shared medical home coordinator model at the local level to improve quality of care for CYSHCN in rural areas and support clinic transition to the medical home model of care.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	35.0	45.0	50.0	55.0	60.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.1 - Host a statewide learning collaborative for pediatric and family practice clinics focused on practice improvement and care delivery related to pediatric oral health.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	30.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.2 - Fund the Idaho Oral Health Program to provide dental sealants, apply fluoride varnish, offer oral health education, and refer elementary school students to dental homes.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	3,500.0	3,525.0	3,550.0	3,575.0	3,600.0

Field Level Notes for Form 10a ESMs:

None

ESM 14.1 - Through CoIIN Infant Mortality efforts, increase referrals to smoking cessation services for pregnant women.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	25.0	30.0	35.0	40.0	45.0

Field Level Notes for Form 10a ESMs:

None

ESM 14.2 - Through CoIIN Infant Mortality efforts, increase referrals to smoking cessation services for women of reproductive age.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	500.0	525.0	550.0	575.0	580.0

Field Level Notes for Form 10a ESMs:

None

Form 10b
State Performance Measure (SPM) Detail Sheets

State: Idaho

SPM 1 - Immunizations: Percent of children at kindergarten enrollment who are adequately immunized.

Population Domain(s) – Child Health

Goal:	Increase the percentage of children at kindergarten enrollment who meet state immunization requirements.									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of children at kindergarten enrollment who are adequately immunized</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Number of children who enroll for kindergarten</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>100</td> </tr> </table>		Numerator:	Number of children at kindergarten enrollment who are adequately immunized	Denominator:	Number of children who enroll for kindergarten	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of children at kindergarten enrollment who are adequately immunized									
Denominator:	Number of children who enroll for kindergarten									
Unit Type:	Percentage									
Unit Number:	100									
Healthy People 2020 Objective:	<ul style="list-style-type: none"> • IID-7 Achieve and maintain effective vaccination coverage levels for universally recommended vaccines among young children • IID-1 Reduce, eliminate, or maintain elimination of cases of vaccine-preventable diseases • IID-17 Universal vaccination state - Allotment for uninsured. They will get vaccinated at no cost. 									
Data Sources and Data Issues:	<p>Idaho Immunization Program</p> <p>Data Notes: The adequately immunized definition is based upon immunization recommendations for a given birth cohort at the time of kindergarten enrollment. Immunization recommendations include age-appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B, Varicella and Hepatitis A. This definition excludes exemptions and conditional admittance. At 6.5%, Idaho had the highest exemption rate in the nation for the 2014/2015 school year.</p>									
Significance:	<p>According to the Centers for Disease Control and Prevention, providing vaccinations is one of the most effective methods for protecting children against serious and potentially fatal conditions. The 2015 National Immunization Survey revealed that only 65.9% of Idaho children aged 19-35 months had received the recommended vaccinations compared with 71.6% of children nationally (CDC, 2015). Further, only 85.9% of children at kindergarten enrollment met state immunization requirements (Idaho Immunization Program, 2015). The MCH Program determined that using vaccine coverage at Kindergarten enrollment is the best measure for this domain because the state requires children receive certain vaccinations at school entry. Even if a child did not receive the appropriate vaccinations at a younger age, they can still catch up on the immunization schedule. 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.</p>									

SPM 2 - Medical Specialist Access: Percent of children with special health care needs who needed or received specialist care in the past 12 months, and experienced some problem accessing care.

Population Domain(s) – Children with Special Health Care Needs

Goal:	Decrease the percent of children with special health care needs who needed or received specialist care in the past 12 months, and experienced some problem accessing care.									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of families who reported some problem getting specialist care for a child aged 0 to 17 who needed care from a specialist doctor during the past 12 months</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Number of families who reported a child aged 0 to 17 needed care from a specialist doctor during the past 12 months.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>100</td> </tr> </table>		Numerator:	Number of families who reported some problem getting specialist care for a child aged 0 to 17 who needed care from a specialist doctor during the past 12 months	Denominator:	Number of families who reported a child aged 0 to 17 needed care from a specialist doctor during the past 12 months.	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of families who reported some problem getting specialist care for a child aged 0 to 17 who needed care from a specialist doctor during the past 12 months									
Denominator:	Number of families who reported a child aged 0 to 17 needed care from a specialist doctor during the past 12 months.									
Unit Type:	Percentage									
Unit Number:	100									
Healthy People 2020 Objective:	<p>AHS-6.2 Reduce the proportion of persons who are unable to obtain or delay obtaining necessary medical care</p> <p>MICH-31 Increase the proportion of children aged 0 to 11 years with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems.</p>									
Data Sources and Data Issues:	<p>National Survey of Children's Health - www.childhealthdata.org</p> <p>As a national data source, only state-level data are available and will not provide geographic breakdowns within the state.</p>									
Significance:	<p>The 2015 Maternal and Child Health Needs Assessment determined that improving access to medical specialists for CYSHCN was a priority need. This concern about access has remained a priority since the last five-year reporting cycle (2011-2015). Pediatric specialists are proportionally inaccessible or unavailable in the majority of counties in Idaho. Data were obtained from the Idaho Medical Association to identify shortage areas for pediatric medical specialists. A total of 27 pediatric specialties were identified; only 17 of the specialties identified are available in Idaho and 10 of them are only offered in one county. Further data analysis revealed:</p> <ul style="list-style-type: none"> • Only 10 of the 44 counties in Idaho have any pediatric specialists • Only 17 of the 27 pediatric specialties are available in the state • Of the 17 specialties that are practiced in the state, 10 of them are only offered in a single county <p>To impact this measure, the MCH Program will continue to fund specialty clinics around the state, partner with out-of-state specialty physicians to bring them to Idaho for clinics, work with the Public Health Districts and hospitals to assess specialist needs, pay for medical travel for children enrolled in the Children's Special Health Program to access medical specialists not offered in the state, and link newborns to specialist care through the Newborn Screening Program.</p>									

SPM 3 - Injury Prevention: Unintentional death rate to children under 5 years of age
Population Domain(s) – Perinatal/Infant Health

Goal:	Reduce the unintentional death rate to children under 5 years of age.									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of fatalities due to unintentional injuries to children under 5 years of age (3-Year Aggregate)</td> </tr> <tr> <td>Denominator:</td> <td>Number of children under 5 years of age (3-Year Aggregate)</td> </tr> <tr> <td>Unit Type:</td> <td>Rate</td> </tr> <tr> <td>Unit Number:</td> <td>100,000</td> </tr> </table>		Numerator:	Number of fatalities due to unintentional injuries to children under 5 years of age (3-Year Aggregate)	Denominator:	Number of children under 5 years of age (3-Year Aggregate)	Unit Type:	Rate	Unit Number:	100,000
Numerator:	Number of fatalities due to unintentional injuries to children under 5 years of age (3-Year Aggregate)									
Denominator:	Number of children under 5 years of age (3-Year Aggregate)									
Unit Type:	Rate									
Unit Number:	100,000									
Healthy People 2020 Objective:	<p>IVP-1 Reduce fatal and nonfatal injuries</p> <p>MICH 1.5 Reduce the rate of post-neonatal deaths (between 28 days and 1 year)</p> <p>MICH-1.9 Reduce the rate of infant deaths from sudden unexpected infant deaths (includes SIDS, unknown cause, accidental suffocation, and strangulation in bed)</p> <p>MICH-3.1 Reduce the rate of deaths among children 1 to 4 years</p>									
Data Sources and Data Issues:	<p>Idaho Vital Statistics</p> <p>Data Notes: The MCH Program will aggregate three years of mortality data to determine the unintentional death rate to children under 5 years of age. Three-year aggregate data will be used to control for volatility of the annual rate, knowing that cases can fluctuate from year to year.</p>									
Significance:	<p>During the needs assessment process, injury prevention was a reoccurring theme, which was ultimately combined with healthy parenting, to create the priority need of supporting services, programs, and activities that promote safe and healthy family functioning. In the FY 2016 Application/FY 2014 Annual Report, selection of “NPM 7: Injury Prevention” was considered but disregarded because Idaho does not have hospital admission/discharge data and is not included in the State Inpatient Databases (SID), which is the national data source for the NPM. The state did not want to abandon focus on injury prevention, so the State Performance Measure was developed to address injury prevention using fatality data. Specifically, the state will use the measure of the rate of fatalities due to unintentional injuries per 100,000 children under 5 years of age. According to the Children’s Safety Network National Injury and Violence Prevention Resource Center, unintentional injury was the leading cause of death for young children aged 1 to 4 years in the state from 2008-2012 (2015 Idaho State Fact Sheet). Further, the number one cause of death and disabilities to children is injuries (AMCHP, 2009). This comes at an expense of \$50 billion to the United States in the form of medical costs and lost productivity. For these reasons, it is essential that injury prevention efforts are enforced and effective (AMCHP, 2009). Idaho’s MCH program’s efforts such as infant mortality surveillance, safe sleep campaigns, home visiting, and poison control efforts have all been shown to be effective in preventing unintentional injuries.</p>									

Form 10b
State Outcome Measure (SOM) Detail Sheets

State: Idaho

No State Outcome Measures were created by the State.

Form 10c
Evidence-Based or –Informed Strategy Measure (ESM) Detail Sheets

State: Idaho

ESM 1.1 - Host meetings with the WIC Program, MIECHV Program, and the Family Planning Program to raise awareness of, disseminate information about, encourage enhanced tracking of, and develop coordinated referral strategies related to routine care for women

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

Goal:	The MCH Program aims to host at least 4 meetings between the WIC, MIECHV, and Family Planning Programs to raise awareness of, disseminate information about, encourage enhanced tracking of, and develop coordinated referral strategies for routine care.									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of meetings hosted in past 12 months between the MCH, WIC, MIECHV, and Family Planning Programs to discuss routine care for women.</td> </tr> <tr> <td>Denominator:</td> <td>Number of meetings hosted in past 12 months between the MCH, WIC, MIECHV, and Family Planning Programs to discuss routine care for women.</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>12</td> </tr> </table>	Numerator:	Number of meetings hosted in past 12 months between the MCH, WIC, MIECHV, and Family Planning Programs to discuss routine care for women.	Denominator:	Number of meetings hosted in past 12 months between the MCH, WIC, MIECHV, and Family Planning Programs to discuss routine care for women.	Unit Type:	Count	Unit Number:	12	
Numerator:	Number of meetings hosted in past 12 months between the MCH, WIC, MIECHV, and Family Planning Programs to discuss routine care for women.									
Denominator:	Number of meetings hosted in past 12 months between the MCH, WIC, MIECHV, and Family Planning Programs to discuss routine care for women.									
Unit Type:	Count									
Unit Number:	12									
Data Sources and Data Issues:	The MCH leadership team and BSU evaluation team will track the number of collaboration meetings. Agendas will be developed and minutes will document the meeting content.									
Significance:	Currently, Idaho's Supplemental Nutrition Program for Women, Infants, and Children (WIC), Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, and the Family Planning Program provide some degree of education about and referral to prenatal care for pregnant women. However, these programs provide information, offer referrals, and collect data with varying consistency. Research shows that building and strengthening partnerships between Title V MCH programs and other state and community-based agencies is one strategy to link women with comprehensive preconception, prenatal, and interconception care. The MCH Program intends to host at least 4 meetings between the WIC, MIECHV, and Family Planning Programs to raise awareness of, disseminate information about, encourage enhanced tracking of, and develop coordinated referral strategies for routine care. It is anticipated that the information gleaned from these meetings will help inform future MCH strategies to increase utilization of prenatal and preventive woman care and these strategies will be implemented in coming years.									

ESM 4.1 - Through collaboration with the MIECHV program and the WIC program, host a breastfeeding education and support training to home visitors across the state.

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

Goal:	The MCH Program, in collaboration with the MIECHV and WIC Programs, will fund and host one meeting for home visitors focused on evidence-based strategies for providing breastfeeding education and support to new mothers.									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of home visitors who received education about best-practices for supporting breastfeeding among new mothers</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Number of home visitors who received education about best-practices for supporting breastfeeding among new mothers</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>100</td> </tr> </table>		Numerator:	Number of home visitors who received education about best-practices for supporting breastfeeding among new mothers	Denominator:	Number of home visitors who received education about best-practices for supporting breastfeeding among new mothers	Unit Type:	Count	Unit Number:	100
Numerator:	Number of home visitors who received education about best-practices for supporting breastfeeding among new mothers									
Denominator:	Number of home visitors who received education about best-practices for supporting breastfeeding among new mothers									
Unit Type:	Count									
Unit Number:	100									
Data Sources and Data Issues:	The MCH leadership team and BSU evaluation team will collect the number of home visitors who participated in the training. Attendance will be based on sign-in sheets or online logins (if the training is hosted remotely).									
Significance:	<p>According to the Centers for Disease Control's 2014 Breastfeeding Report Card, 84.4% of Idaho infants are reported to have ever been breastfed, yet only 24.8% are reported to have been exclusively breastfed through 6 months. The MIECHV program currently serves pregnant women and new mothers. According to the Association of Maternal and Child Health Programs, other states have realized success in increasing breastfeeding duration rates in home visiting programs when home visitors are trained on best practices for supporting breastfeeding moms. Other research (Hannula et al., 2008 and Oliveira et al., 2001) shows that home visits during the postnatal period were effective for addressing mothers' concerns about breastfeeding, providing education, linking them with community resources, and involving other family members. For FY2017, the Idaho MCH Program plans on collaborating with the MIECHV Program to fund training for home visitors, which will be facilitated by WIC staff, on breastfeeding education, how to answer mother's questions regarding breastfeeding, how to encourage fathers to support breastfeeding, and how to link families with community resources.</p>									

**ESM 5.1 - Through ColIN Infant Mortality efforts, provide safe sleep practice education to health care providers.
NPM 5 – Percent of infants placed to sleep on their backs**

Goal:	Increase the number of health care providers trained in safe sleep practices in order to reduce infant sleep-related deaths by improving safe sleep practices among parents.									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of health care providers who participated in safe sleep training</td> </tr> <tr> <td>Denominator:</td> <td>Number of health care providers who participated in safe sleep training</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>500</td> </tr> </table>	Numerator:	Number of health care providers who participated in safe sleep training	Denominator:	Number of health care providers who participated in safe sleep training	Unit Type:	Count	Unit Number:	500	
Numerator:	Number of health care providers who participated in safe sleep training									
Denominator:	Number of health care providers who participated in safe sleep training									
Unit Type:	Count									
Unit Number:	500									
Data Sources and Data Issues:	ColIN Infant Mortality Data:									
Significance:	<p>Approximately 3,500 infants die of sudden unexpected infant deaths (SUID) in the U.S. each year. Twelve fatalities occurred as a result of SUIDs in Idaho in 2012 (Idaho Child Fatality Review Team, 2015). Most SUIDs cases occur while the infant is sleeping in an unsafe sleep environment. SUIDs deaths include Sudden Infant Death Syndrome (SIDS), defined as death in an infant less than 1-year old that cannot be explained even after a thorough investigation, unknown causes, accidental suffocation, and strangulation in bed. Accidental suffocation can be caused by soft bedding, bed sharing with another person, and when an infant becomes wedged between a mattress and a wall or bed frame. Infant strangulation can occur when an infant’s head and neck become wedged in between crib railings or becomes caught in bedding or a blanket (CDC, 2016).</p> <p>The objectives of safe sleep programs are to improve parental education regarding the sleep safety of their infants in order to reduce incidences of SUIDs. Successful methods for improving parent safe sleep knowledge range from hospital staff education to crib distribution programs. Such efforts have been shown to increase parental knowledge, reduce bed-sharing rates, increase supine sleeping rates, and decrease incidences of SIDS. Thus, increasing the number of health care professionals receiving the safe sleep training will increase the number of parents educated about sleep safety and should help decrease the incidence of SUIDs in Idaho.</p>									

ESM 5.2 - Through CoIIN Infant Mortality efforts, support hospital certification through the Cribs for Kids Safe Sleep Hospital Certification Program

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

Goal:	Increase the number of birthing hospitals in the state certified through the Cribs for Kids Safe Sleep Hospital Certification Program in order to reduce infant sleep-related deaths by improving safe sleep practices.									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of birthing hospitals that were certified through the Cribs for Kids Safe Sleep Hospital Certification Program</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Number of birthing hospitals that were certified through the Cribs for Kids Safe Sleep Hospital Certification Program</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>50</td> </tr> </table>		Numerator:	Number of birthing hospitals that were certified through the Cribs for Kids Safe Sleep Hospital Certification Program	Denominator:	Number of birthing hospitals that were certified through the Cribs for Kids Safe Sleep Hospital Certification Program	Unit Type:	Count	Unit Number:	50
Numerator:	Number of birthing hospitals that were certified through the Cribs for Kids Safe Sleep Hospital Certification Program									
Denominator:	Number of birthing hospitals that were certified through the Cribs for Kids Safe Sleep Hospital Certification Program									
Unit Type:	Count									
Unit Number:	50									
Data Sources and Data Issues:	CoIIN Infant Mortality Data – Hospital certification data will be collected and reported to the MCH Program by Inland Northwest SIDS Foundation, which is the Cribs for Kids affiliate that guides hospitals through the certification process.									
Significance:	<p>Approximately 3,500 infants die of sudden unexpected infant deaths (SUID) in the U.S. each year. Twelve fatalities occurred as a result of SUIDs in Idaho in 2012 (Idaho Child Fatality Review Team, 2015). Most SUIDs cases occur while the infant is sleeping in an unsafe sleep environment. SUIDs deaths include Sudden Infant Death Syndrome (SIDS), defined as death in an infant less than 1-year old that cannot be explained even after a thorough investigation, unknown causes, accidental suffocation, and strangulation in bed. Accidental suffocation can be caused by soft bedding, bed sharing with another person, and when an infant becomes wedged between a mattress and a wall or bed frame. Infant strangulation can occur when an infant’s head and neck become wedged in between crib railings or becomes caught in bedding or a blanket (CDC, 2016).</p> <p>The objectives of safe sleep programs are to improve parental education regarding the sleep safety of their infants in order to reduce incidences of SUIDs. Successful methods for improving parent safe sleep knowledge range from hospital staff education to crib distribution programs. Such efforts have been shown to increase parental knowledge, reduce bed-sharing rates, increase supine sleeping rates, and decrease incidences of SIDS. Thus, increasing the number of hospitals who implement safe sleep policies and provide training and education to staff and parents will increase the number of parents educated about sleep safety and should help decrease the incidence of SUIDs in Idaho.</p>									

ESM 8.1 - For clinics participating in the shared medical home coordinator model, support quality improvement activities to address overweight and obesity among pediatric patients.

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

Goal:	For clinics addressing overweight/obesity in the medical home demonstration, increase the percent of pediatric patients identified as being overweight/obese who were counseled on healthy eating and physical activity from the baseline of the project.									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of pediatric patients identified as overweight/obese who received counseling on healthy eating and physical activity</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Number of pediatric patients identified as overweight/obese</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>100</td> </tr> </table>		Numerator:	Number of pediatric patients identified as overweight/obese who received counseling on healthy eating and physical activity	Denominator:	Number of pediatric patients identified as overweight/obese	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of pediatric patients identified as overweight/obese who received counseling on healthy eating and physical activity									
Denominator:	Number of pediatric patients identified as overweight/obese									
Unit Type:	Percentage									
Unit Number:	100									
Data Sources and Data Issues:	Eastern Idaho Public Health District Data collected will be based on clinic registries and will involve a small number of pediatric patients from one or two clinics.									
Significance:	<p>According to 2011/2012 National Survey of Children’s Health data, Idaho children fare better than children nationally for maintaining a healthy weight. About 28% of Idaho children were considered overweight or obese (based on BMI) compared with 31% of children nationally. For FY 2017, the MCH Program intends to address overweight and obesity among children via the medical home demonstration for CYSHCN. A medical home coordinator (MHC) works out of the health district to partner with up to three pediatric or primary care clinics in the area to support transformation to a patient-centered medical home. One of the medical clinics participating in the demonstration has elected to address obesity among all of their pediatric patients. The shared medical home coordinator will assist the clinic with quality improvement activities to address obesity and help ensure that families receive educational tools and counseling.</p> <p>Through a learning collaborative that was held in the state in 2014/2015 by the Children’s Healthcare Improvement Collaborative (CHIC) Project, there is evidence that suggests quality improvement support from a MHC is an effective strategy for assessing, treating, educating, and linking patients to resources. At the beginning of the project, the medical home coordinator will document the percentage of pediatric patients who were overweight or obese and received appropriate education/counseling via chart review. This data will establish a baseline. The medical home coordinator will support the clinic for 12 months to improve processes to increase the number of overweight/obese patients that receive education/counseling.</p>									

ESM 10.1 - Through collaboration with the Adolescent Pregnancy Prevention Program (APP), assess awareness of and the reasons why adolescents do not seek well-visit preventive care.

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

Goal:	Use information gleaned from adolescents participating in the Reducing the Risk assessment to determine knowledge of and barriers to adolescent well-visits to inform future strategies to improve utilization of well-visit care among adolescents								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Conduct assessment of adolescents' awareness and utilization of well-visit care, as well as barriers to receipt of care</td> </tr> <tr> <td>Denominator:</td> <td>Conduct assessment of adolescents' awareness and utilization of well-visit care, as well as barriers to receipt of care</td> </tr> <tr> <td>Unit Type:</td> <td>Text</td> </tr> <tr> <td>Unit Number:</td> <td>Yes/No</td> </tr> </table>	Numerator:	Conduct assessment of adolescents' awareness and utilization of well-visit care, as well as barriers to receipt of care	Denominator:	Conduct assessment of adolescents' awareness and utilization of well-visit care, as well as barriers to receipt of care	Unit Type:	Text	Unit Number:	Yes/No
Numerator:	Conduct assessment of adolescents' awareness and utilization of well-visit care, as well as barriers to receipt of care								
Denominator:	Conduct assessment of adolescents' awareness and utilization of well-visit care, as well as barriers to receipt of care								
Unit Type:	Text								
Unit Number:	Yes/No								
Data Sources and Data Issues:	<p>The Adolescent Pregnancy Prevention Program. Data will be collected on a quarterly basis from each site implementing the Reducing the Risk curriculum.</p> <p>The data are self-reported and adolescents may not fully understand the difference between well-visits and sports physical exams, immunization visits, and other medical visits.</p>								
Significance:	<p>According to 2011/2012 National Survey of Children's Health data, Idaho children are lagging behind children nationally for receiving a preventive well-visit in the past year—only 73% of Idaho children had received a well-visit compared with 84% of children nationally. Further, less than one-third (31.7%) of Medicaid and CHIP insured adolescents in Idaho had received at least one well care visit in the past year (HHS, 2014).</p> <p>For FY 2017, to understand the barriers to seeking or receiving care among adolescents, the MCH Program has collaborated with the state's Title V Adolescent Health Coordinator and the Adolescent Pregnancy Prevention (APP) Program to assess awareness of and the reasons why adolescents do or do not seek routine preventive care. 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 (RTR) 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 RTR curriculum is delivered in all seven health districts by coordinators across 15 sites. As part of the RTR class, a participant survey is administered at the beginning and end of the course. The MCH Program will develop and add questions to the survey to assess awareness and barriers. The team will measure this strategy by determining whether or not the assessment was conducted. Based on the results of the survey, the MCH Program will develop evidence-based strategies to address identified barriers and raise awareness for adolescent well-visits. According to the Centers for Medicare and Medicaid Services (2014), offering resources, training, and incentives to adolescents and families to encourage preventive care is a proven strategy for promoting adolescent well-visits.</p>								

ESM 11.1 - Fund and support the shared medical home coordinator model at the local level to improve quality of care for CYSHCN in rural areas and support clinic transition to the medical home model of care.

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

Goal:	Support the medical home demonstration to improve quality of care for CYSHCN in rural areas and support clinic transition to the medical home model of care with goals of improved experience of care, enhanced health of populations, and reduced costs.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of children on clinic registries who were identified as having special needs</td> </tr> <tr> <td>Denominator:</td> <td>Number of children on clinic registries who were identified as having special needs</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>500</td> </tr> </table>	Numerator:	Number of children on clinic registries who were identified as having special needs	Denominator:	Number of children on clinic registries who were identified as having special needs	Unit Type:	Count	Unit Number:	500
Numerator:	Number of children on clinic registries who were identified as having special needs								
Denominator:	Number of children on clinic registries who were identified as having special needs								
Unit Type:	Count								
Unit Number:	500								
Data Sources and Data Issues:	<p>Eastern Idaho Public Health District</p> <p>Each clinic defines their special needs population by identifying two diagnoses (in addition to adolescent depression) to be included on their patient registry. Diagnoses vary from clinic to clinic and do not encompass all children with special needs in the clinics.</p>								
Significance:	<p>According to the 2009/2010 National Survey of CSHCN, Idaho CYSHCN fared the same as their peers when it came to receiving care within a medical home (42.9% compared with 43.0%, respectively). The American Academy of Pediatrics promotes the application of the medical home approach for all children, and specifically for CYSHCN (AAP, 2012).</p> <p>To enhance quality of care for CYSHCN, the MCH Program intends to leverage the success of the existing medical home demonstration for CYSHCN. The model involves a shared medical home coordinator (MHC) approach. The MHC works out of the health district to partner with up to three pediatric or primary care clinics in the area to support transformation to a patient-centered medical home. The MHC helps with educating practices on quality improvement strategies and identifying patient populations. 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 and creating care plans to help manage each child's condition in a patient-centered way.</p> <p>The demonstration is underway in one health district in eastern Idaho. The MHC is working with two clinics—one with a large suburban pediatric population, and another with a small rural population. The clinics identify their special needs patients using patient registries and implement quality improvement approaches with the help of the MHC to enhance their care quality. The patient registries are a population health management tool that tracks data for patients with certain conditions and can help improve care delivery and health outcomes. Research has shown that utilizing a MHC resulted in increased patient-centered care, improved patient population management, and increased providers and family satisfaction.</p>								

ESM 13.1 - Host a statewide learning collaborative for pediatric and family practice clinics focused on practice improvement and care delivery related to pediatric oral health.

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

Goal:	Improve the integration of oral health into primary medical care. Educating health care providers about oral health and introducing oral health assessments will help with integration efforts.									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of clinics participating in the pediatric oral health learning collaborative</td> </tr> <tr> <td>Denominator:</td> <td>Number of clinics participating in the pediatric oral health learning collaborative</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of clinics participating in the pediatric oral health learning collaborative	Denominator:	Number of clinics participating in the pediatric oral health learning collaborative	Unit Type:	Count	Unit Number:	100	
Numerator:	Number of clinics participating in the pediatric oral health learning collaborative									
Denominator:	Number of clinics participating in the pediatric oral health learning collaborative									
Unit Type:	Count									
Unit Number:	100									
Data Sources and Data Issues:	Idaho Health and Wellness Collaborative for Children									
Significance:	<p>Oral health is increasingly recognized as having overall health implications. Research has shown a link to diabetes, heart and lung disease, stroke, respiratory illnesses, and pre-term, low-birth weight infants. Childhood dental disease sets the stage for a lifetime of poor oral health and puts a financial burden on the family. Approximately 19% of Idaho children under the age of 18 experienced a toothache, decayed teeth, or unfilled cavities in the past 12 months, and approximately 20% did not receive any dental care in the past 12 months. Ninety-seven percent of Idaho is designated as a dental health professional shortage area. Because of this lack of access to dental care, it is imperative that oral health be assessed in the primary care health setting.</p> <p>In FY 2016/2017, the MCH Program will partner with IHAWCC to host a learning collaborative focused on practice improvement and care delivery related to pediatric oral health care. According to IHAWCC, a learning collaborative is “an opportunity for healthcare providers and practices to participate in a structured quality improvement process to raise the quality of care they deliver.” Qualis Health (2012) indicated that medical providers must understand the impact of poor oral health on overall health status, and ideally, primary care medical providers need to be trained to conduct oral health screenings, provide education, and apply fluoride varnish during well-visits. Practices participating in the learning collaborative would be encouraged to either provide fluoride varnish at well-child visits or conduct a brief screening and make a referral to a dental provider, increase documentation in the electronic medical record (EMR) system, and make and follow-up appointments when appropriate.</p>									

ESM 13.2 - Fund the Idaho Oral Health Program to provide dental sealants, apply fluoride varnish, offer oral health education, and refer elementary school students to dental homes.

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

Goal:	Increase the number of children who receive dental sealants as a method to reduce dental caries.									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of dental sealants applied in school-based settings through the Idaho Oral Health Program</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Number of dental sealants applied in school-based settings through the Idaho Oral Health Program</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>5,000</td> </tr> </table>		Numerator:	Number of dental sealants applied in school-based settings through the Idaho Oral Health Program	Denominator:	Number of dental sealants applied in school-based settings through the Idaho Oral Health Program	Unit Type:	Count	Unit Number:	5,000
Numerator:	Number of dental sealants applied in school-based settings through the Idaho Oral Health Program									
Denominator:	Number of dental sealants applied in school-based settings through the Idaho Oral Health Program									
Unit Type:	Count									
Unit Number:	5,000									
Data Sources and Data Issues:	Idaho Oral Health Program									
Significance:	<p>Oral health is increasingly recognized as having overall health implications. Research has shown a link to diabetes, heart and lung disease, stroke, respiratory illnesses, and pre-term, low-birth weight infants. Childhood dental disease sets the stage for a lifetime of poor oral health and puts a financial burden on the family. Approximately 19% of Idaho children under the age of 18 experienced a toothache, decayed teeth, or unfilled cavities in the past 12 months, and approximately 20% did not receive any dental care in the past 12 months. Ninety-seven percent of Idaho is designated as a dental health professional shortage area. Because of this lack of access to dental care, it is imperative that the Idaho Oral Health Program continue focus on preventive dental care for children.</p> <p>To address the priority need to improve MCH population access to medical homes and linkage to dental care, the MCH Program will continue to fund the Idaho Oral Health Program’s contracts with the Public Health Districts (PHDs) for dental care among school-age children. In 2014, 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. According to the Centers for Disease Control and Prevention (2015), dental sealants are a critical preventive dental service and can reduce decay by 60 to 80 percent in two years after application. Further, school-based dental sealant programs are a great way to reach children and result in cost-savings for families. All seven PHDs in Idaho provide dental sealants to elementary school children through School-Based/Linked Dental Sealant Clinics and two annual events focused on the education and application of dental sealants. Along with providing dental sealants, the PHDs also provided oral health screenings, fluoride varnish applications, oral health education, and dental home referrals as needed.</p>									

ESM 14.1 - Through CoIIN Infant Mortality efforts, increase referrals to smoking cessation services for pregnant women.

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

Goal:	Increase utilization of the Idaho Quitline among pregnant women and thereby increase the percentage of pregnant women who have attempted to quit smoking in the past 12 months									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of pregnant women who called the Quitline</td> </tr> <tr> <td>Denominator:</td> <td>Number of pregnant women who called the Quitline</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>2,000</td> </tr> </table>		Numerator:	Number of pregnant women who called the Quitline	Denominator:	Number of pregnant women who called the Quitline	Unit Type:	Count	Unit Number:	2,000
Numerator:	Number of pregnant women who called the Quitline									
Denominator:	Number of pregnant women who called the Quitline									
Unit Type:	Count									
Unit Number:	2,000									
Data Sources and Data Issues:	Idaho Quitline									
Significance:	<p>According to the Idaho PRATS, 5.5% of mothers who gave birth in 2014 smoked cigarettes during their last trimester of pregnancy. According to the Idaho BRFSS, 15% of Idaho women were smokers in 2013. To address the priority need of decreasing substance abuse, specifically tobacco use, 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. In an effort to increase referrals to tobacco cessation programs and/or nicotine replacement therapies (NRT), a pilot of two healthcare provider clinics is assessing the 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. Further, the Idaho Quitline is tracking calls for tobacco cessation counseling and referral for pregnant women and women aged 18 to 44. The Quitline promotes the use of NRT for these women, with a prescription from a doctor. Research (Dolan-Mullen, 1999; Crawford et al., 2008) showed that NRT was a promising smoking cessation strategy for pregnant women. Further, according to the Association of State and Territorial Health Officials (2013), offering pregnancy specific and postpartum Quitline services to women is a recommended strategy to improve smoking cessation. The MCH Program is focusing on quit attempts via calls to the Quitline rather than smoking cessation because research shows smokers experience high relapse rates and repeated quit attempts. In fact, smokers make between eight and 11 quit attempts, on average, before successfully quitting. For women who quit smoking during pregnancy, up to 75 to 80% resume smoking after delivery. Therefore, Quitline callers are on the path to quitting smoking, even if relapse occurs after the call.</p>									

ESM 14.2 - Through CoIIN Infant Mortality efforts, increase referrals to smoking cessation services for women of reproductive age.

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

Goal:	Increase usage of the Quitline among women aged 18 to 44 and thereby increase the percentage of women of reproductive age that have attempted to quit smoking in the past 12 months									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of women aged 18 to 44 who called the Quitline</td> </tr> <tr> <td>Denominator:</td> <td>Number of women aged 18 to 44 who called the Quitline</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>5,000</td> </tr> </table>		Numerator:	Number of women aged 18 to 44 who called the Quitline	Denominator:	Number of women aged 18 to 44 who called the Quitline	Unit Type:	Count	Unit Number:	5,000
Numerator:	Number of women aged 18 to 44 who called the Quitline									
Denominator:	Number of women aged 18 to 44 who called the Quitline									
Unit Type:	Count									
Unit Number:	5,000									
Data Sources and Data Issues:	Idaho Quitline									
Significance:	<p>According to the Idaho PRATS, 5.5% of mothers who gave birth in 2014 smoked cigarettes during their last trimester of pregnancy. According to the Idaho BRFSS, 15% of Idaho women were smokers in 2013. To address the priority need of decreasing substance abuse, specifically tobacco use, 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. In an effort to increase referrals to tobacco cessation programs and/or nicotine replacement therapies (NRT), a pilot of two healthcare provider clinics is assessing the 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. Further, the Idaho Quitline is tracking calls for tobacco cessation counseling and referral for pregnant women and women aged 18 to 44. The Quitline promotes the use of NRT for these women, with a prescription from a doctor. Research (Dolan-Mullen, 1999; Crawford et al., 2008) showed that NRT was a promising smoking cessation strategy for pregnant women. Further, according to the Association of State and Territorial Health Officials (2013), offering pregnancy specific and postpartum Quitline services to women is a recommended strategy to improve smoking cessation. The MCH Program is focusing on quit attempts via calls to the Quitline rather than smoking cessation because research shows smokers experience high relapse rates and repeated quit attempts. In fact, smokers make between eight and 11 quit attempts, on average, before successfully quitting. For women who quit smoking during pregnancy, up to 75 to 80% resume smoking after delivery. Therefore, Quitline callers are on the path to quitting smoking, even if relapse occurs after the call.</p>									

**Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)**

State: Idaho

Form Notes for Form 10d NPMs and SPMs

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
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	90.0	100.0
Numerator	18	19	19	18	28
Denominator	18	19	19	20	28
Data Source	Idaho Newborn Screening Program				
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

None

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)

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

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2015

Field Note:

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** 2014

Field Note:

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** 2013

Field Note:

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** 2012

Field Note:

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

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

5. **Field Name:** 2011

Field Note:

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

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

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)

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

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2015

Field Note:

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

2. **Field Name:** 2014

Field Note:

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

3. **Field Name:** 2013

Field Note:

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

4. **Field Name:** 2012

Field Note:

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

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

5. **Field Name:** 2011

Field Note:

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

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

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)

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

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2015

Field Note:

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** 2014

Field Note:

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** 2013

Field Note:

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** 2012

Field Note:

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

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

5. **Field Name:** 2011

Field Note:

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

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

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)

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

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2015

Field Note:

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

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

2. **Field Name:** 2014

Field Note:

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

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

3. **Field Name:** 2013

Field Note:

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

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

4. **Field Name:** 2012

Field Note:

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

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

5. **Field Name:** 2011

Field Note:

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

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

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
Annual Objective	46.0	47.0	47.0	49.0	49.0
Annual Indicator	46.6	46.6	46.6	46.6	46.6
Numerator					
Denominator					
Data Source	National Survey of CSHCNs 2010				
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2015

Field Note:

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

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

2. **Field Name:** 2014

Field Note:

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

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

3. **Field Name:** 2013

Field Note:

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

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

4. **Field Name:** **2012**

Field Note:

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

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

5. **Field Name:** **2011**

Field Note:

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

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

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
Annual Objective	75.0	75.0	75.0	75.0	75.0
Annual Indicator	68.8	64.5	64.5	70.2	65.9
Numerator					
Denominator					
Data Source	NIS	NIS	NIS	NIS	NIS
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

- Field Name:** 2015

Field Note:
FAD for Form 10a 22.1
- Field Name:** 2014

Field Note:
Based on 4:3:1:3*:3:1:4 rate.
- Field Name:** 2013

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

The percentages come from the National Immunization Survey. No numbers are given as to appropriate population numerator or denominator.
- Field Name:** 2012

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

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

Comparable data point in 2011 was 59.3.
- Field Name:** 2011

Field Note:

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

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

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

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	16.0	15.0	15.0	13.7	13.3
Annual Indicator	11.5	11.7	9.5	9.0	9.0
Numerator	385	391	322	311	311
Denominator	33,425	33,513	33,906	34,410	34,410
Data Source	Birth Certificate				
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2015

Field Note:

Due to out-of-state birth certificates not received as of date of entry 2014 values are used as estimate.

Data Alerts:

None

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

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

Field Level Notes for Form 10d NPMs:

-
1. **Field Name:** 2015
-
- Field Note:**
 The Idaho Smile Survey is conducted every four years conducted through out the school year. Data was collected during the 2012/2013 school year.
- Numerator and denominator not provided as the results would be from weighted survey data and imply artificial precision.
-
2. **Field Name:** 2014
-
- Field Note:**
 The Idaho Smile Survey is conducted every four years conducted through out the school year. Data was collected during the 2012/2013 school year.
- Numerator and denominator not provided as the results would be from weighted survey data and imply artificial precision.
-
3. **Field Name:** 2013
-
- Field Note:**
 The Idaho Smile Survey is conducted every four years conducted through out the school year. Data was collected during the 2012/2013 school year.
- Numerator and denominator not provided as the results would be from weighted survey data and imply artificial precision.
-
4. **Field Name:** 2012

Field Note:

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

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

5. **Field Name:** **2011**

Field Note:

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

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

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.

	2011	2012	2013	2014	2015
Annual Objective	4.3	4.0	3.9	3.0	2.9
Annual Indicator	2.2	2.2	4.2	6.1	5.3
Numerator	8	8	15	22	19
Denominator	359,046	357,402	357,803	360,071	360,071
Data Source	Death Certificate	Death Certificate	Death Certificate	Death Certificate	Department of Transportation
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2015

Field Note:

Death count preliminary total from Idaho Department of Transportation for 2015. IDT records usually reflect deaths at the scene of an accident and therefore will be lower than subsequent death certificate data.

2015 population data by age not available at time of entry, 2014 used as best estimate for denominator.

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

2. **Field Name:** 2014

Field Note:

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

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	52.2	53.0	53.0	55.1	55.2
Annual Indicator	53.0	57.1	57.1	61.7	62.1
Numerator					
Denominator					
Data Source	PRATS	PRATS	PRATS	PRATS	PRATS
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2015

Field Note:

Data source is the 2014 Idaho PRATS survey. Data for 2014 births is not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numerator and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision. Rate reported has approximately +/- 2 percent confidence limits from survey methodology.

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

2. **Field Name:** 2014

Field Note:

Data source is the 2013 Idaho PRATS survey. Data for 2014 births is not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numerator and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision. Rate reported has approximately +/- 2 percent confidence limits from survey methodology.

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

3. **Field Name:** 2013

Field Note:

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

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

4. **Field Name:** 2012

Field Note:

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

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

5. **Field Name:** 2011

Field Note:

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

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

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	98.8	99.6	99.6	99.3	99.3
Annual Indicator	99.4	99.3	99.1	99.3	99.8
Numerator	20,273	20,500	20,152		21,687
Denominator	20,397	20,650	20,337		21,731
Data Source	HiTrack	HiTrack	HiTrack	HiTrack	HiTrack
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2015

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

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

2. **Field Name:** 2014

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

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

3. **Field Name:** 2013

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

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

4. **Field Name:** 2012

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

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

5. **Field Name:** 2011

Field Note:

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

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

Data Alerts:

None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	10.0	9.0	9.0	9.0	9.0
Annual Indicator	9.0	11.3	10.0	10.8	6.3
Numerator	37,721	48,315	45,859	48,213	27,709
Denominator	417,962	427,360	456,430	448,259	438,646
Data Source	Current Population Survey				
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2015

Field Note:

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

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

2. **Field Name:** 2014

Field Note:

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

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

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

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

3. **Field Name:** 2013

Field Note:

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

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

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

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

4. **Field Name:** **2012**

Field Note:

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

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

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

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

5. **Field Name:** **2011**

Field Note:

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

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

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

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

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.

	2011	2012	2013	2014	2015
Annual Objective	29.5	29.4	28.9	28.8	28.8
Annual Indicator	29.4	28.9	28.1	28.4	28.0
Numerator	7,012	6,555	5,639	5,342	4,423
Denominator	23,828	22,716	20,060	18,843	15,785
Data Source	State WIC Data	State WIC Data	State WIC Database	State WIC Database	State WIC Database
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2015
	Field Note:	As of last certification visit per child within age group with valid height and weight measurement.
2.	Field Name:	2014
	Field Note:	As of last certification visit per child within age group with valid height and weight measurement.
3.	Field Name:	2013
	Field Note:	As of last certification visit per child within age group with valid height and weight measurement.
4.	Field Name:	2012
	Field Note:	As of last certification visit per child.

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	8.4	8.3	8.3	8.0	8.0
Annual Indicator	8.1	8.0	8.1	8.2	8.2
Numerator	1,804	1,838	1,812	1,878	1,878
Denominator	22,277	22,916	22,323	22,840	22,840
Data Source	Birth Certificate				
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2015

Field Note:

Due to out-of-state birth certificates not received as of date of entry 2014 values are used as estimate.

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	9.8	9.8	16.5	16.5	16.5
Annual Indicator	23.3	20.2	18.5	13.9	13.9
Numerator	27	23	21	16	16
Denominator	116,117	113,782	113,634	114,723	114,723
Data Source	Death Certificates	Death Certificate	Death Certificate	Death Certificate	Death Certificate
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2015
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Field Note:

2015 death records have not been finalized, 2014 deaths have been used as best estimate.

2015 population data by age not available at time of entry, 2014 used as best estimate

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	99.0	99.0	99.0	99.0	76.0
Annual Indicator	99.0	99.0	75.7	72.8	72.8
Numerator			165	147	147
Denominator			218	202	202
Data Source	No reliable data source	No reliable data source	Birth Certificate	Birth certificate	Birth certificate
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2015

Field Note:
 Births in Idaho at facilities with NICU class III or higher.

 Since birth records not finalized for 2015 at this time, 2014 is used as best estimate.

2. **Field Name:** 2014

Field Note:
 Births in Idaho at facilities with NICU class III or higher.

3. **Field Name:** 2013

Field Note:
 Births in Idaho at facilities with NICU class III or higher.

4. **Field Name:** 2012

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

5. **Field Name:** 2011

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

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	73.2	73.6	75.0	75.0	75.0
Annual Indicator	74.4	73.9	73.3	74.2	74.2
Numerator	16,529	16,884	16,309	16,907	16,907
Denominator	22,206	22,841	22,242	22,784	22,784
Data Source	Birth Certificate				
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2015

Field Note:

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

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

Due to out-of-state birth certificates not received as of date of entry 2014 values are used as estimate.

2. **Field Name:** 2014

Field Note:

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

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

3. **Field Name:** 2013

Field Note:

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

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

4. **Field Name:** 2012

Field Note:

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

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

5. **Field Name:** 2011

Field Note:

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

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

Data Alerts:

None

Form 10d
State Performance Measures (SPMs) (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	37.3
Numerator					
Denominator					
Data Source	YRBS	YRBS	YRBS	YRBS	YRBS
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** 2015

Field Note:

Results from: RESULTS OF THE 2015 IDAHO YOUTH RISK BEHAVIOR SURVEY , Numerator and denominator not available. Latest data available.

2. **Field Name:** 2014

Field Note:

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

3. **Field Name:** 2013

Field Note:

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

4. **Field Name:** 2012

Field Note:

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

5. **Field Name:** 2011

Field Note:

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

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	55.6
Numerator					
Denominator					
Data Source	PRATS	PRATS	PRATS	PRATS	PRATS
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** 2015

Field Note:

Data source is the 2014 Idaho PRATS survey. Data for 2015 births is not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numerator and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision. Rate reported has approximately +/- 2 percent confidence limits from survey methodology.

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

2. **Field Name:** 2014

Field Note:

Data source is the 2013 Idaho PRATS survey. Data for 2014 births is not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numerator and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision.

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

3. **Field Name:** 2013

Field Note:

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

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

4. **Field Name:** 2012

Field Note:

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

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

5. **Field Name:** **2011**

Field Note:

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

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

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

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	26.4
Numerator					
Denominator					
Data Source	YRBS	YRBS	YRBS	YRBS	YRBS
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	Field Name:	2015
	Field Note:	Results from: RESULTS OF THE 2015 IDAHO YOUTH RISK BEHAVIOR SURVEY , Numerator and denominator not available. Latest data available.
2.	Field Name:	2014
	Field Note:	Results from: RESULTS OF THE 2013 IDAHO YOUTH RISK BEHAVIOR SURVEY , Numerator and denominator not available. Latest data available.
3.	Field Name:	2013
	Field Note:	Results from: RESULTS OF THE 2013 IDAHO YOUTH RISK BEHAVIOR SURVEY , Numerator and denominator not available. Latest data available.
4.	Field Name:	2012
	Field Note:	Results from: RESULTS OF THE 2011 IDAHO YOUTH RISK BEHAVIOR SURVEY , Numerator and denominator not available. Latest data available.
5.	Field Name:	2011
	Field Note:	Results from: RESULTS OF THE 2011 IDAHO YOUTH RISK BEHAVIOR SURVEY , Numerator and denominator not available. Latest data available.

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	48.6	48.3	48.3
Numerator	10,890	11,019	10,676	10,867	10,867
Denominator	21,909	22,538	21,947	22,514	22,514
Data Source	Birth Certificate				
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1. **Field Name:** 2015

Field Note:
Based on records where valid pre-pregnancy height and weight were recorded on birth certificates.

Due to out-of-state birth certificates not received as of date of entry, 2014 values are used as estimate.
2. **Field Name:** 2014

Field Note:
Based on records where valid pre-pregnancy height and weight were recorded on birth certificates.
3. **Field Name:** 2013

Field Note:
Based on records where valid pre-pregnancy height and weight were recorded on birth certificates.
4. **Field Name:** 2012

Field Note:
Based on records where valid pre-pregnancy height and weight were recorded on birth certificates.
5. **Field Name:** 2011

Field Note:
Based on records where valid pre-pregnancy height and weight were recorded on birth certificates.

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	42.7
Numerator					
Denominator					
Data Source	PRATS	PRATS	PRATS	PRATS	PRATS
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** 2015

Field Note:

Data source is the 2014 Idaho PRATS survey. Data for 2015 births is not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numerator and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision. Rate reported has approximately +/- 2 percent confidence limits from survey methodology.

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

2. **Field Name:** 2014

Field Note:

Data source is the 2013 Idaho PRATS survey. Data for 2014 births is not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision.

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

3. **Field Name:** 2013

Field Note:

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

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

4. **Field Name:** 2012

Field Note:

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

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

5. **Field Name:** **2011**

Field Note:

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

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

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	79.8
Numerator					
Denominator					
Data Source	PRATS	PRATS	PRATS	PRATS	PRATS
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** 2015

Field Note:

Data source is the 2014 Idaho PRATS survey. Data for 2015 births is not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numerator and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision. Rate reported has approximately +/- 2 percent confidence limits from survey methodology.

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

2. **Field Name:** 2014

Field Note:

Data source is the 2013 Idaho PRATS survey. Data for 2014 births is not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numerator and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision.

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

3. **Field Name:** 2013

Field Note:

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

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

4. **Field Name:** 2012

Field Note:

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

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

5. **Field Name:** 2011

Field Note:

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

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

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	94.2
Numerator	19,675	21,761	22,016	21,412	21,380
Denominator	22,762	23,888	23,934	22,968	22,686
Data Source	SIR 2011	SIR 2012	SIR 2013	SIR 2014	SIR 2015
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** 2015

Field Note:

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

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

2. **Field Name:** 2014

Field Note:

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

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

3. **Field Name:** 2013

Field Note:

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

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

4. **Field Name:** 2012

Field Note:

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

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

5. **Field Name:** 2011

Field Note:

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

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

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	91.1
Numerator	17,736	18,396	20,160	20,860	21,331
Denominator	22,659	22,636	23,232	23,210	23,422
Data Source	SIR 2011	SIR 2012	SIR 2013	SIR 2014	SIR 2015
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** 2015

Field Note:

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

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

2. **Field Name:** 2014

Field Note:

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

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

3. **Field Name:** 2013

Field Note:

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

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

4. **Field Name:** 2012

Field Note:

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

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

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

5. **Field Name:** 2011

Field Note:

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

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

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

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 current application/annual report.

State Action Plan Table

State: Idaho

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

[State Action Plan Table](#)

Abbreviated State Action Plan Table

State: Idaho

Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Increase percent of women accessing prenatal health care	NPM 1 - Well-Woman Visit	ESM 1.1	

Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
Improve breastfeeding rates	NPM 4 - Breastfeeding	ESM 4.1	
Support services, programs, and activities that promote safe and healthy family functioning	NPM 5 - Safe Sleep	ESM 5.1 ESM 5.2	
Support services, programs, and activities that promote safe and healthy family functioning			SPM 3

Child Health

State Priority Needs	NPMs	ESMs	SPMs
Decrease the prevalence of childhood overweight and obesity	NPM 8 - Physical Activity	ESM 8.1	
Improve childhood immunization rates			SPM 1

Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
Improve maternal and child health population access to medical homes	NPM 10 - Adolescent Well-Visit	ESM 10.1	

Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
Improve access to medical specialists for children and youth with special health care needs	NPM 11 - Medical Home	ESM 11.1	
Improve access to medical specialists for children and youth with special health care needs			SPM 2

Cross-Cutting/Life Course

State Priority Needs	NPMs	ESMs	SPMs
Decrease substance abuse among maternal and child health populations	NPM 14 - Smoking	ESM 14.1 ESM 14.2	
Improve maternal and child health population access to medical homes	NPM 13 - Preventive Dental Visit	ESM 13.1 ESM 13.2	