Idaho's 2010 Maternal and Child Health Five Year Needs Assessment

1. Process for Conducting Needs Assessment

Goals and Vision

It is the vision of the Idaho Department of Health and Welfare (IDHW) to provide leadership for the development and implementation of a sustainable, integrated health and human services system. With a focus on the values of integrity, customer service and quality, the Department carries out its mission to promote and protect the health and safety of Idahoans. Within this context, the goal of Idaho's Title V Maternal and Child Health (MCH) program continues to be the improvement of health for women of child bearing age and children with a particular emphasis on children with special health care needs (CSHCN). This document provides an analysis of the existing gaps in service and care in Idaho MCH and CSHCN programs. The document also outlines seven specific priorities for improving the health of Idaho's women and children during the coming five year period, 2010 through 2015. Commitment to the selected state priorities and performance measures will assist in focusing resources and support.

Leadership

The leadership team for Idaho's 2010 Assessment consisted of seven primary individuals. These core members were:

- MCH Director / Bureau Chief of Clinical and Preventive Services
- Manager of the Children's Special Health Care Program (CSHP)
- MCH Senior Data Analyst
- Pregnancy Risk Assessment Tracking System (PRATS) Manager
- Bureau Chief of Vital Statistics and Health Policy
- Division of Public Health Special Projects Coordinator
- Administrative Assistant for the Bureau of Clinical and Preventive Services

While this group met regularly, the Administrator of the Division of Public Health, where Title V is located, was kept informed of activities and progress. The Administrator participated when practical and provided guidance and support throughout the needs assessment process.

Methodology

The leadership team began the assessment process with a review of the 2005 MCH Needs Assessment, existing state and national performance measures, health status indicators and health system capacity indicators as reported in Idaho's 2009 Block Grant and 2007 Annual Report. Vital statistics data, PRATS data, Idaho Behavioral Risk Factors Surveillance System (BRFSS), program data from family planning and CSHP, as well as other state and national reports were reviewed.

A concurrent process of face-to-face interviews with all program managers within the Division of Health who have programs that touch on any aspect of maternal and child health was also conducted. This qualitative process identified programmatic and process strengths and gaps that would not be identified by review of the quantitative data only. This assessment placed MCH related programs on a grid looking at the MCH populations (pregnant women, mothers and infants, children, and children with special health care needs) against the four service areas of direct health care, enabling services, population based services, and infrastructure building. (Appendix A)

From this quantitative and qualitative data, the leadership team developed a list of eleven potential priorities that addressed needs of each of the three MCH populations. These potential priorities were evaluated against the current national performance measures, national outcome measures, health system capacity indicators and state measures to assure adequate ability to collect data. Selection of the potential priorities was limited to those areas the committee felt progress could be made. In the current economic recession, the IDHW is limited in funding, positions and the ability to start new programs. Potential priorities were considered if they fit with existing efforts and did not require new initiatives.

To gather stakeholder and public input, two surveys were developed and disseminated. One survey (Appendix B) asked individuals to rank the eleven identified

priorities, and the second (Appendix C) was specific to access to care for families with children with special health care needs. From the ranking survey, the top seven would be identified as Idaho's state MCH priorities for the next five year period, 2010 through 2015. Both surveys were disseminated via the internet using Survey Monkey®.

Survey Monkey® allowed the Department to reach out to a very diverse group of people across the entire state while doing so on a very limited budget. An invitation to complete the survey was sent to 77 key stakeholders, including family advocacy groups such as Idaho Parents Unlimited and the Early Childhood Coordinating Council, local and state level partners, and program participants. The cover letter invited these individuals to share the survey with their coalitions, members, and partners as appropriate for MCH. Additionally, there was an open invitation to the public to participate on the IDHW website. A total of 191 completed responses were received. The largest group of responses was received from individuals who were self-identified as representatives of a government agency, 45.5 percent. This group included state and local level employees. In Idaho, the seven local public health districts provide the service arm for many, though not all, MCH programs. The second greatest response group was those who were self-identified as an individual (parent, guardian or self), at 32.9 percent (Table 1).

MCH FIVE YEAR NEEDS ASSESSMENT SURVEY		
Participant Respondent Category		
	Frequency	Percent
Individual (parent, guardian, self)	63	33
Other (please specify)	3	2
Representative of a for-profit company	7	4
Representative for a government agency	87	45
Representative for a non-profit group	31	16
TOTAL	191	100%

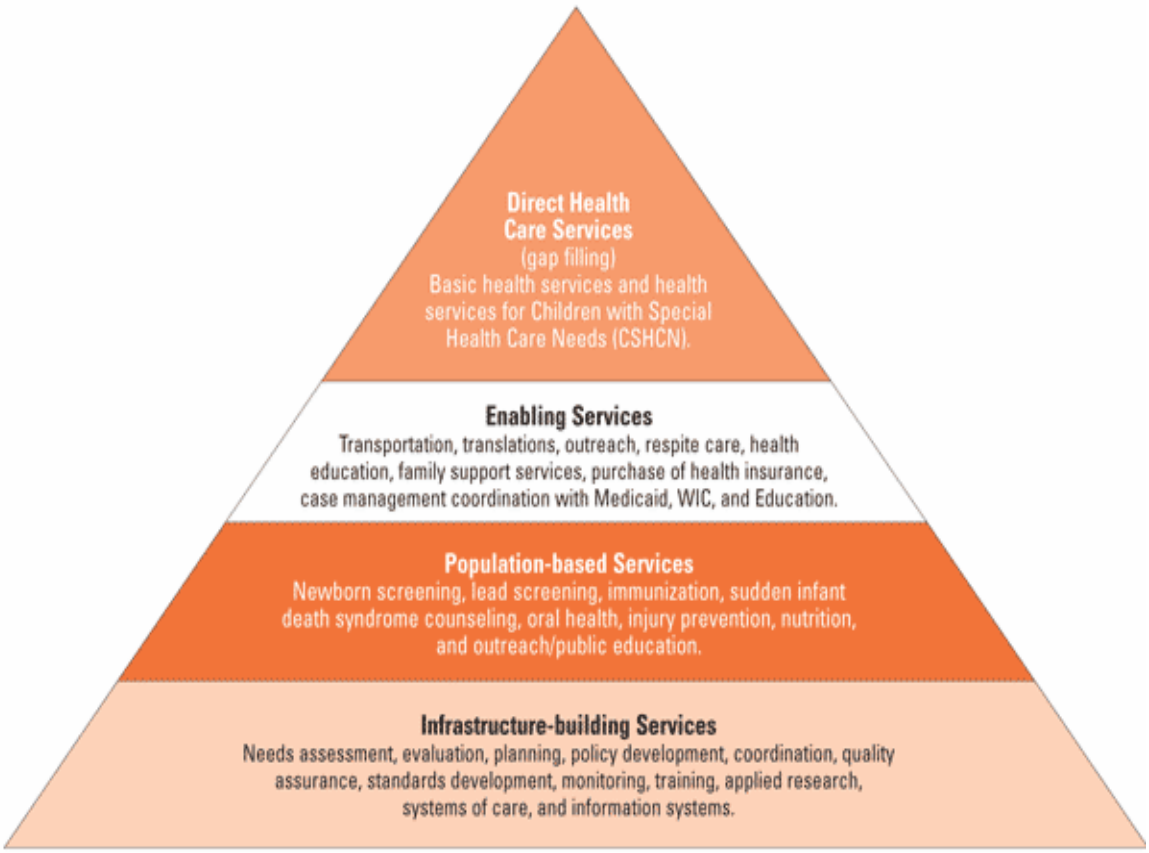
The initial request asked that the recipient share the survey with their staff, coalitions, and partners as appropriate to the MCH population. The web-based nature of the survey meant that beyond the initial invitation, we had no control over who participated. We were able to control the responses that were included in the results to a limited degree. For instance, responses identified as coming from out-of-state organizations were

excluded. The format also meant that groups who were effective in getting their members to respond, may have artificially "weighted" the results. School nurses, for instance, were well represented in the responses and represented diverse geographic regions of Idaho.

The web-based format was effective in generating responses from individuals and the general public. An omission in our survey design was requesting the county of residence for each respondent. This information would have provided a more complete picture of statewide needs.

Methods for Assessing the Three MCH Populations and State Capacity

An inventory of MCH services was compiled through interviews with a wide variety of IDHW Division of Public Health staff. Each of the three MCH populations – pregnant women, mothers and infants, children and children with special health care needs – was assessed for existing programs and efforts in each of the state capacity areas (Figure 1).



While the program grid (Appendix A) illustrates the tremendous amount of work done through the Division of Public Health that directly impacts MCH populations, it also brings to light gaps. For instance, the MCH Director can more effectively monitor how the surveillance and data analysis done by IDHW is used by the Department and others to inform policy and move initiatives forward, thereby improving the health of Idaho's mothers, children and CSHCNs. Additionally, the service grid only assesses MCH services and capacity within the Division of Public Health.

Data Sources

A wide variety of state and national data sources were used during the assessment. These are noted in the Reference Section. Two additional sources were interviews and survey data collected using two on-line tools.

As previously noted, interviews were conducted with program managers and bureau chiefs within the Division of Public Health whose programs provide services or impact MCH populations. While all interviews were conducted by the same individual, the interview process was very informal. Most of the interviewees had minimal, if any, knowledge of the MCH Needs Assessment. Additionally, most of the programs in question do not receive funding directly from the MCH Block Grant. The informal nature of the interviews and inconsistent knowledge of MCH may have resulted in an incomplete overview of services provided.

Linkages between Assessment, Capacity, and Priorities, Strengths and Weaknesses of Assessment Process and Dissemination

The ranking process was successful in reaching a broad and diverse group of stakeholders and participants for input. Numerous anecdotal comments were received on the difficulty of ranking the eleven survey items, because they were all viewed as important. Respondents were appreciative of the importance of each item to the MCH population of Idaho. Identifying data gaps and reviewing MCH programs within the Division of Public Health was instrumental in crafting potential priorities. Assuring that all potential priorities were tied to specific measures linked each of the steps of the process.

The priority areas were developed to address the weaknesses identified by the data that could realistically be influenced by program change or development. It was important to the committee to put forth only potential priorities that were realistic for the coming five year period and for which meaningful data could be collected. The biggest challenge was focusing on what we are able to do with the MCH Block Grant resources available to us. In 2010, Idaho has minimal state general funds supporting MCH programs, cutbacks in funding and personnel, and very limited ability to start new initiatives or programs. The simplicity of Idaho's 2010 assessment process was efficient, effective and put forth priority options that are realistic for the economic times in which we find ourselves.

Idaho was successful in soliciting approval on the final priority areas from a wide range of stakeholders. The survey was disseminated through partners, coalitions and stakeholder mailing lists. The completed assessment will be disseminated through the same means. While a limited number of hard copies will be printed, the full assessment will be available electronically.

2. Partnership Building and Collaboration Efforts

The IDHW Division of Public Health has many of the state level programs that address maternal and child health. The majority of these programs are in either the Bureau of Clinical and Preventive Services or the Bureau of Community and Environmental Health. The Bureau of Clinical and Preventive Services has oversight of the MCH Block Grant and the CSHP. Organizational charts for the Division of Public Health and its Bureaus can be found in Appendix D.

Formal collaborations within the Division of Public Health occur bi-weekly in staff meetings and quarterly in business planning meetings. Processes and objectives are formalized and measured through the Division of Public Health Operational Plan. With so many MCH programs within the Division of Public Health, and due to Idaho's small size, informal collaboration and communication occurs often and effectively.

A Cooperative Agreement is in place between the Division of Public Health and the Division of Medicaid. (Appendix E) While this agreement formalizes the relationship

between the two Divisions, excellent working relationships have evolved particularly between Medicaid, the MCH Director and the CSHCN Manager. Informal collaborations occur at least monthly and often more frequently.

Formal relationships through coalitions and committees connect the MCH Director and CSHCN Program Manager to a wide variety of private and public stakeholders. Some of these organizations are the Children's Trust Fund, Head Start, local public health districts, State Department of Education, Infant Toddler Program, Idaho Child Care Program, Idaho Association for the Education of Young Children, Idaho Coalition Against Sexual and Domestic Violence, Early Childhood Coordinating Council, Idaho Disabilities Council, Idaho Perinatal Project, Kids Count, Saint Luke's Children's Specialty Center and Healthy Tomorrows, among others.

Idaho's program for CSHCNs has fostered and strengthened relationships with the two family support programs in Idaho: Idaho Parents Unlimited (IPUL) and Idaho Families of Adults with Disabilities (IFAD). The ranking survey was distributed through each of these groups with very good response. Those responding to the survey as "Individual (parent, guardian or self)," was the second largest group totaling one-third of all respondents. In addition to seeking family input in the ranking process, a separate survey was distributed through each of these organizations to assess access to care issues for children with special health care needs throughout Idaho. The Department's efforts to solicit input from families through these two organizations were well received. With that being said, while an electronic survey is efficient and far reaching, it is impersonal which may have had a limiting effect on the number of responses received. (See Table 1.)

3. Strengths and Needs of the Maternal and Child Health Population Groups and Desired Outcomes

- PREGNANT WOMEN, MOTHERS, AND INFANTS

Between 2005 and 2008, the number of live births to Idaho residents has increased 9.1 percent from 23,064 to 25,156, respectively. As of 2008, this was the highest number of resident births recorded for Idaho. This 9.1 percent increase in resident live births was

approximately three times the increase seen for live births nationally during the same time period. The 2008 birth rate for Idaho was 16.5 per 1,000 population, which was nearly 18 percent higher than the national birth rate for the same year.[9] For the U.S., the 2008 (preliminary) birth rate was 14.0 per 1,000.[11] Since 1992, Idaho's birth rate has been consistently higher than the national birth rate.

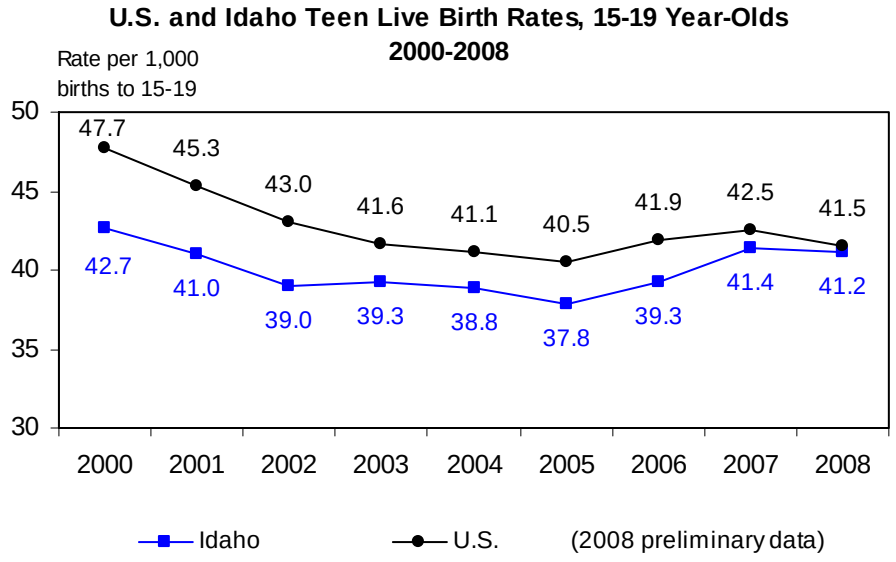
When compared with national figures, Idaho residents are fairing better in both low birth weight (less than 2,500 grams) and preterm birth (gestation less than 37 completed weeks) rates. [9] Nationally, 8.2 percent of live births were low birth weight in 2008 (preliminary). [11] Among Idaho residents, the percentage of low birth weight was 6.5 percent in 2008, which is a slight decrease from 6.6 percent in 2007. Teen mothers (aged 15 to 19) and older mothers (aged 35 and older) had higher rates of low birth weight than mothers aged 20 to 34. [9] Idaho's percentage of preterm births at 9.8 percent was approximately 20 percent lower than the national figure of 12.3 percent for 2008 (preliminary). [11] Although Idaho's preterm birth and low birth weight rates are comparatively better than a large proportion of other states, continued focus on reducing low birth weight and preterm births is warranted.

According to preliminary data, the U.S. infant mortality rate decreased from 6.9 per 1,000 live births in 2005, to 6.8 per 1,000 live births in 2007, the most recent preliminary data available. [11] During the past decade, Idaho's infant mortality rates have ranged from a high of 7.5 per 1,000 live births in 2000 to a record low of 5.8 per 1,000 live births in 2008. Further, the record low rate in 2008 is nearly 15 percent lower than the infant mortality rate in 2007 (6.8 per 1,000 live births). In 2008, the number of infant deaths decreased by almost 14 percent from the previous year (146 infant deaths in 2008 compared with 164 infant deaths in 2007). However, because rates are based on a relatively small number of infant deaths in Idaho, fluctuation from year to year is not unusual.[9] For both the U.S. and Idaho, the leading causes of infant death include birth defects, sudden infant death syndrome (SIDS), and disorders related to short gestation and low birth weight.[9,11]

Idaho is now the only state lacking an infant and child mortality review board. Establishing such a board would allow for comprehensive and multidisciplinary review of infant and child death cases in order to understand risk factors and contributing causes

to the deaths, and ultimately use the results to prevent future deaths and improve children's health and safety.[4]

In 2008, there were 2,672 pregnancies among Idaho teens aged 15 to 19 (pregnancy statistics include live births, induced terminations, and reportable stillbirths). Since 1999, the teen pregnancy rate for Idaho residents has decreased almost 5 percent (from 51.2 pregnancies per 1,000 females in 1999 to 48.7 in 2008). However, pregnancy rates did vary depending upon age. The pregnancy rate for teens aged 15 to 17 has dropped by nearly 19 percent in the past decade, whereas the rate for teens aged 18 to 19 has increased by nearly 6 percent. Of the pregnancies among teens aged 15 to 19, 84.7 percent resulted in live birth, 14.8 percent resulted in induced termination, and less than 1 percent were stillbirth. The Idaho live birth rate for teens aged 15 to 19 was 41.2 per 1,000 in 2008. (Table 2)



This is a nearly five percent increase in the teen live birth rate since 2006 (39.3 per 1,000).[9] Idaho's increase in the teen birth rate is contrary to change in the teen birth rate nationally. According to preliminary 2008 data, the birth rate for U.S. teens aged 15 to 19 was 41.5 births per 1,000, which is a two percent decrease from 2007, and a one percent decrease from 2006.[11] Given the socioeconomic burdens of teen pregnancy and births, the increase in Idaho's teen birth rate bears concern.

Preconception health care focuses on screening for health conditions and eliminating or reducing risk factors that could impact a women and her fetus if she becomes pregnant

such as family planning, folic acid consumption, healthy weight, chronic conditions, and smoking and drinking behaviors. Preconception health is important for any woman of reproductive age even if she is not planning on becoming pregnant. According to 2008 resident population estimates, there were 288,070 women of reproductive age in Idaho (females aged 15 to 44). Among Idaho women aged 18 and older who gave birth in 2008, 34.7 percent had unintended pregnancies, 55.7 percent were at a healthy weight prior to pregnancy (BMI of 18.5 to 24.9), 38.6 percent took a multivitamin regularly during the month before becoming pregnant (taking a multivitamin four or more times per week), and 38.4 percent consumed alcohol and 17.3 percent smoked cigarettes during the three months prior to pregnancy.[8]

- CHILDREN

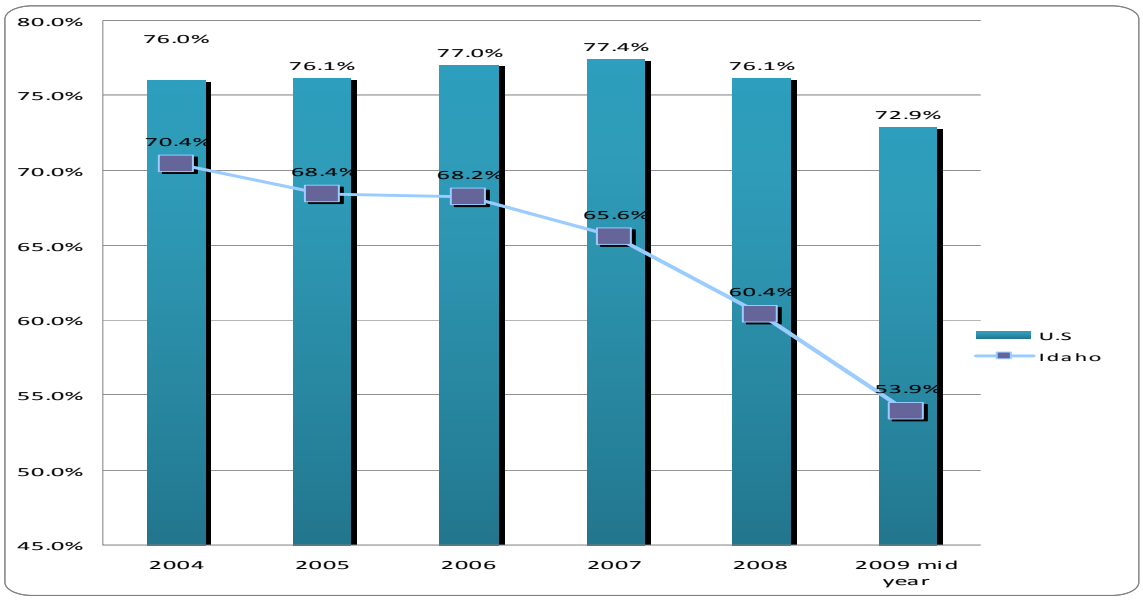
While the number of children age 0 through 17 years in Idaho has increased by 38,000 between 2000 and 2007, children as a percent of the total population has decreased slightly from 28 percent to 27 percent.[7] This 1.5 percent growth rate in the population is approximately five times the growth rate for the same population nationally. Idaho's population of young children age 0 through 4 years saw an increase of 3 percent which is approximately three times the growth rate for the corresponding population nationally.[1] In 2007, 21 percent of the population of children age 0 through17 was minority. While this is significantly lower than the national percentage of 43 percent for the same population, the Idaho trend indicates a steady increase in minority children.[7]

Between 2003 and 2007, the number of single working mothers in Idaho increased 4.4 percent while the national number of single working mothers decreased by 11.8 percent. During this same period, there was slight decrease in the number of unemployed families with children.[7] As Idaho and the nation have entered current economic recession, it is expected that the negative impact will be evident in future indicators.

Review of the health data indicated two primary areas of concern for Idaho's children: the immunization rate of Idaho's two-year olds, and the high rate of intentional self-harm among Idahoan's aged 10 through 44. The 2008 National Immunization Survey (NIS) indicates that only 60.4 percent of Idaho's 19 to 35 month olds were up-to-date by 24 months of age for the 4:3:1:3:3:1 immunization series. This series indicates

four doses of DTaP vaccine (Diphtheria, Tetanus and Pertussis), three doses of Polio vaccine, one dose of MMR vaccine (Measles, Mumps and Rubella), three doses of Hib vaccine (Haemophilus Influenza Type B), three doses of Hepatitis B vaccine and one dose of Varicella (chicken pox) vaccine. The national average for the 4:3:1:3:3:1 series is 76.1 percent (Figure 2).[3] When compared with other states and Washington, D. C., Idaho ranks 49th for completion of this vaccine series.[3] The impact of this low rate is reflected in high rates of vaccine preventable diseases. In 2008, Idaho reported 40 cases of pertussis and 2 cases of mumps.[9] Neither varicella nor influenza are reportable conditions in Idaho.

Figure 2 **Immunization Rates for the 4:3:1:3:3:1 Series**



For Idaho children age 1 through 19, accidents are the leading cause of death. For youth age 10 through 19, intentional self-harm is the second leading cause of death. Idaho is consistently among the states with the highest suicide deaths per capita and ranks third in youth suicide.[9] MCH National Performance Indicator 16 shows that since 2005, Idaho has seen a significant increase in the rate of suicide deaths among youths aged 15 through 19. The 2007 Youth Risk Behavior Survey, indicates that 16.9 percent of youth attending traditional high schools reported seriously considering suicide and 8.4 percent reported making at least one attempt.[10]

Since 2003, reported child abuse and neglect has increased slightly. However, the 2006 rate of 4.2 cases per 1,000 children is significantly lower than the rate of 8.5 cases per 1,000 children that Idaho experienced in 2000.[1,7] There is, of course, great concern that the current economic recession will impact families and place children at greater risk than has been experienced over the past ten years.

While the health of Idaho's MCH populations may be negatively impacted by numerous challenges, strides have been made in improving systems and strengthening relationships. An advantage of smaller states is an ability to interact frequently and consistently with partners and stakeholders at the local level, in the private sector, and throughout state government. Over the past five years Idaho has developed relationships with family advocacy groups representing children with special health care needs; contracted for improved delivery of health care services for CSHCNs; informed policy to address declining immunization rates; supported statewide coalition efforts to address numerous MCH issues; and maximized the impact of MCH funding on targeted populations.

- <u>CHILDREN WITH SPECIAL HEALTH CARE NEEDS</u>

Children with Special Health Care Needs in Idaho are fairing better than national averages in several indicators as published by HRSA/MCHB and other groups. Idaho's per-student special education spending is more than 5 percent higher than the national average.[2] As a percentage of all children, Idaho has 2.5 percent less CSHCNs than the national average 13.9 of percent.[15] A greater percentage of Idaho CSHCNs are enrolled in Medicaid than the national average, and 100 percent of Idaho's pediatricians accept Medicaid coverage.[2] A greater than average percentage of Idaho CSHCNs are covered by both public and private insurance.[2] All Idaho children, not just CSHCNs, are doing better than the national average in more than half of the health and well-being indicators from the 2007 *National Survey of Children's Health.*[14] More Idaho CSHCNs have a primary care provider, and report that their care is "family centered," than the national average.[2]

While Idaho lacks a medical school, and therefore, lacks some specialty physicians, CSHP, using Title V funds, imports metabolic and genetic physicians from Oregon to provide much needed specialty services to Idaho's CSHCNs.

The 2007 *National Survey of Children's Health* also lists some CSHCN-related areas where Idaho continues to rate below the national average. In most insurance coverage categories, Idaho ranks below national averages for CSHCNs.[2,15] Idaho's childhood-immunization rates and rates for preventative oral care continue to lag behind national averages for all children.[14]

It is known that geographic access to medical services continues to be a challenge for certain conditions and in certain areas of the state. Idaho has only two pediatricians per hundred children, as opposed to the more than seven per hundred, that is the national average.[2] There are no practitioners of several medical specialties in the state; and of the specialists who are in the state, many are limited to the southwestern region where the capital city of Boise is located. In the *MCH Five Year Needs Assessment Survey* (Appendix B) conducted to establish state MCH priorities for the next five years, the number one need identified by providers, parents and organizations was "Improve access to medical specialists for children with special health care needs."

As part of this five-year needs assessment, the Idaho CSHP conducted the *CSHCN Five Year Needs Assessment Survey* (Appendix C) of a convenience sample of families who have children with special healthcare needs. The survey was released through the two primary parent organizations who work with CSHCNs in Idaho: IPUL and IFAD. The survey examines geographic lack of access to medical specialties in Idaho, and some of the results cast a stark light on the problem. A full 66 percent of the respondents answered "yes" to the question, "Does traveling to visit your child's medical specialist present your family with difficulty?" When asked "Has your child ever missed an appointment with his or her specialist for travel-related reasons, 39 percent responded "yes."

When looking at how many miles a family has to travel to visit their child's medical specialist, one quarter of the families have to travel over 100 miles, and more than half of those have to travel over 250 miles. Of the families who have to travel over 100 miles to reach their specialist, 12 percent must visit their specialist more than twice per year.

The Health Resources and Services Administration's (HRSA) '05-'06 CSHCN Chartbook shows that Idaho is doing worse than the national average for CSHCN school absences. While we have no correlative data between the two, it is likely that Idaho's geographic lack of access to medical specialists is a contributor to the days-of-school-missed.

4. MCH Program Capacity by Pyramid Levels

- **Direct Health Care Services**

The availability of direct health care services is one of Idaho's largest, if not the largest, MCH challenges. Of Idaho's 44 counties, 41 are federally designated as Primary Care Health Professional Shortage Areas (HPSAs), 38 are Dental HPSAs, and all 44 are Mental HPSAs (Appendix F). Idaho only has 67 primary care physicians per 100,000 population, compared to the national average of 99, and 61.5 percent of Idahoans lack access to mental health care, compared to the national average of 18.4 percent.

In addition to primary care, dental care, and mental health care shortages, Idaho also suffers from a dramatic shortage of every medical specialty, and particularly those specialties which serve CSHCNs. Idaho has a rate of only 40 specialist physicians per 100,000 population, compared to the national average of 97.

Of the 135 American Medical Association-designated medical specialties, there are no physicians practicing 31 of those specialties in Idaho. Some examples of the medical specialties not practiced in Idaho are: pediatric urology, pediatric critical care medicine, surgical oncology, musculoskeletal oncology, medical genetics, hematology, clinical pathology, and adolescent internal medicine.

In addition to the specialties not practiced in Idaho, there are another 32 specialties where only a single physician is providing services in the state. With only a single exception, the single physician is practicing in the Boise area. Some examples of single-physician services in Idaho are: craniofacial surgery, developmental-behavioral pediatrics, pediatric internal medicine, pediatric anesthesiology, pediatric cardiothoracic surgery, pediatric infectious disease, pediatric radiology, pediatric gastroenterology, and trauma surgery.

For the 72 remaining specialties where at least two physicians are practicing in Idaho, there is an attached map for each specialty (Appendix F). Each map shows, at the county level, the population to specialist ratio in thousands of persons per physician. The lower the number the better, since that means fewer persons per medical specialist. The maps are colored by the following scheme: 1) counties with no fill color do not have a physician of that specialty practicing within their border, 2) the lightly shaded counties have one specialist per 5,000 or more population, 3) the medium shaded counties have one physician per 2,000 – 4,999 population, and 4) the darkly shaded counties have one physician per 1 – 1,999 population. The lighter the color of a county on the map, the worse the population to specialist ratio is for that county.

Some highlights of data most directly relevant to the MCH population are:

- Of Idaho's 44 counties, only two have child neurologists practicing in them. In Bonneville county there is one child neurologist per 50,700 population, and in Ada county, where the capital of Idaho is located, there is one per 384,700 population.
- Only three counties in Idaho have a child and adolescent psychiatrist providing services. In Bannock county, there is one per 27,500 population, in Ada there is one per 64,100 population, and in Kootenai there is one per 43,500 population.
- Only two counties have specialists in neonatal-perinatal medicine. In Bonneville county there is one provider per 50,700 population and in Ada county there is one per 48,100 population.
- There are only two pediatric orthopedists in Idaho and both work in Ada county.
- Only five counties in Idaho have critical care pulmonologists, and the *best* population to specialist ratio is 32,100:1.
- Only 25 percent of Idaho's counties have a pediatrician providing services.
- Idaho just retained its first pediatric pulmonologist in the spring of 2010.

Recognizing that geographic lack of access to medical specialists is *the* primary problem facing CSHCNs in Idaho today, the CSHP conducted the *CSHCN Five Year Needs Assessment Survey* to quantify the problem. The online survey was promoted through CSHCN advocacy groups, but the actual response was lower

than expected (n=40). However, even with the low response rate, the data – while not generalizable – is still useful to Idaho's CSHCN program.

Some of the more interesting results of the survey are:

- 63 percent of respondents answered "yes" to the question, "Does traveling to visit your child's medical specialist present your family with difficulty?"
- 37 percent responded "yes" to the question, "Has your child ever missed an appointment with his or her specialist for travel-related reasons.
- When asked how far they had to travel to reach their medical specialist, a whopping 13.6 percent reported having to travel further than 250 miles, and an additional 9.1 percent reported having to travel between 100 and 250 miles.
- Of the people who have to travel over 100 miles to reach their specialist, 17.4 percent have to make this trip more than four times per year.

Lack of access to care for children with special health care needs goes beyond geographic challenges and includes challenges like insurance and other financial barriers or language/cultural barriers. However, the first obstacle is always the consideration of whether or not a service is being provided at all. If there is no doctor providing a specialty service, then the questions of whether or not Medicaid is accepted, or whether or not someone in the office can speak Spanish, become moot points.

It is likely that low population-density states like Idaho will continue to experience geographic access challenges for the foreseeable future. When these states also lack a medical school, like Idaho, the challenge of access to direct health care services will only be compounded.

IDHW assures limited direct health care services and prevention services for the MCH and CSHCN populations through contracts and agreements with local public health districts and private providers.

Idaho's seven public health districts provide access to Title X Family Planning services throughout Idaho. The public health districts are the only Title X delegate agencies in the state. The demand for family planning services through these agencies far outweighs available funding to provide the services. The seven districts support family planning services with approximately $2.7 million annually. An additional $588,000 of

MCH funding also helps support the local family planning programs. The public health districts do not provide primary care. While not supported with Title X funding, community health centers and federally qualified health centers provide family planning services and primary care throughout Idaho as well.

Using MCH Block Grant funds, IDHW contracts with the Children's Specialty Center at Saint Luke's Regional Medical Center in Boise to provide direct health care services for children with metabolic conditions and cystic fibrosis, as well as families and children with genetic disorders. Idaho does not have a medical geneticist or metabolic physician in residence. Idaho's CSHP has arranged for physicians with these specialties to travel from Oregon to provide these services to Idaho children. While most of the clinics are held in Boise, the physicians do travel to eastern and northern Idaho several times a year to see patients. Families with children with special health care needs in northern Idaho receive most of there care in Spokane, Washington, while eastern Idaho families will often travel to Salt Lake City, Utah for care. The state priority measure to improve access to medical specialists for CSHCNs addresses this concern directly.

- **Enabling Services**

A number of enabling services are available to Idaho's MCH populations, most notably WIC, Medicaid, and care coordination for CSHCN. With Medicaid and all MCH funded programming being within one agency, the Idaho Department of Health and Welfare, coordination and collaboration of these programs occurs frequently and efficiently. CSHP provides care coordination, covers capped costs for uninsured children with specific conditions, and covers transportation costs to medical specialists. For limited conditions, such as cystic fibrosis and PKU, CSHP is the payer of last resort.

In 2009, the CSHP moved all care coordination for CSHCNs from a contractor back to the program where it is managed by an RN. This has provided consistency in program delivery and has resulted in service and fiscal efficiencies. Additionally, the CSHP collaborates with IPUL and IFAD as well as the Department of Education to provide transition services for CSHCNs throughout Idaho.

Annually, the provision of enabling services typically accounts for less than one percent of the total funding available through the federal-state Title V Block Grant partnership.

- **Population-Based Services**

The largest percentage of the federal-state Title V Block Grant partnership total is spent on population-based services. This was 56.9 percent in 2008 and projected to be 53.7 percent in 2009. The supported programs have primarily been oral health, injury prevention, and immunizations. Changes in 2010 to the manner in which the state and private insurance companies support vaccine purchase will decrease the amount of MCH funding used to support the immunization program. Idaho's Newborn Screening Program is almost entirely funded through provider funds. The only exception is a small contract with a pediatrician to provide consultation on newborn screening questions on an as needed basis. The consultation contract is supported with Title V funds.

Many of the population-based services in Idaho are provided through contracts with the seven local public health districts. The public health districts are quasi-governmental agencies with multi-county jurisdictions. Partnering with the public health districts for population based services such as oral health, provides the opportunity for services to be available to residents of all Idaho counties.

- **Infrastructure-Building Services**

Even in the face of economic challenges, Idaho has made strides over the past five years particularly in its capacity to deliver high quality efficient services for CSHCNs. The CSHP has implemented fiscal and administrative efficiencies, brought case management back into the Department, up-dated Administrative Rules, established working relationships with statewide advocacy organizations, and developed a database that not only improves client services, but also allows the retrieval of program, fiscal and client information. As noted, the greatest challenge facing Idaho families with children needing special health services is access to care. It will be necessary for us to assure that during the coming five year period Idaho develops the infrastructure to integrate CSHCNs into health care reform through the Patient Protection and Affordable Care Act (PPACA).

As we look at the unmet needs of Idaho's MCH population, it is evident from the CSHCN survey and analysis of provider availability that access to care is an important issue. As Idaho works through the implementation of PPACA, maintaining collaborative relationships with Medicaid, the Idaho Primary Care Association, the local public health districts, and others will be imperative to strengthening the infrastructure for the MCH population.

5. Selection of State Priority Needs

List of Potential Priorities

The following is a list of the assessment team's potential priority areas by MCH population groups. This list was compiled by the assessment leadership committee. These priorities were chosen based on data and the ability to address the issue using existing programs and infrastructure. These eleven priority areas were included in the survey to stakeholders, partners, and families to be ranked. The top seven in the ranking survey were then used as Idaho's priority areas for the 2010 to 2015 five year period.

PREGNANT WOMEN AND INFANTS

- Reduce premature births and low birth weight.
- Reduce teen pregnancy.
- Assure the intendedness of pregnancies.
- Increase awareness of the importance of preconception and prenatal health care.
- Decrease dental disease among pregnant women, mothers and children.

CHILDREN AND ADOLESCENTS

- Improve immunization rates.
- Decrease the prevalence of overweight and obese children.
- Reduce intentional injuries (maltreatment, attempted suicide) in children and youth.
- Reduce unintentional injuries to children and youth.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

- Improve transitional service systems for CSHCNs.
- Improve access to medical specialists for CSHCNs.

- **Methodologies for Ranking / Selecting Priorities**

The ranking process allowed for a breakout of results by five response groups – public health districts, IDHW, non-government (including individuals), other agencies and schools – as well as a cumulative, all Idaho response. (Appendix G)

While the priority of "access to medical specialists for CSHCNs" did not rank in the top seven for either health districts or IDHW, the ranking was strong enough in the other three response groups to place this need as number three overall. Similarly, the priority of addressing Idaho's low childhood immunization rates did not place in the top seven with the non-government response group. While the public health districts ranked immunization rates as the number one priority, their low response rate was not enough to pull this priority above the rank of number five.

To reflect the input of all response groups, the top seven rankings for all Idaho respondents were selected as the MCH priorities for the upcoming five year period. The most notable needs that did not make the top seven were to "decrease dental disease in MCH populations" and "reduce unintentional injuries to children and youth."

- **Priorities Compared with Prior Needs Assessment**

The priority areas identified in the 2005 Needs Assessment were:

1. Pregnant Women and Children: Increase awareness of Medicaid programs for pregnant women and children across provider and community networks.
2. Perinatal Depression: Identify screening tools and work with state professional groups and the regional perinatal coalitions to develop mechanisms to assure appropriate use of the tools and availability of referral resources for perinatal depression.
3. EPSDT Screenings: Develop strategies to assure that EPSDT screenings and follow-up are occurring as appropriate for all infants, children and adolescents.
4. Adolescents: Assess the adolescent population risk behaviors and design interventions to target this population with input from teenagers and parents of targeted groups.
5. CSHCN: Strengthen the existing care coordination system and access to specialty care to address the complex needs of all CSHCNs.

6. Cultural Competency: Improve cultural competency across all programs that work with the MCH population.
7. Dental Health: Increase the awareness of the need for dental care during pregnancy and increase the number of women who seek dental care during pregnancy.
8. Health Education: Strengthen health education in the public schools, including strategies to assure that school health educators receive up-to-date training on health topics.
9. Systems Development: Develop and strengthen existing system collaboration efforts that focus on outcomes for the MCH population.
10. Overweight and Obesity: Develop and implement strategies to reduce the problem of overweight and obesity among school age children.

In 2006, a number of political and funding decisions greatly influenced Idaho's MCH Title V program and in turn, the ability to address the priorities as put forth in the 2005 Assessment. The ten priorities were reworked into seven priorities that encompassed the overarching issues and recommendations of the 2005 Assessment: to strengthen collaborative efforts, system development, collection, review and use of meaningful data and infrastructure building. The seven priorities were defined by the Division of Public Health Administrator, the MCH Director, and the Division of Public Health Special Projects Coordinator. As with this Assessment, data such as immunization rates, teen pregnancy rates, etc., as well as the existing systems, organization and personnel were considered in the selection of priorities.

The seven priorities guiding the Idaho MCH efforts from 2007 to 2010 were:

1. Continue to develop data collection and analysis capabilities to assess needs and evaluate outcomes.
2. The Division of Public Health will work with Medicaid to explore options to maximize services to the MCH population.
3. Through collaboration, move MCH programs, including CSHCN, to sustainable infrastructure building activities.

4. Reduce vaccine preventable diseases by increasing the immunization rate of children 0 to 2 years of age.
5. Work with Medicaid, the Division of Behavioral Health, and other partners to address identified needs and establish referral sources for MCH mental health issues such as perinatal depression and teen suicide.
6. Assess adolescent population risk behaviors and design interventions to target this population with input from teenagers and parents of the targeted groups.
7. Increase population based education and awareness of the importance of dental care for the MCH population, such as women during pregnancy.

Only one priority from the last assessment period is carried over, and that is improving Idaho's childhood immunization rates. As reported in the 2008 National Immunization Survey, Idaho ranks 49th with a rate of 60.4 percent.[3] This low rate exposes Idaho's infants and children to an unacceptable level of risk for vaccine preventable illness.

Two new priorities are elements of broader objectives from the last assessment. These are the reduction of the rate of teen pregnancy and improved access to medical specialists for CSHCNs. Idaho's teen pregnancy rate for 15 to 17 year olds has historically remained well below the Healthy People 2010 goal of 43 pregnancies per 1,000. Idaho's rate for this age group reached a low of 20.8 in 2005. Since that time, the rate has been moving up again with 23.8 pregnancies per 1,000 females aged 15 to 19 in 2008. When looking at 2008 data for females aged 15 to 19 years old, the pregnancy rate jumps up to 48.7 with the live birth rate at 41.2 per 1,000.[9]

Idaho continues to lack adequate ratios of primary care providers as well as specialist physicians, making access an ongoing challenge for CSHCNs. Improving access to specialty care for these families throughout Idaho was ranked as the number one issue by individuals who participated in the survey. Due to geography and long distances, having specialists available in Boise does not necessarily equate to access for all Idaho residents. Developing this infrastructure will depend on collaborative efforts with neighboring states. (Maps illustrating Idaho's health care provider shortage areas are in Appendix F.)

A reduction in the rate of childhood overweight and obesity was a priority that was eliminated during the 2006 review of Idaho's priorities and is now back on the list. Oral health came through the current ranking process in last place in this assessment and will not be a priority for the coming five year period. The most significant difference in the identified priorities between this assessment and the last is the improved specificity of the priorities and the identification of specific measures to monitor progress of how Idaho's MCH populations are faring in these priority areas.

Another new state priority is to reduce intentional injuries and intentional self-harm in children and youth. Over the 2003 to 2006 period, the reported numbers of child abuse and neglect has increased slightly. Cases peaked in 2005, with 1,912 cases reported. Reported cases in 2006 totaled 1,651. Idaho has also seen a steady increase in out-of-home placements with an annual average of nearly 155.[1] The data also indicates that intentional injuries and intentional self-harm are both areas where Idaho can improve. In 2008, suicide was the second leading cause of death for Idaho's 15 to 24 year olds and for males age 10 to 14. While Idaho ranks tenth in suicide deaths per capita, it ranks third in youth suicide.[9]

- **Priority Needs and Capacity**

Of the seven selected state priorities, six would primarily be seen as population-based services. Access to medical specialists for CSHCNs would fall into the category of direct health care services. Because the state of Idaho does not have the capacity to start new initiatives or significantly expand existing efforts, potential priorities were considered specifically if there was some existing program to monitor and potentially build. Most of these efforts are population-based with extensive education and outreach components. Success in these priority areas is dependent on partnerships and collaborations. For instance, efforts to impact teen pregnancy rates rely on Title X contracts with the seven local public health districts. Efforts to address childhood obesity depend on partnerships with the State Department of Education, as well as the local public health districts.

While education and outreach regarding preconception and perinatal health care and the rate of premature and low-birth weight babies is dependent on IDHW's collaboration with the Idaho Perinatal Project (IPP), the infrastructure for surveillance and analysis

through Idaho's Pregnancy Risk Assessment Tracking System (PRATS) are very much a function of IDHW. In fact, IDHW provides critical surveillance and analysis capabilities for the MCH population by supporting an analyst dedicated to MCH programs and issues.

6. Outcome Measures – Federal and State

Below is a list of the State Priority Measures for the 2010 through 2015 MCH reporting period. The priorities are listed by MCH population groups and are in no particular order. Each priority is followed by the pertinent performance and outcome measures to monitor progress. State Performance Measures that are highlighted in yellow are new for this reporting period.

Idaho's 2010 State Priorities and Measures

NPM	National Performance Measures
SPM	State Performance Measures
NOM	National Outcome Measures
HSCM	Health Systems Capacity Measure
HSCI	Health System Capacity Indicator
HSI	Health Status Indicator

PREGNANT WOMEN AND INFANTS

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

- *Reduce the incidence of teen pregnancy.*
  - NPM 8 The rate of birth (per 1,000) for teenagers aged 15-17 years.

- SPM 1 Percent of 9th - 12th grade students that report having engaged in sexual intercourse.
- HSI 07A Live births to women of all ages enumerated by maternal age and race.

- *Increase the percent of women incorporating effective preconception and prenatal health practices.*
  - NPM 15 Percentage of women who smoke in the last 3 months of pregnancy.
  - NPM 18 Percentage of infants born to women receiving prenatal care beginning in the first trimester.
  - SPM 2 Percent of pregnant women 18 and older who received dental care during pregnancy.
  - SPM 4 Percent of women 18 and older who fell into the "normal" weight category according to the Body Mass Index (BMI=18.5 to24.9) prior to pregnancy.
  - SPM 5 Percent of women 18 and older who regularly (4 or more times per week) took a multivitamin in the month prior to getting pregnant.
  - SPM 6 Percent of women 18 and older who gave birth and drank alcohol in the 3 months prior to pregnancy.
  - HSCM 4 Percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

CHILDREN AND ADOLESCENTS

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

- *Decrease childhood overweight and obesity prevalence.*
  - NPM 11 Percentage of mothers who breastfeed their infants at 6 months of age.
  - NPM 14 Percent of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.
  - SPM 3 Percent of 9th - 12th grade students that are overweight.

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

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

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

Needs Assessment Summary

Since the 2005 MCH Assessment, there has been a tremendous amount of change in Idaho effecting the MCH and CSHCN populations. The impact to IDHW from the economic recession has been significant. During SFY 2009 and continuing today, people are coming to IDHW offices in record numbers. Against that backdrop of record growth, the Department's budget for SFY 2011, approved in the 2010 legislative session, reflects a 5.6% decrease in State general funds from the SFY 2010 original appropriation and a 25.7% decrease from the 2009 original general fund appropriation. This dramatic budget reduction resulted in furloughs, layoffs, and the closure of nine field offices across Idaho. In state fiscal year 2010, shortfalls in state revenues resulted in each employee taking 108 hours of furlough, of which time the entire Department was closed for nine days. In order to realize the new substantially lower baseline budget for state fiscal year 2011 in addition to closing nine field offices the Department laid-off 127 individuals. To compound the impact of the Department's situation to Idaho citizens, Idaho's Medicaid program is facing a state general fund shortfall of approximately $46 million.

As evidenced by a steady and continual increase in Idaho's WIC caseload, the economic recession has placed a greater number of Idaho's families and children in need of population based services and enabling services. The caseload in Idaho WIC clinics

has increased 10% over the past two years. As reported by the Department of Labor, Idaho's seasonally adjusted unemployment rate in April 2010 was 9.1 percent compared with 9.7 percent nationally. In April of 2009, Idaho's unemployment rate was 7.8 percent. With amassing needs and shrinking resources, the focus becomes maintaining a basic level of public health services for Idaho's MCH population. The cornerstones of public health – improved immunization rates, low rates of teen pregnancy, improved birth outcomes, reduced rates of intentional injuries and self-harm and access to care – rise to the surface as the priority needs of the community.

The frustration of increasing need coupled with decreasing resources was reflected in the survey comments. For instance, one person wrote, "It was hard to rate these issues on a scale because so many of them are of extremely high importance." Another wrote, "Many maternal and child problems are complex and inter-related – priorities don't address the need to provide multiple services to overburdened and at risk families." The power of prevention was not lost on the respondents as evidenced by the comment, "I would like to see Health and Welfare use [their] limited funding on prevention programs that increase the health and well being of the most people possible and target services to those most impacted by poor health outcomes."

The MCH population will need the MCH leadership to use data to drive programmatic and fiscal decisions. The MCH population also needs MCH leadership to identified needs and priorities clearly and effectively with partners and stakeholders. The first steps of this have been taken by clearly identifying MCH and State Performance Measures that are tied to the identified priorities. The tandem challenges of the economic recession and health care reform will impact Idaho's MCH programs in unforeseen ways over the next five year period. The MCH program's ability to quantify and trend the health of the MCH population will be fundamental in assuring the overall health of Idaho families continues to improve.

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MCH Five-year Needs Assessment
Services Grid

	Direct Health Care	**Enabling Services**	**Population Based Services**	**Infrastructure Building**
Pregnant Women, Mothers and Infants	1. Reduce the rate of unintended pregnancies 2. ADAP 3. Provide supplemental nutritious foods to qualifying women and infants (WIC) 4. Diagnosis and treatment referral for women with positive cancer screens (WHC) 5. Family Planning	1. Cancer screening for women (WHC) 2. Nutrition education, breastfeeding support, and referrals to alternate services (WIC) 3. HIV Prevention 4. Provision of oral health products for WIC population	1. Newborn Screening Activities including: NBS, NBS-provider education, Parent education 2. Breastfeeding friendly worksite promotion project. 3. Cancer screening education for the public 4. Tobacco Cessation education 5. "No sun for baby" program – skin cancer 6. Sexual violence prevention 7. Education on mercury in fish, and lead paint	1. Work with Region X and grantees to take forward recommendations for updating Title X Guidelines. 2. M&E of data on the health behaviors of pregnant (and pre- & post-pregnant) women (PRATS). This data is disseminated for use by state agencies, medical providers, research groups and media outlets. 3. Cancer screening education for medical providers. 4. HIV prevention education to providers. 5. STD detection and treatment training. 6. Funding to Districts for skin cancer prevention programs. 7. Migrant Head-start program education about lead-based paints.

MCH Five-year Needs Assessment
Services Grid

	Direct Health Care	Enabling Services	Population Based Services	Infrastructure Building
Children and Adolescents	1. Oral health inputs (fluoride, sealants) for birth-6. 2. Provide supplemental nutritious foods to qualifying children to age 5 (WIC) 3. Family Planning	1. Target teen STI education through available electronic media; web, twitter, etc. 2. Nutrition education and referrals to alternate services for children up to age 5 (WIC)	1. Improve Idaho immunization rates, 4:3:1:3:3:1 through education, outreach and collaboration with the coalition and VFC. 2. Poison Control Center 3. Tobacco-use reduction and prevention 4. STD prevention and testing education. 5. Family planning education 6. Tobacco prevention education TarWars and TATU programs 7. HPV Vaccine education 8. Oral health education 9. Education on poison prevention 10. Injury prevention 11. Prevention of childhood obesity through education efforts around nutrition and physical activity	1. Work with legislators, insurance carriers, providers, and others to develop and implement a sustainable vaccine delivery system in Idaho. 2. Monitor the burden of oral health in K, 3rd and 6th grades. 3. Monitor prevalence of obesity in 3rd graders. 4. Data collected on oral health. 5. Working through health districts to reduce pregnancy risk. 6. EMS/EMT staff trained in pediatric care. 7. EMS working with hospitals to make sure they have appropriate inter-facility transfer agreements and guidelines. 8. EMS ensuring that agencies have appropriate pediatric care equipment (small sizes, etc). 9. Mercury clean-up education for schools 10. Prevention of childhood obesity through Health District programs focusing on nutrition and physical activity.

MCH Five-year Needs Assessment
Services Grid

	Direct Health Care	Enabling Services	Population Based Services	Infrastructure Building
Children with Special Health Care Needs	1. CSHP programs for children with certain birth defects or burns. Mostly for uninsured children except those with PKU and CF where insured children are included. 2. Genetics and Metabolic clinics. 3. Provision of necessary medical foods to qualifying patients under 18 (WIC & CSHP) 4. Ryan White HIV Care program	1. CSHP's transition-to-adulthood curriculum. 2. Metabolic nutrition education for qualifying individuals (WIC & CSHP)	1. Family life and sexual health curriculum for special needs students in public schools.	1. Assess the access barriers to specialized care. 2. Collaborate in the development of telehealth linkages. 3. Data collected on special oral-health needs. 4. EMS/EMT staff specially trained to handle CSHCNs.
Cross-Cutting	1. TB treatment for persons with active and latent TB.	1. Idaho QuitLine for Tobacco Cessation 2. Free Radon testing kits	1. Population-based prevention education activities/efforts. (injury, environmental health, tobacco control, sexual violence, etc) 2. Prevention of exposure to 2nd hand tobacco smoke 3. Education on Radon mitigation 4. Poison control hotline.	1. Work on voluntary enrollment of hospitals in the National Healthcare Safety Network. 2. Build the capacity of healthcare entities to investigate and respond to public health emergencies 3. Tobacco cessation "reminder system" for physicians. 4. Working with insurance companies toward coverage of tobacco cessation programs. 5. Funding to Districts for colon cancer education. 6. Heart Attack and stroke prevention activities to and through hospitals.

Attachment B

MCH Five Year Needs Assessment Survey

1. Are you answering this survey as a:

   Representative of a non-profit group
   Representative of a for-profit group
   Representative of a government agency
   Individual (parent, guardian, self)
   Other (please specify)

2. What is the name of the agency, company, or organization you represent?

3. Please rank the following eleven items in order from what you consider to be the most important (rank 1) to the least important (rank 11).

   -Assure the intendedness of pregnancies.
   -Decrease dental disease among pregnant women, mothers and children.
   -Decrease the prevalence of overweight and obese children.
   -Improve access to medical specialists for children with special healthcare needs.
   -Improve immunization rates.
   -Improve transitional service systems for children with special healthcare needs.
   -Increase utilization of preconception and prenatal health care.
   -Reduce intentional injuries (maltreatment, attempted suicide) in children and youth.
   -Reduce premature births and low birth weight.
   -Reduce teen pregnancy.
   -Reduce unintentional injuries to children and youth.

4. Please add any additional comments you may have regarding services, programs, or care for mothers and children.

Five Year Needs Assessment, CSHCN

1. In which county does your child live?

2. How old is your child? (If he or she is less than one year old, please enter "1")

3. If your child has more than one medical specialist, please respond to all questions in this survey thinking of the medical specialist you have the most difficulty in visit. Which category listed below refers to your child's medical specialist?

Cardiologist	Developmental
Geneticist	Metabolic
Orthopedic	Psychiatric
Neurologic	Pulmonologist
Oncologist	Physical Therapist
Orthodontist	Speech Therapist
Other	

4. Does traveling tovisit your child's medical specialist present your family with difficulty? Difficulty could be from distance, lack of transportation, cost, or other travel-related reasons.

5. Has your child ever missed an appointment with his or her specialist for travel-related reasons?

6. How many miles do you have to travel to visit your child's medical specialist?

0 – 30	100 – 250
31 – 99	More than 250

7. How do you travel to visit your child's medical specialist?

Personal vehicle	Air
Train	Bus
Other	

8. How many times per year does your child visit his or her medical specialist?

Less than once	Three times
Once	Four times
Twice	More than four times

9. Is your child covered by public or private health insurance?

   Public Insurance (such as Medicaid, Medicare, Indian Health Service, or Military)
   Private Insurance (such as Blue Cross or Aetna)
   Both Public and Private Insurance
   No Health Insurance

10. Is your child's health insurance accepted at the closest medical specialist?

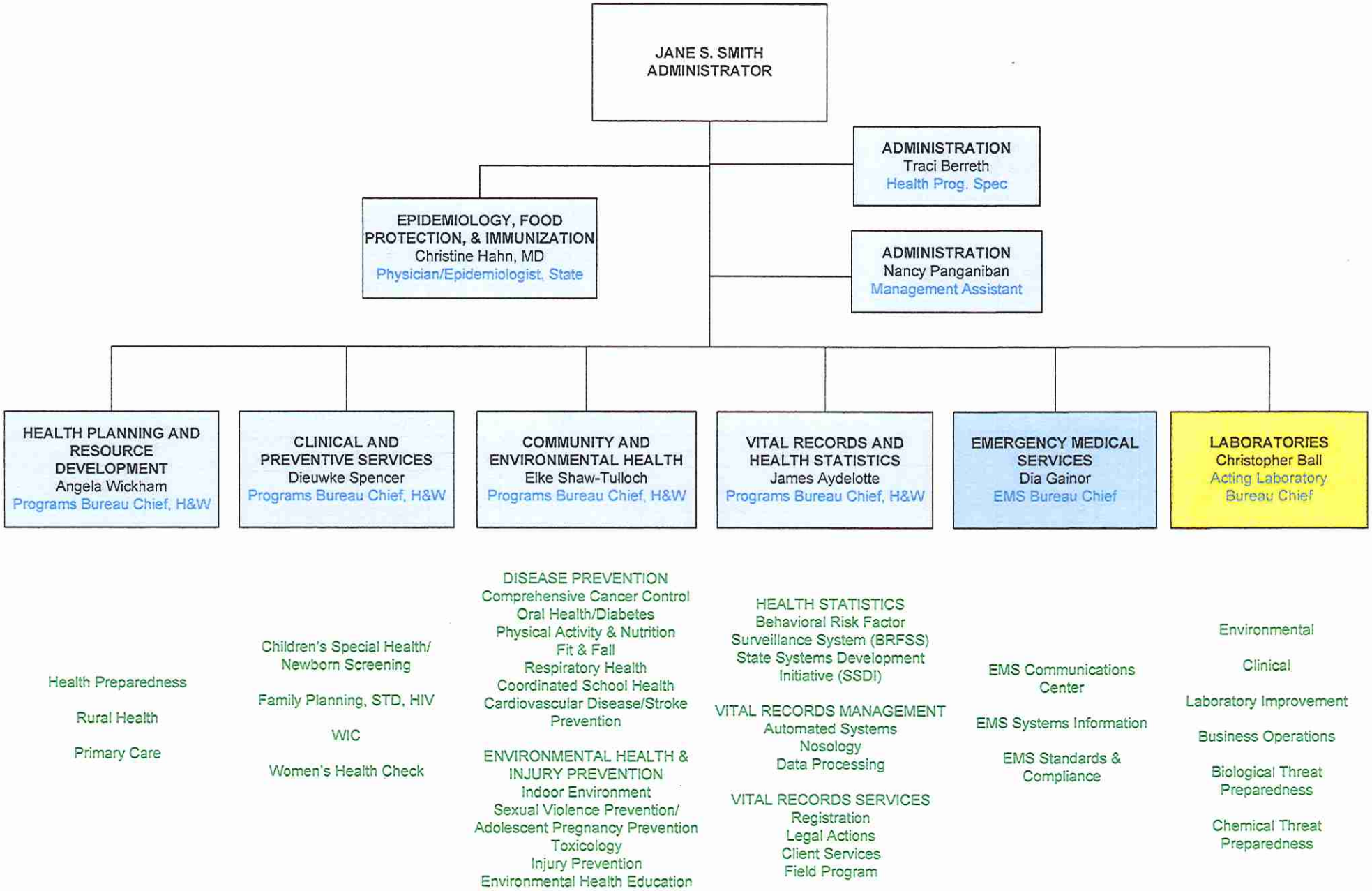
    Yes, the closest medical specialist accepts my child's health insurance.
    No, I have to travel to a more distant provider who will accept my child's insurance.
    I don't know.

Thank you for participating in the Children with Special Healthcare Needs survey.

DIVISION OF PUBLIC HEALTH

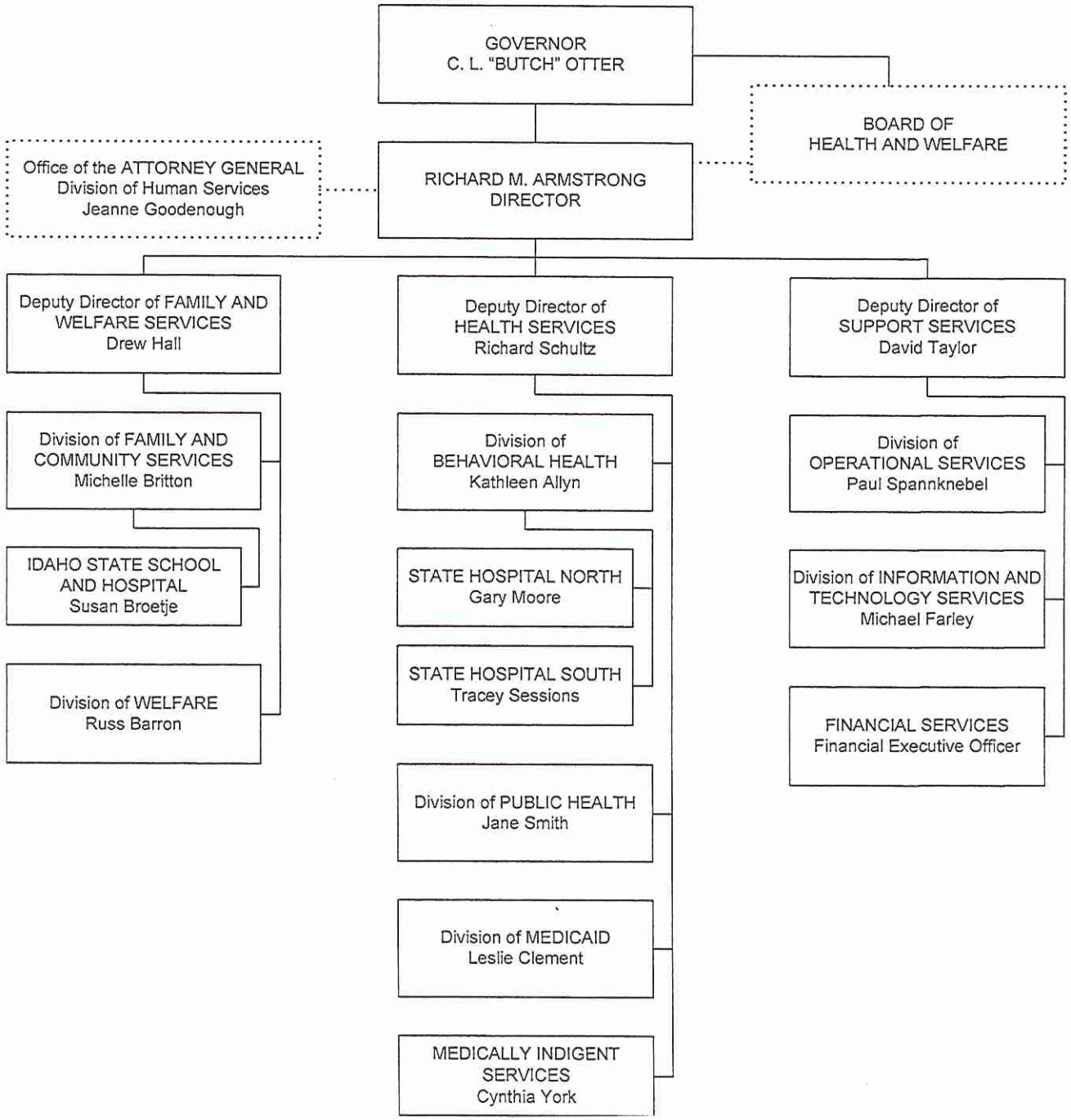
Overview

Attachment D



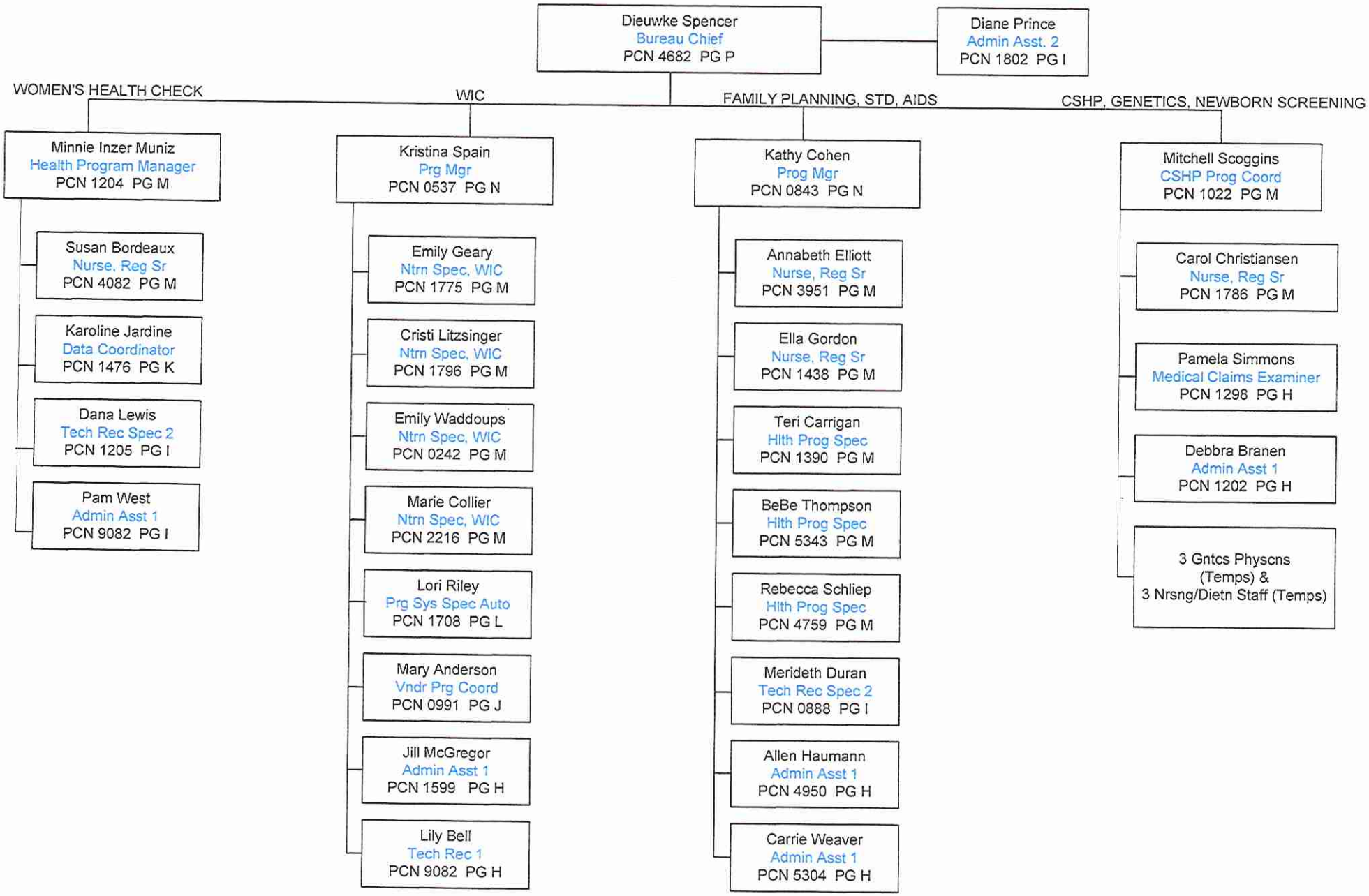
DEPARTMENT OF HEALTH AND WELFARE

Attachment D



IDAHO DEPARTMENT OF HEALTH AND WELFARE
DIVISION OF PUBLIC HEALTH
BUREAU OF CLINICAL & PREVENTIVE SERVICES

Attachment D



Effective: 7/1/10

COOPERATIVE AGREEMENT

BETWEEN

DIVISION OF PUBLIC HEALTH AND DIVISION OF MEDICAID

IDAHO DEPARTMENT OF HEALTH AND WELFARE
(Revised May 2010)

Background

The Division of Public Health and the Division of Medicaid, within the Department of Health and Welfare, have both respective and mutual responsibilities in facilitating the provision of medical services to Idaho citizens. The Division of Public Health has professionals on staff with knowledge and expertise in the area of maternal and child health (MCH), health policy, etc. Consequently, the Division of Public Health staff can provide valuable consultation in drafting, developing, implementing and monitoring certain aspects of some programs supported by the Division of Medicaid. The Division of Medicaid participates in the development and implementation of health policy in collaboration with other Divisions in the Idaho Department of Health and Welfare. The Division of Medicaid has health professional staff with special knowledge and expertise in rules and regulations concerning Medicaid programs and can provide consultation to the Division of Public Health, Bureau of Clinical and Preventive Services (BOCAPS), concerning Medicaid reimbursement for Title V and Title X maternal and child health services. To establish a cooperative and coordinative relationship between the Divisions in carrying out these responsibilities and to meet requirements of the Social Security Act, Title V and Title XIX, and 42 CFR 431.615, a formal Agreement is hereby executed.

Applicability

This agreement specifically refers to relationships of the two divisions concerning the Title XIX (Medical Assistance) Program, the Title V (Maternal and Child Health Block Grant) programs, the Title X (Family Planning) Program, and the Special Supplemental Food Program for Women, Infants, and Children (WIC).

Objectives and Responsibilities

I. Mutual Objectives and Responsibilities:

The following objectives are set forth as requiring participation of both agencies in meeting the needs of eligible Idaho citizens. The divisions will participate in:

A. promoting health services for all eligible families in need of those services in all 44 Idaho counties;

B. enhancing and monitoring of perinatal care statewide, and

C. to the extent allowable/feasible, providing financial support/reimbursement to local health agencies, volunteer health agencies and other groups and individuals engaged in the delivery of health services to infants, children, and women of childbearing age.

II. Division of Public Health, Bureau of Clinical and Preventive Services (BOCAPS) Roles and Responsibilities:

A. Needs Assessment – Collect and analyze health data. Identify needs related to health services for women of childbearing age, infants and children including children with special health care needs.

B. Program Planning – Serve as a focal point for statewide planning of health education, disease prevention, diagnosis, treatment and medical rehabilitative services for women of childbearing age and infants and children. Provide professional expertise to Medicaid staff concerning public health services to be covered by Medicaid and in the development of service provider requirements and rules and regulations of covered services.

C. Program Services Implementation – Develop and monitor BOCAPS service contracts with MCH providers.

D. Program Quality Assurance

1. As requested, provide input into the development of standards and guidelines.
2. As requested, provide training and continuing education to health care providers of MCH services.

E. Program Evaluation – Plan, collect, analyze, interpret, and report data demonstrating the effectiveness of MCH services and the impact on the health status of women of childbearing age, infants and children.

F. When requested, assist Medicaid in provider relations as a liaison with physicians and other health care providers in orientation and education related to MCH services.

G. Conduct outreach with potential clients, including the maintenance of a telephone hotline (Idaho CareLine) providing information and referral to WIC, Title V, Title X, and Title XIX service providers.

H. Promote medical home concepts.

I. Support the Division of Medicaid in assuring the delivery of appropriate developmental and preventive services such as EPSDT screening and immunizations.

III. Division of Medicaid Roles and Responsibilities:

A. Medicaid utilization control and review

1. Collect expenditure data for Medicaid-covered services to analyze use as appropriate.
2. Develop, implement, and monitor Medicaid provider agreements and Medicaid contracts.
3. Refer possible instances of inappropriate billing and/or utilization of Medicaid reimbursement to the Program Integrity Unit for appropriate action.

B. Coordinate with the Division of Public Health to promote awareness of MCH programs.

C. With new or revised service coverage or program changes, the Division of Medicaid will:

1. Develop and promulgate regulations governing new or revised Medicaid-covered services.
2. Coordinate with BOCAPS regarding new or revised services and program changes as appropriate.
3. Inform BOCAPS and providers of covered service changes in Medicaid and regulation changes as appropriate.
4. Inform Regional Medicaid Unit Program Managers of coordination efforts and changes.

IV. Methods

A. Meetings

Meetings between Program Managers, Bureau Chiefs and subject matter experts of the respective Divisions will take place as needed to review progress toward meeting mutual objectives including program policy development and procedure revisions.

B. Adjunctive Eligibility

A pregnant woman, infant, or child whose eligibility has been fully established in the Medicaid program is assured income eligibility for the WIC program.

C. Health Service Coordination

Both divisions will participate in implementation of collaborative services, such as outreach campaigns and referral to a toll-free information line.

D. Joint Evaluation

Evaluation of policies that affect both Divisions shall be accomplished during special meetings, shall be based upon data from program reports and evaluated by mutually agreed upon standards.

E. Reports/Manuals

Each Division will maintain records required by state and federal regulations and, provide reports as requested.

F. Program Data Access

For the purposes of program evaluation, the Division of Medicaid and the Division of Public Health data concerning types and numbers of services provided to clients, as well as numbers of clients receiving specific services, where available. Patient specific information that may be shared, as stipulated under federal guidelines, will be held confidential.

G. Continuous Liaison

Central Office administration of the respective programs shall promote liaison between the regional directors and the district health department directors.

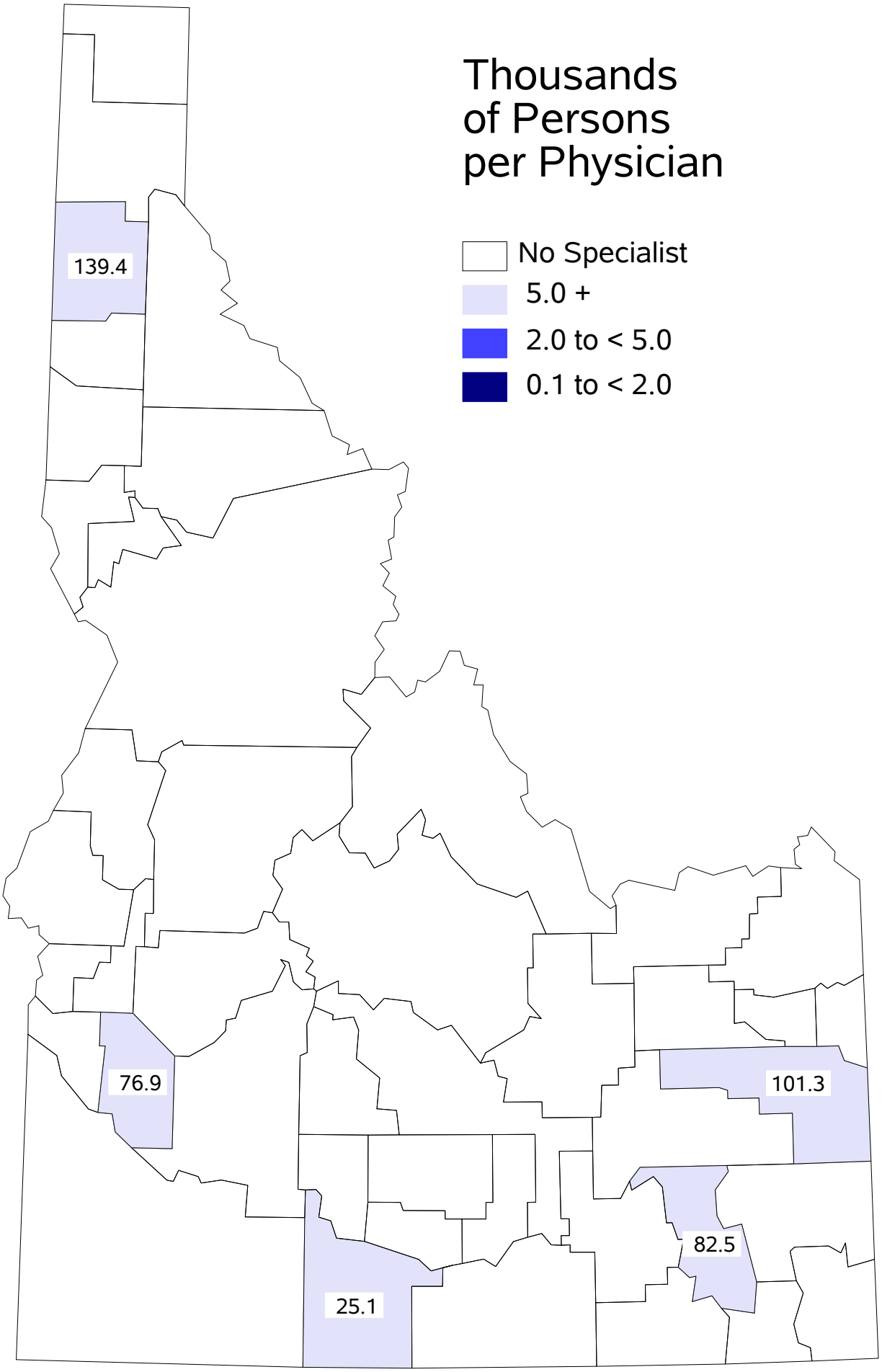
DIVISION OF PUBLIC HEALTH/DIVISION OF MEDICAID

COOPERATIVE AGREEMENT

Jane S. Smith, Administrator Division of Public Health	Date
Leslie Clement, Administrator Division of Medicaid	Date
Richard M. Armstrong, Director Department of Health and Welfare	Date

Medical Specialty=Allergy & Immunology

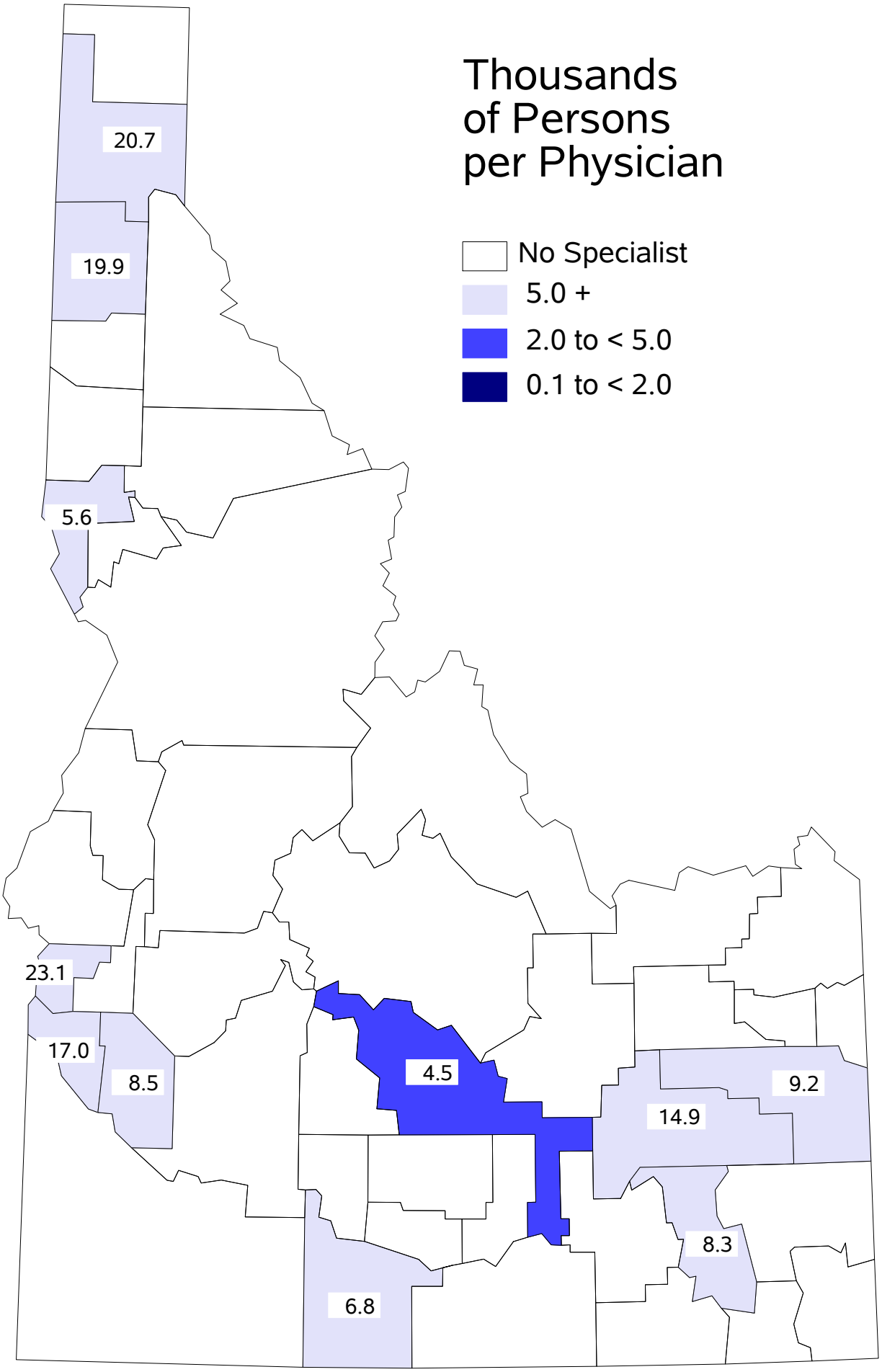
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Anesthesiology

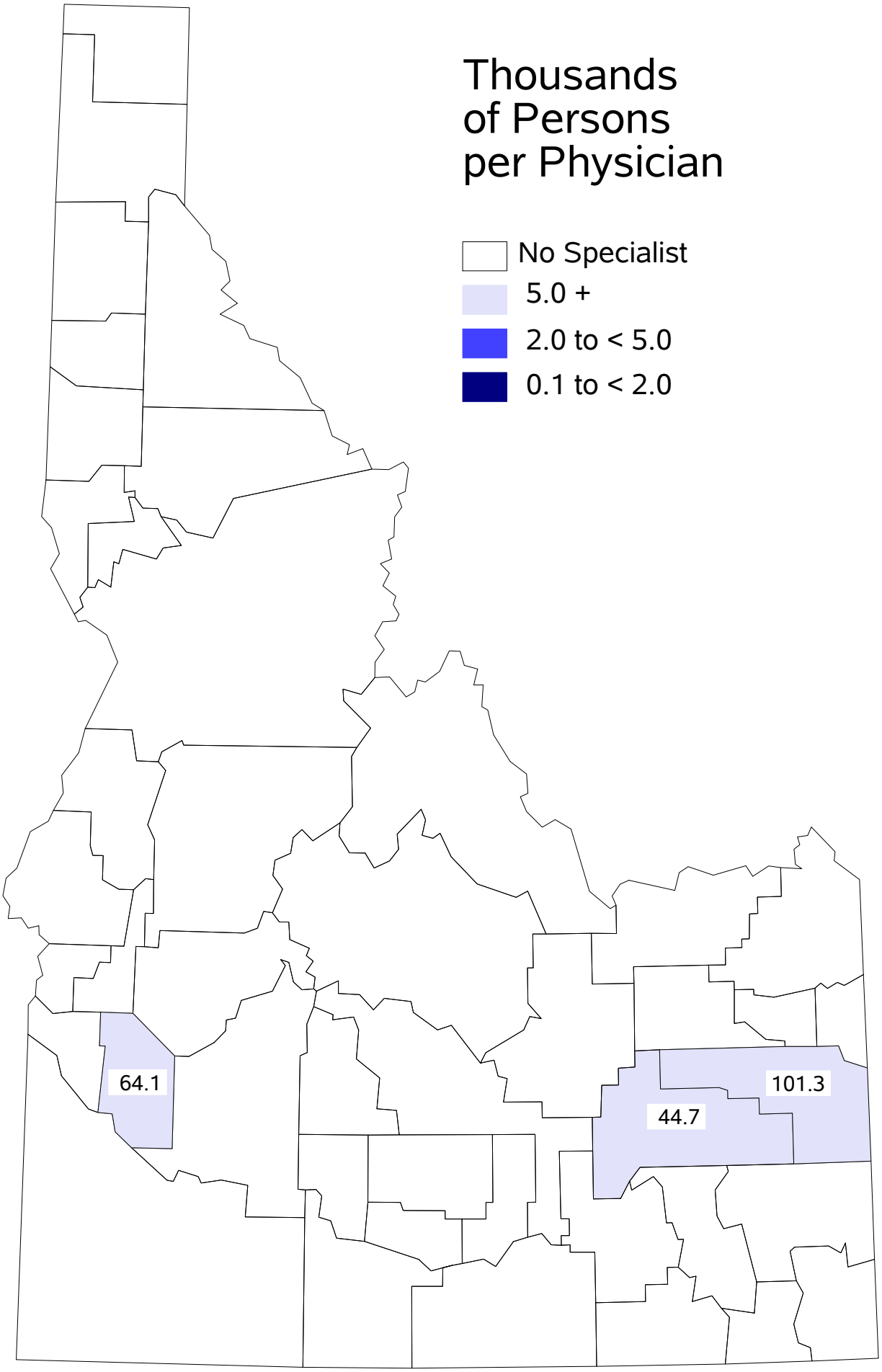
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Pain Medicine (Anesthesiology)

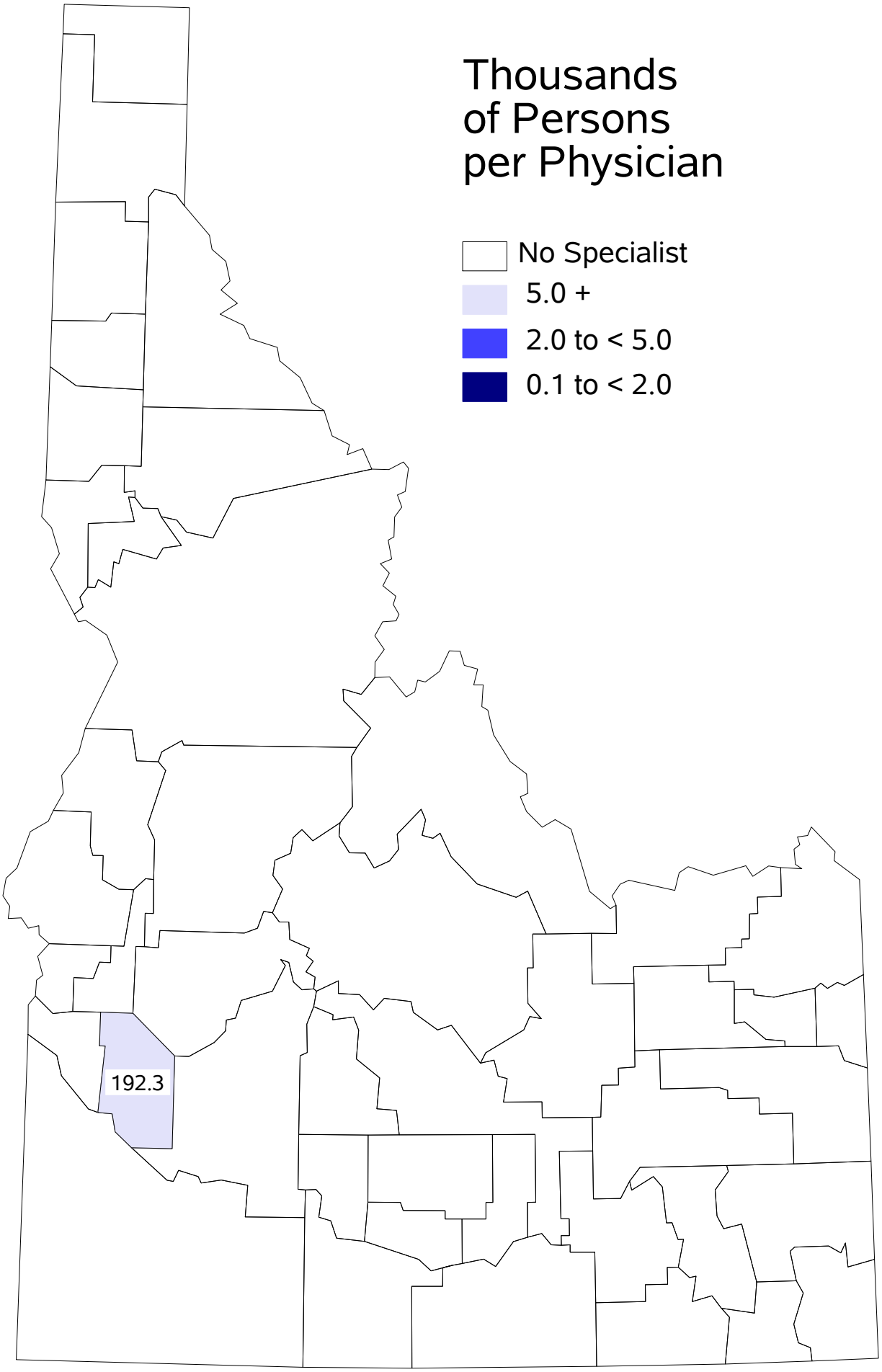
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

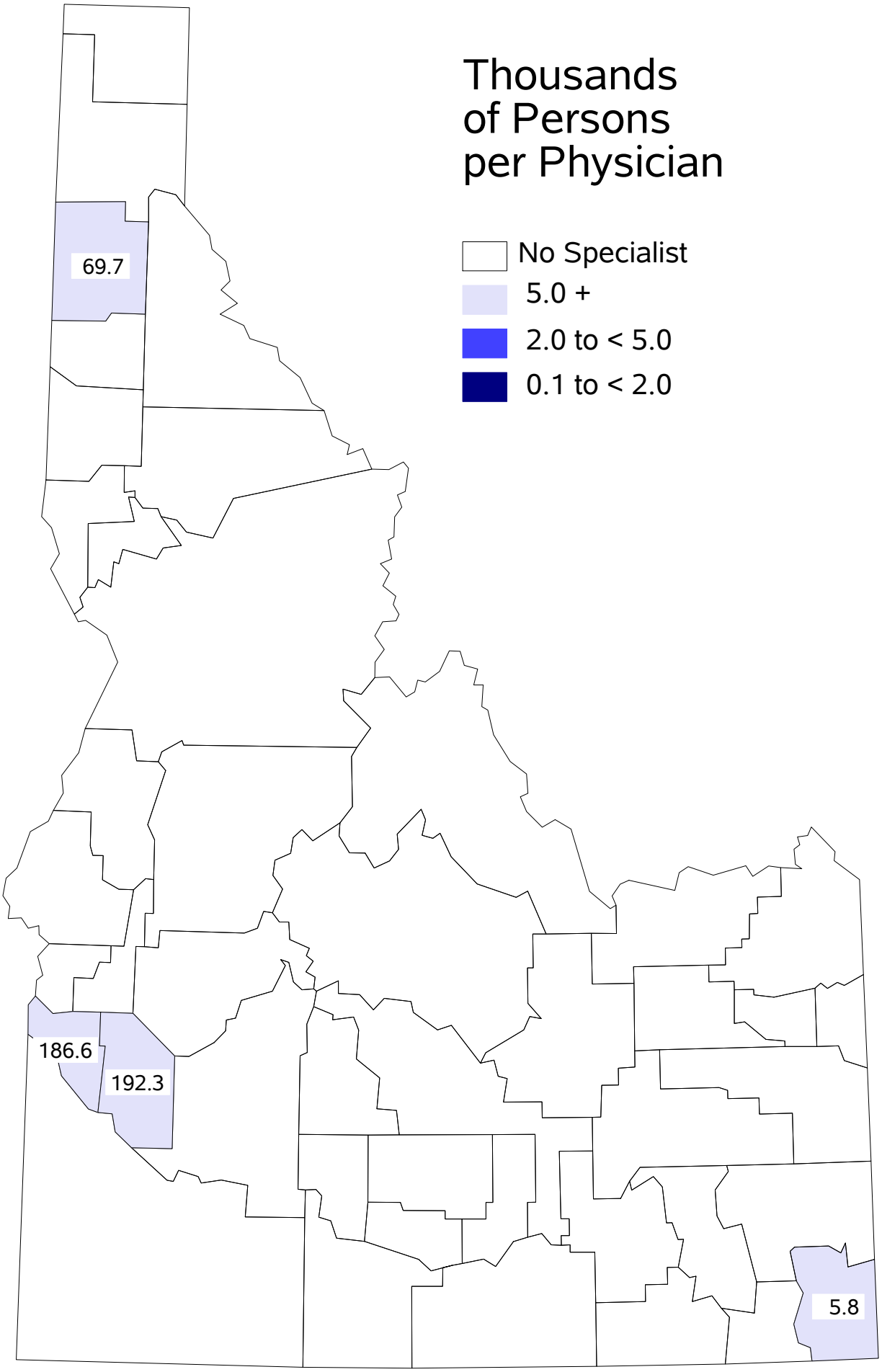
Medical Specialty=Bariatrics or Weight Loss

Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

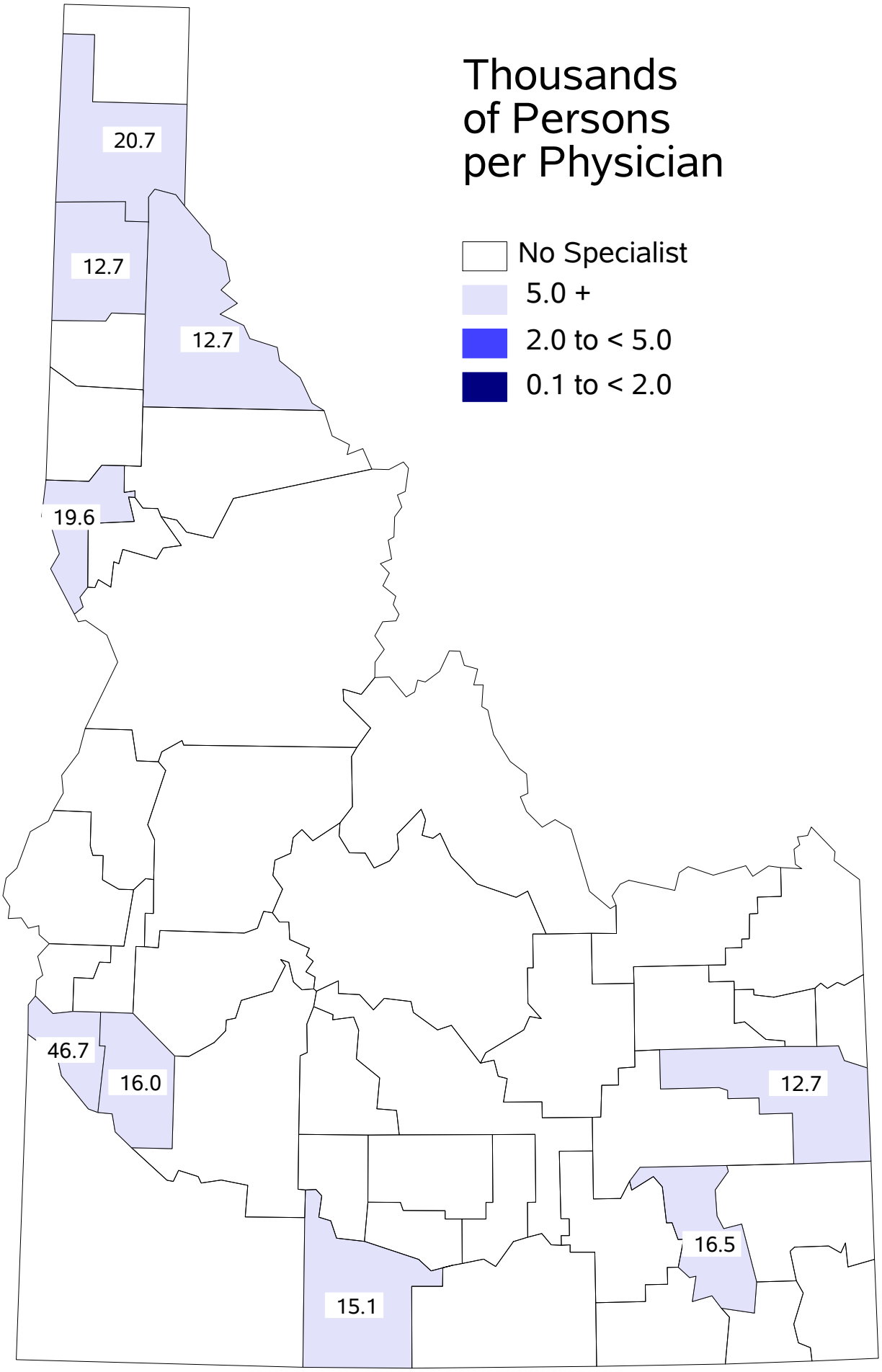
Medical Specialty=Critical Care Medicine (Internal Medicine) Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Cardiovascular Disease

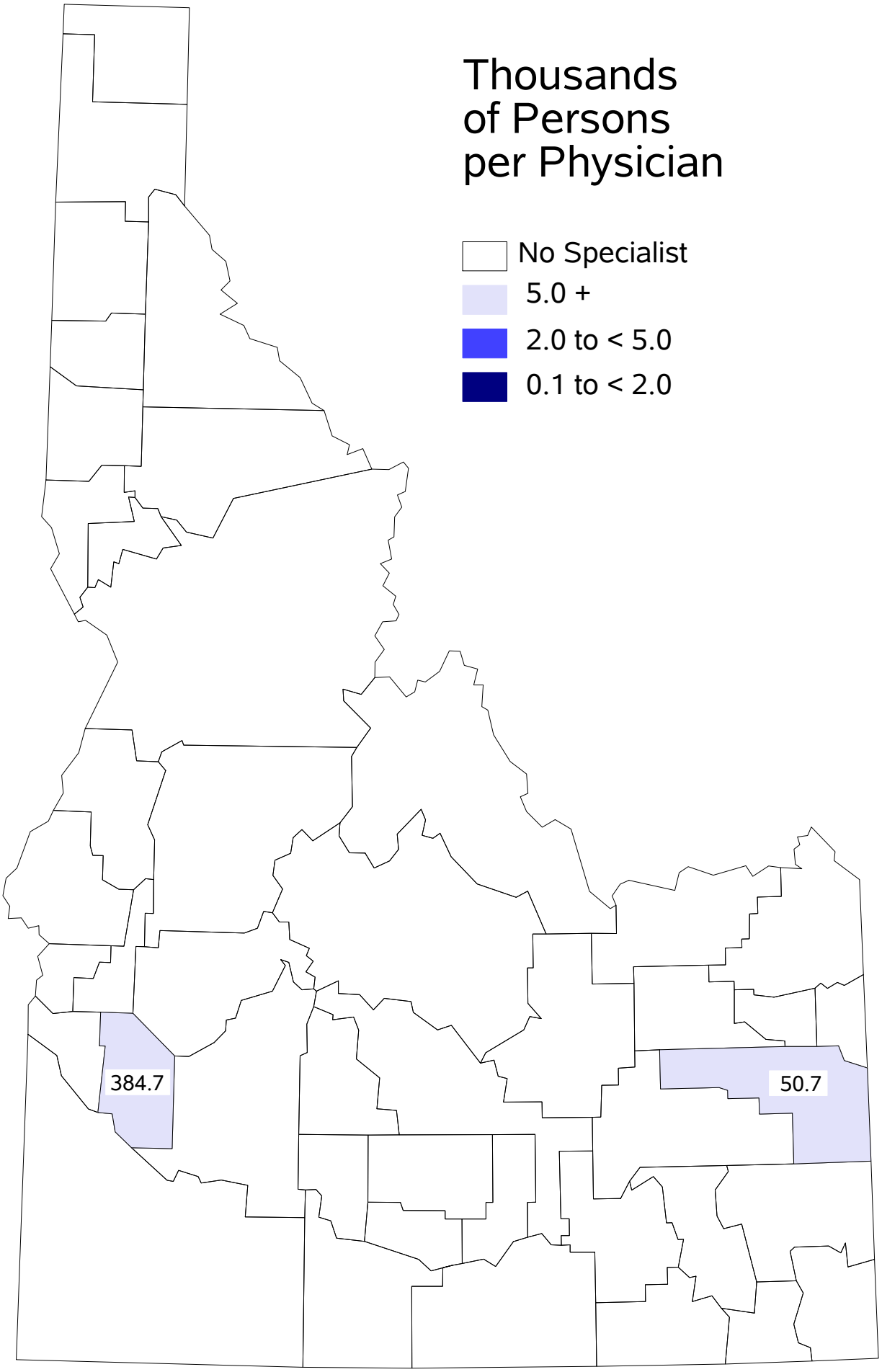
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Child Neurology

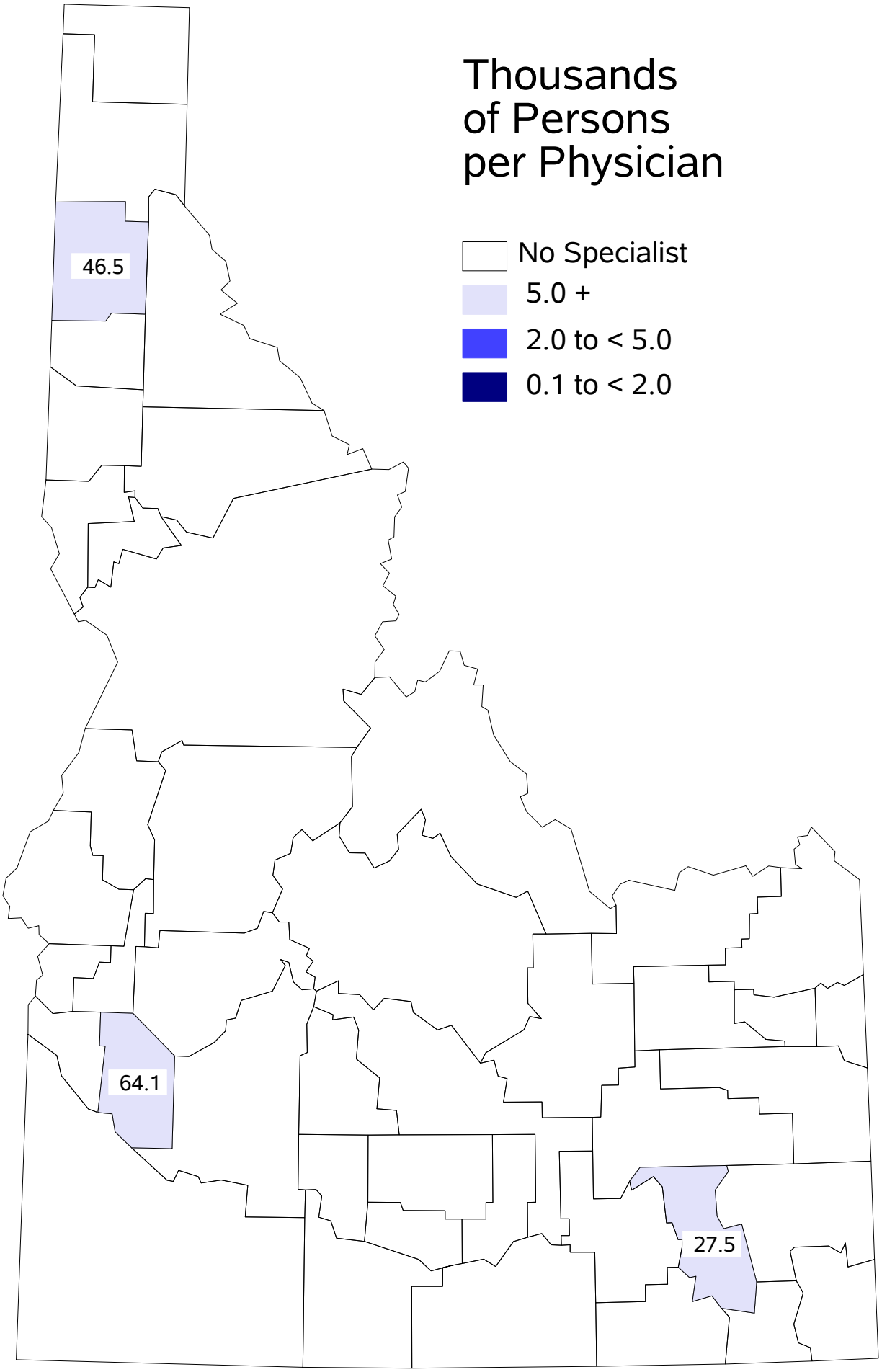
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Child & Adolescent Psychiatry

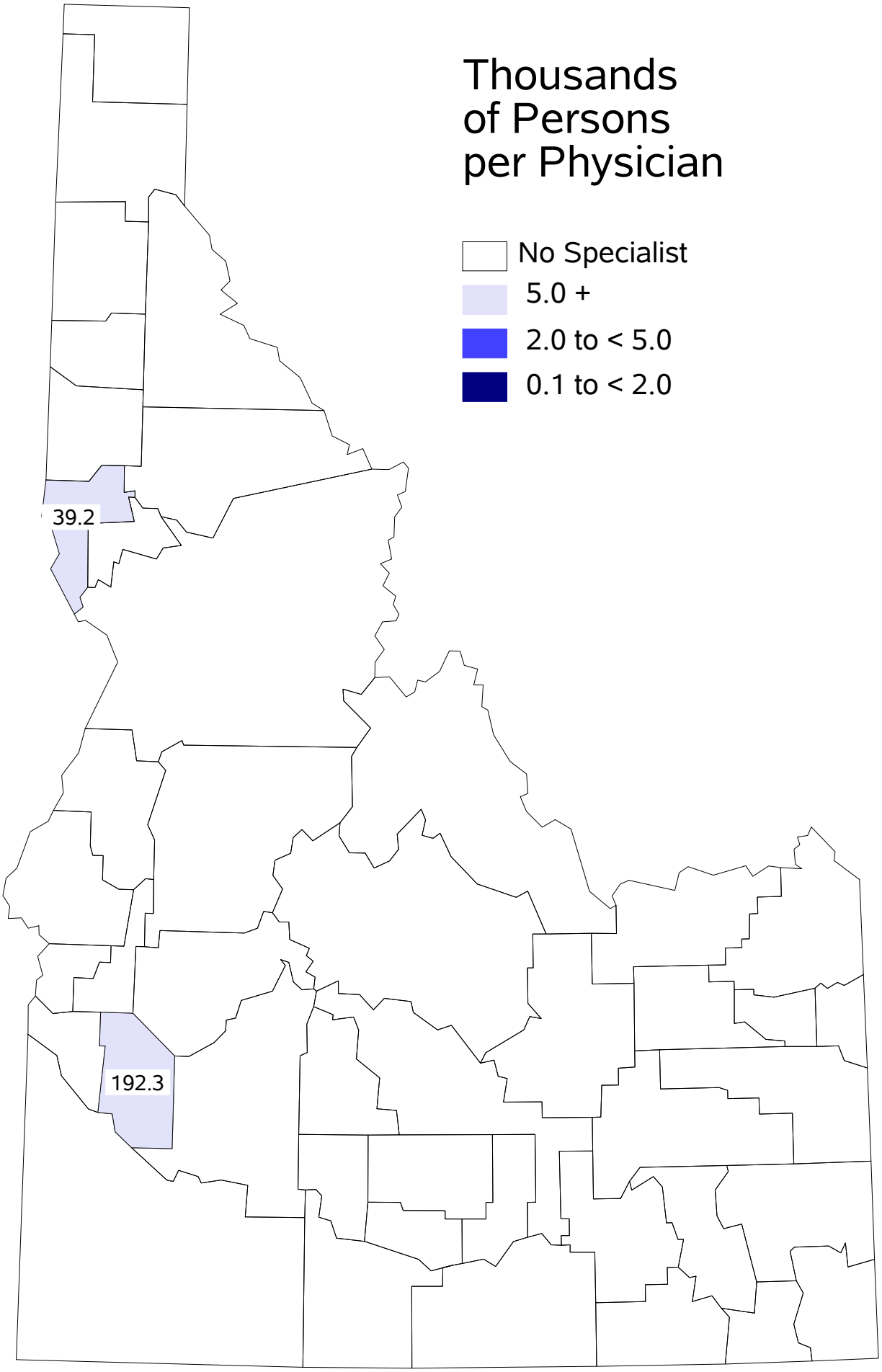
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Colon & Rectal Surgery

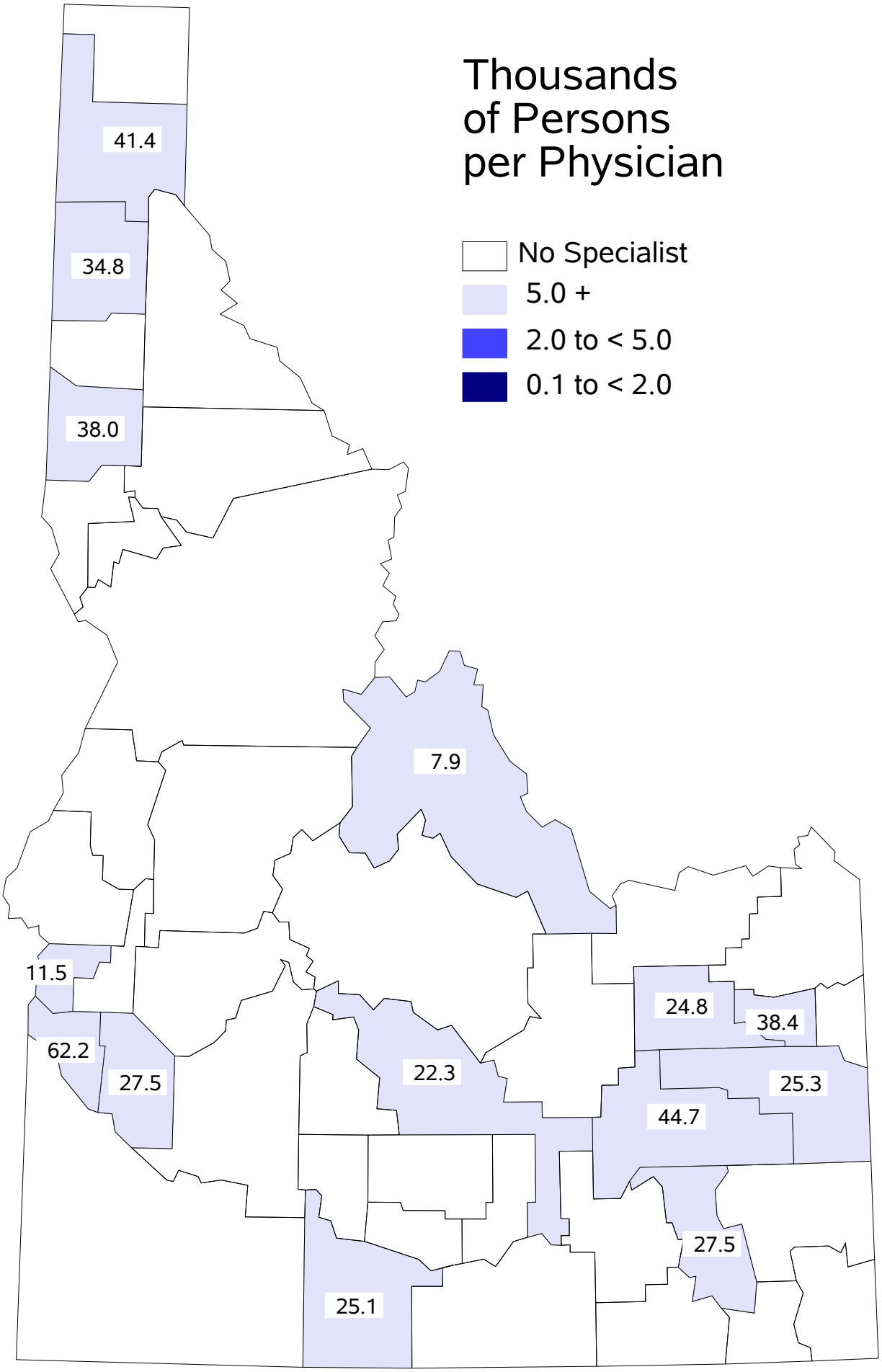
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Dermatology

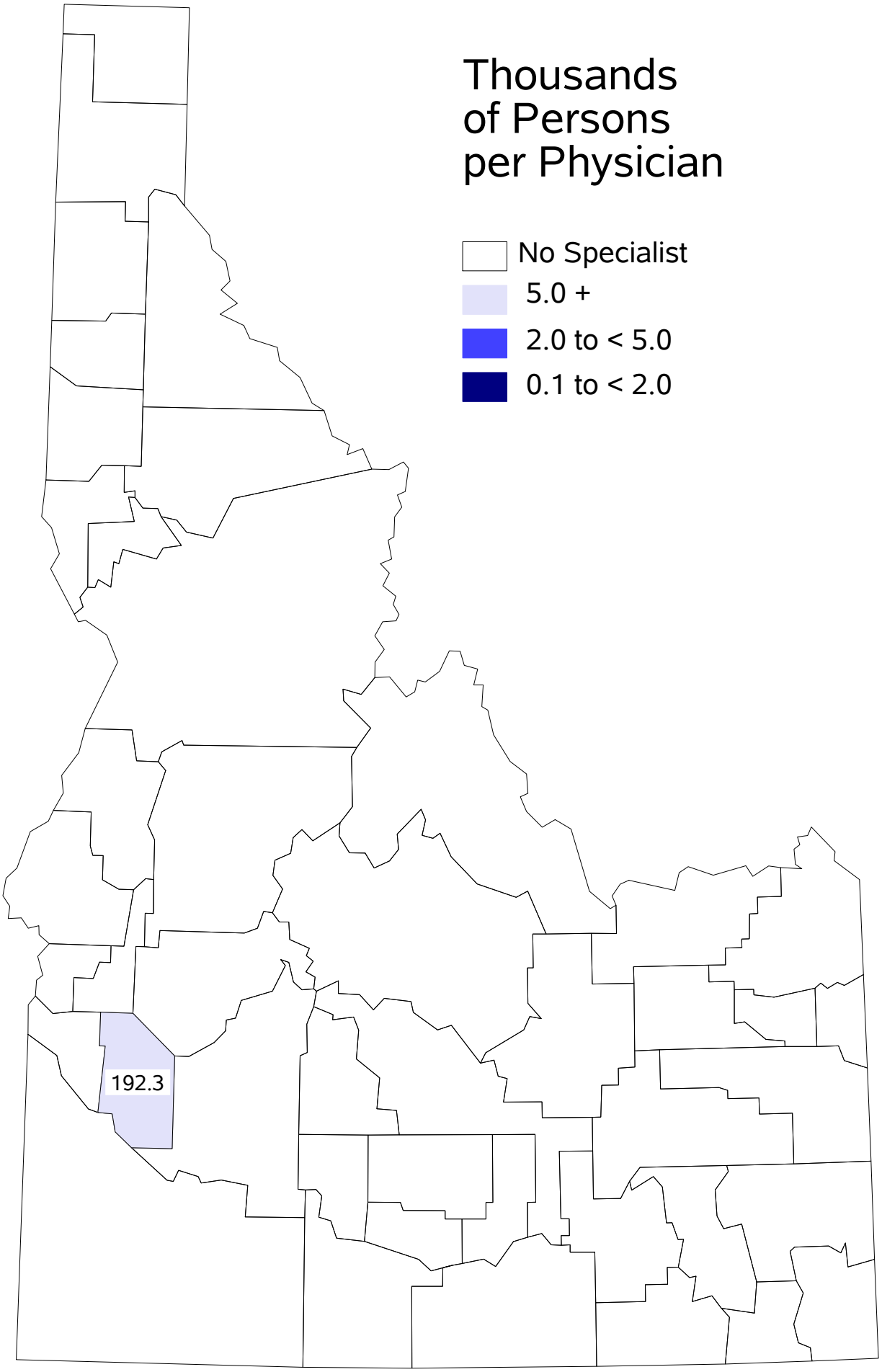
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Dermatopathology

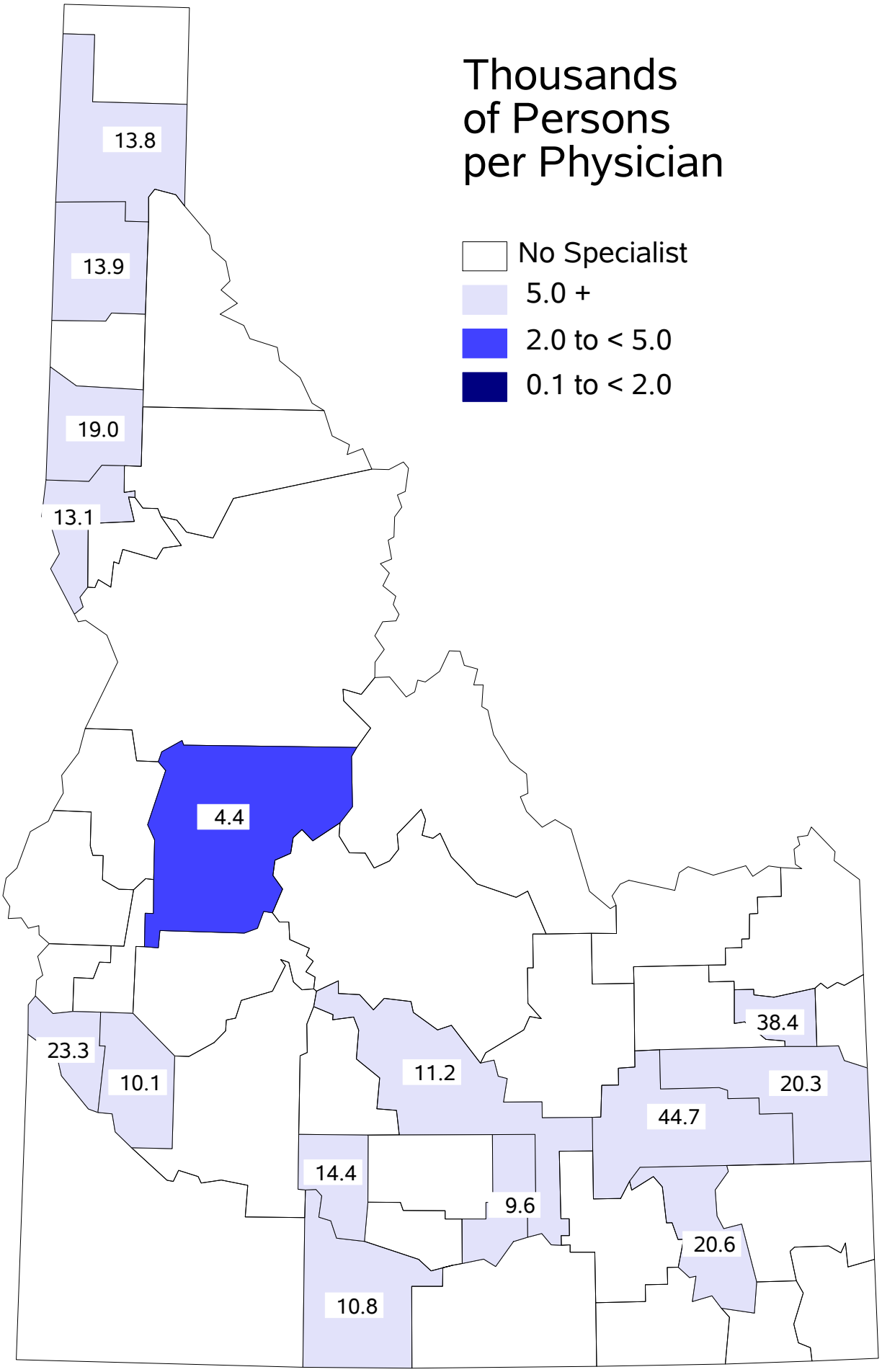
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Diagnostic Radiology

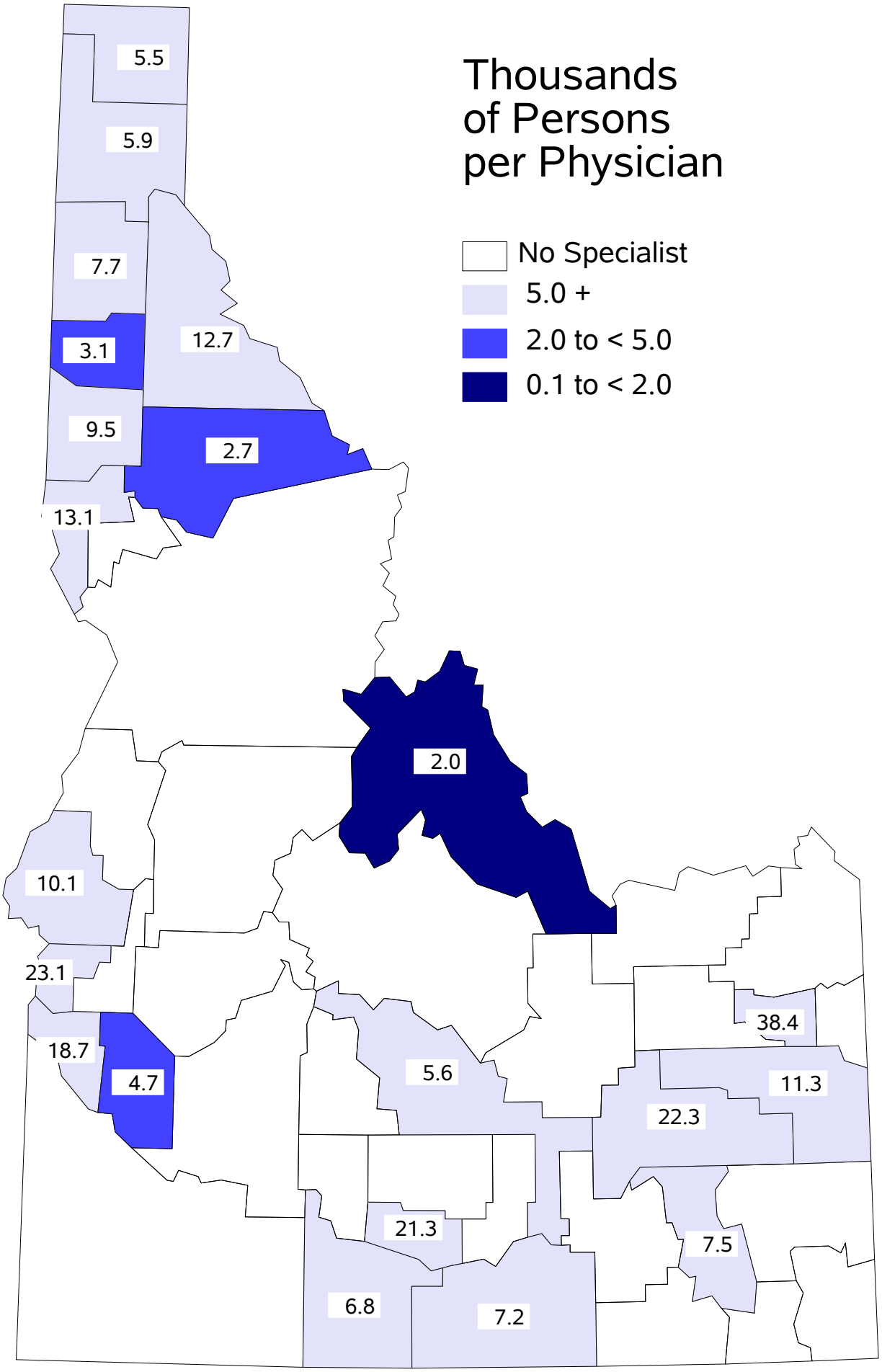
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Emergency Medicine

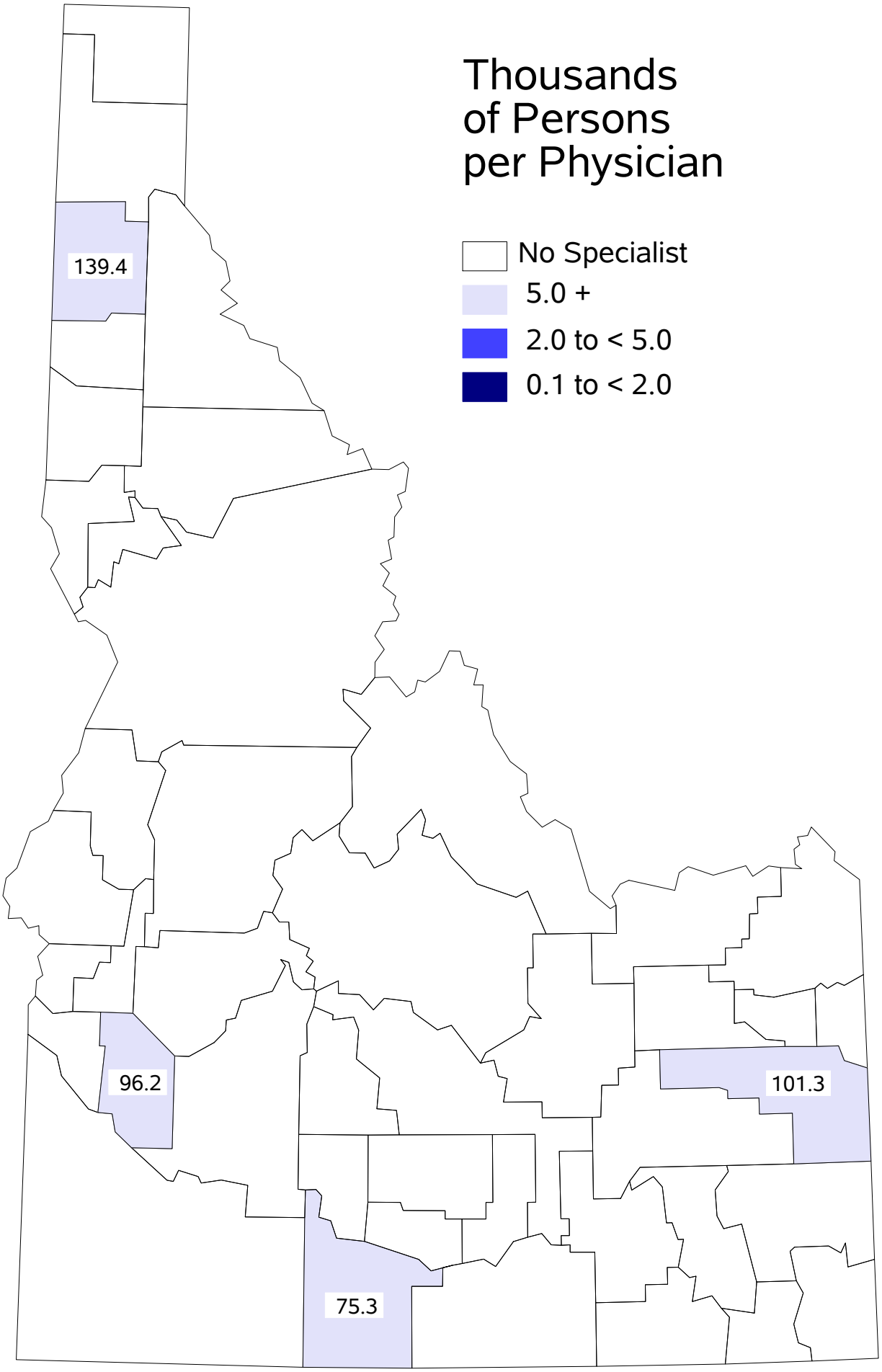
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Endocrinology, Diabetes & Metabolism

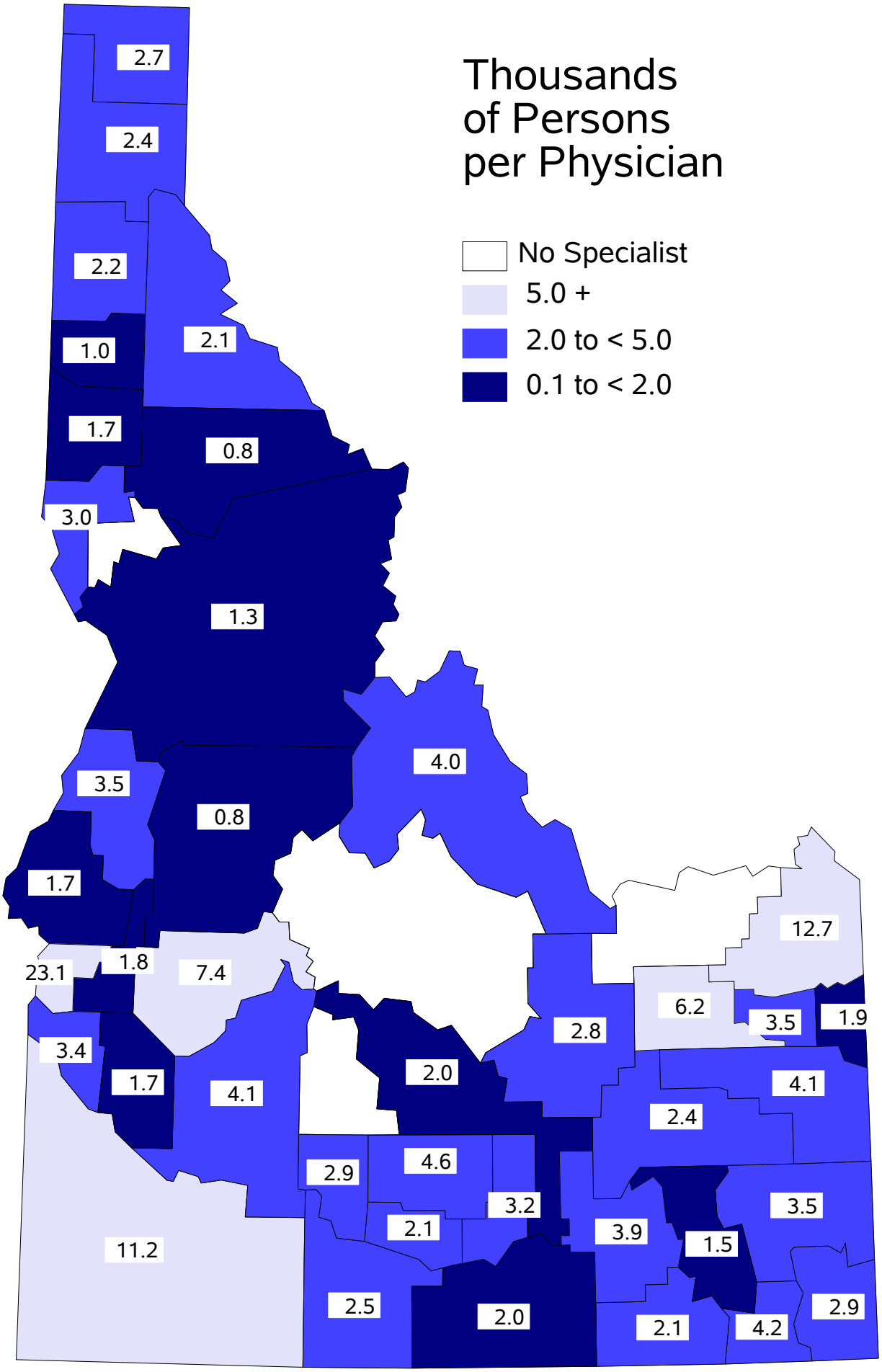
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Family Medicine

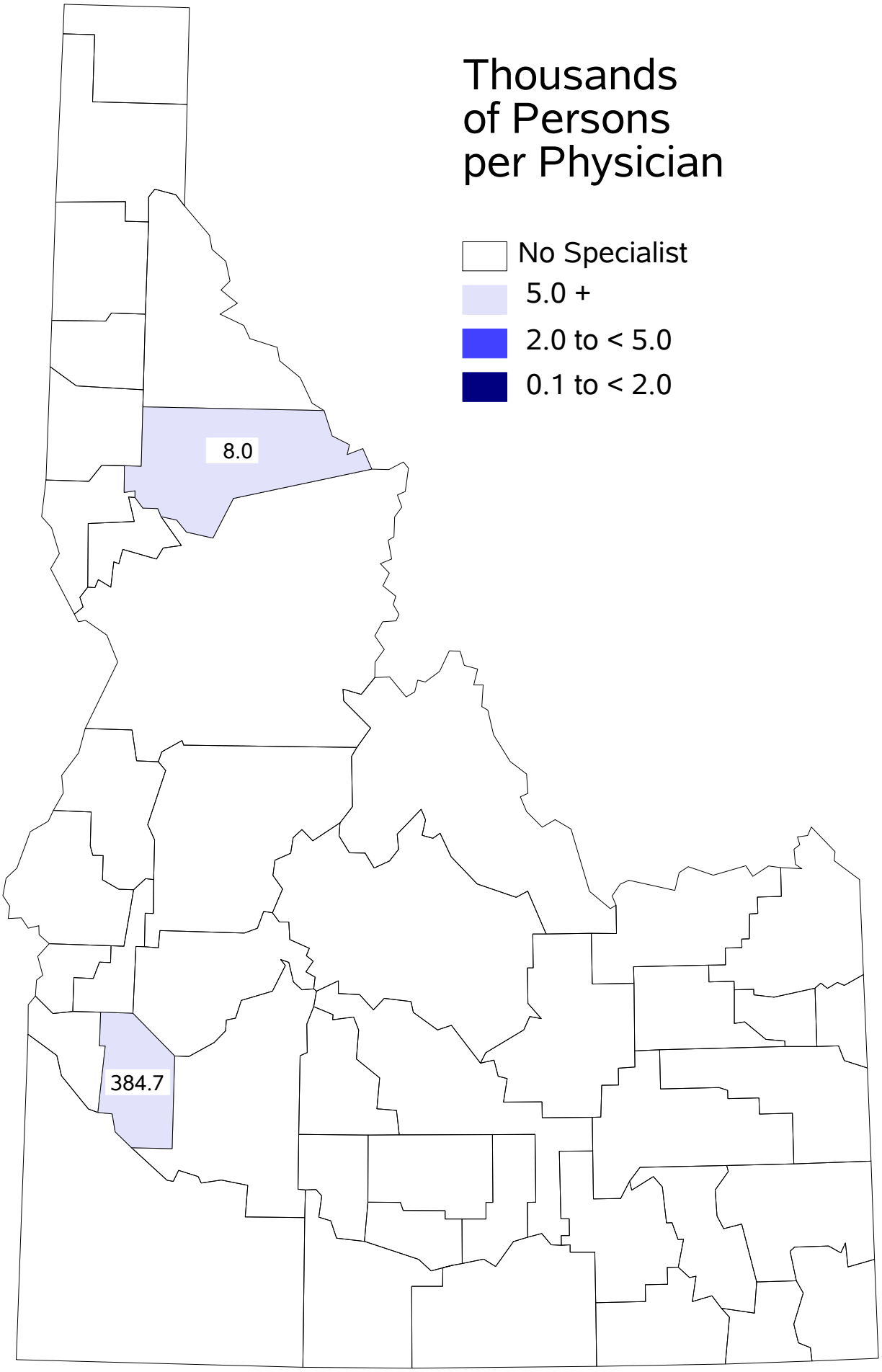
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Forensic Pathology

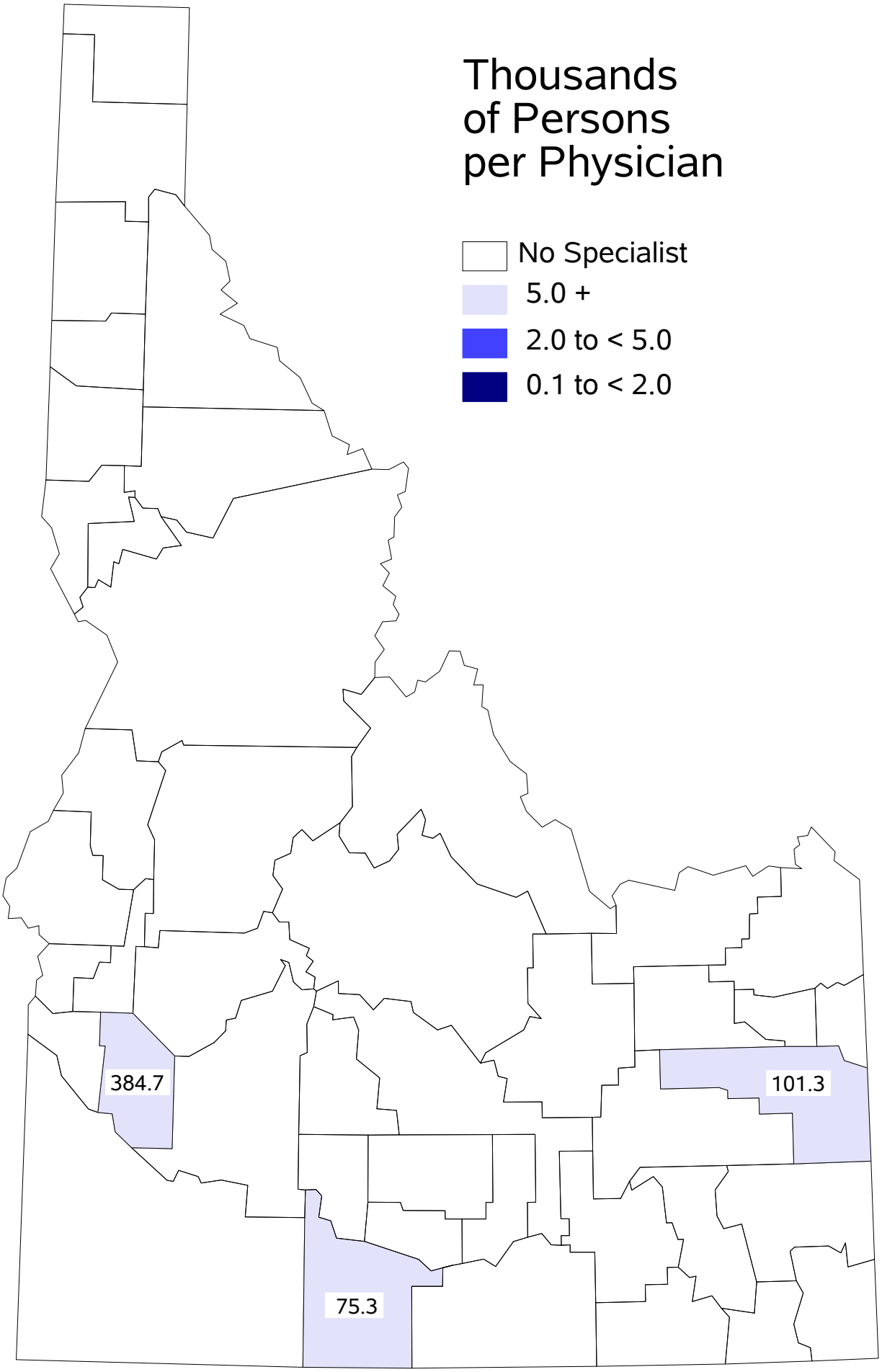
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Facial Plastic Surgery

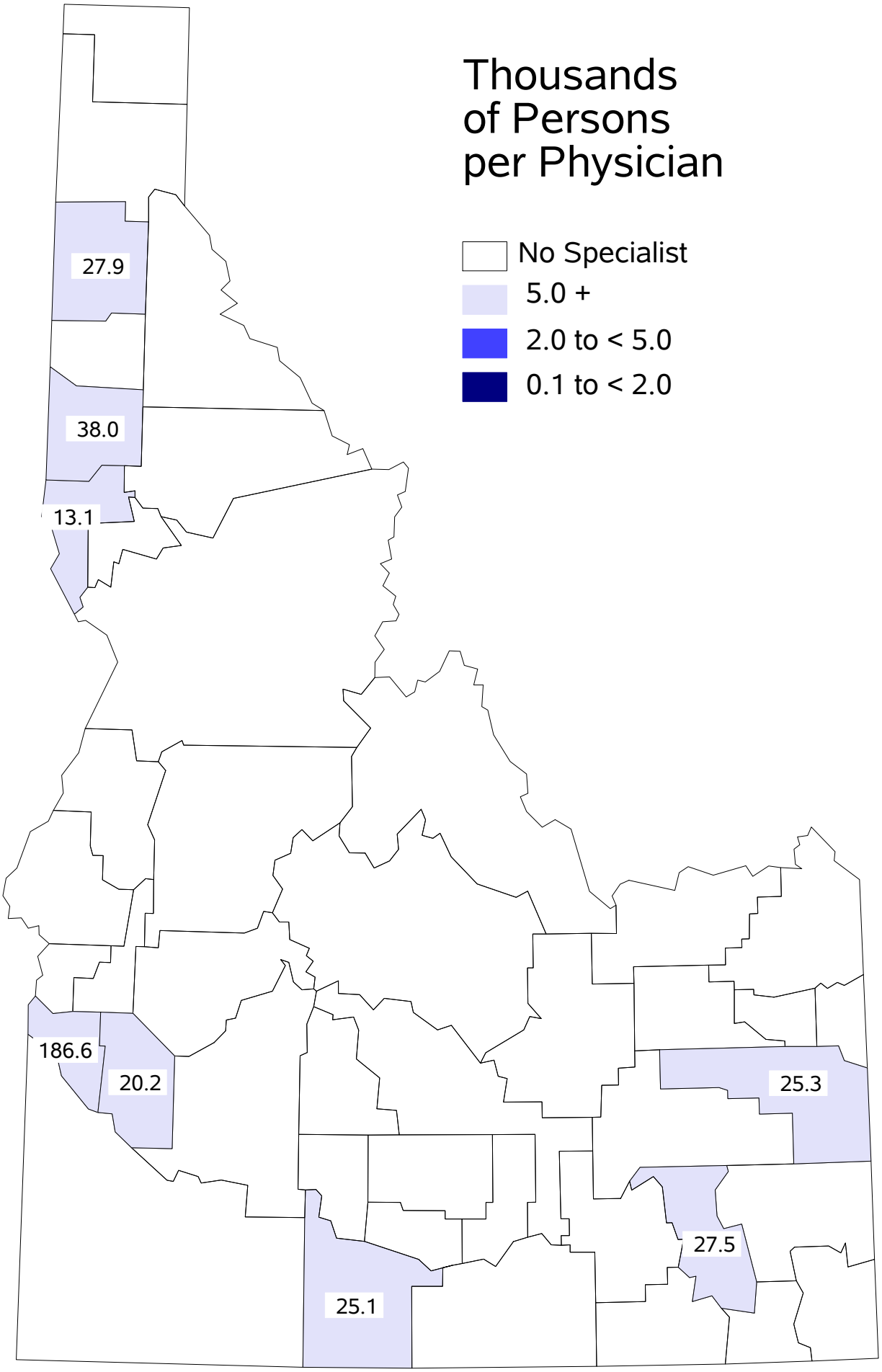
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Gastroenterology

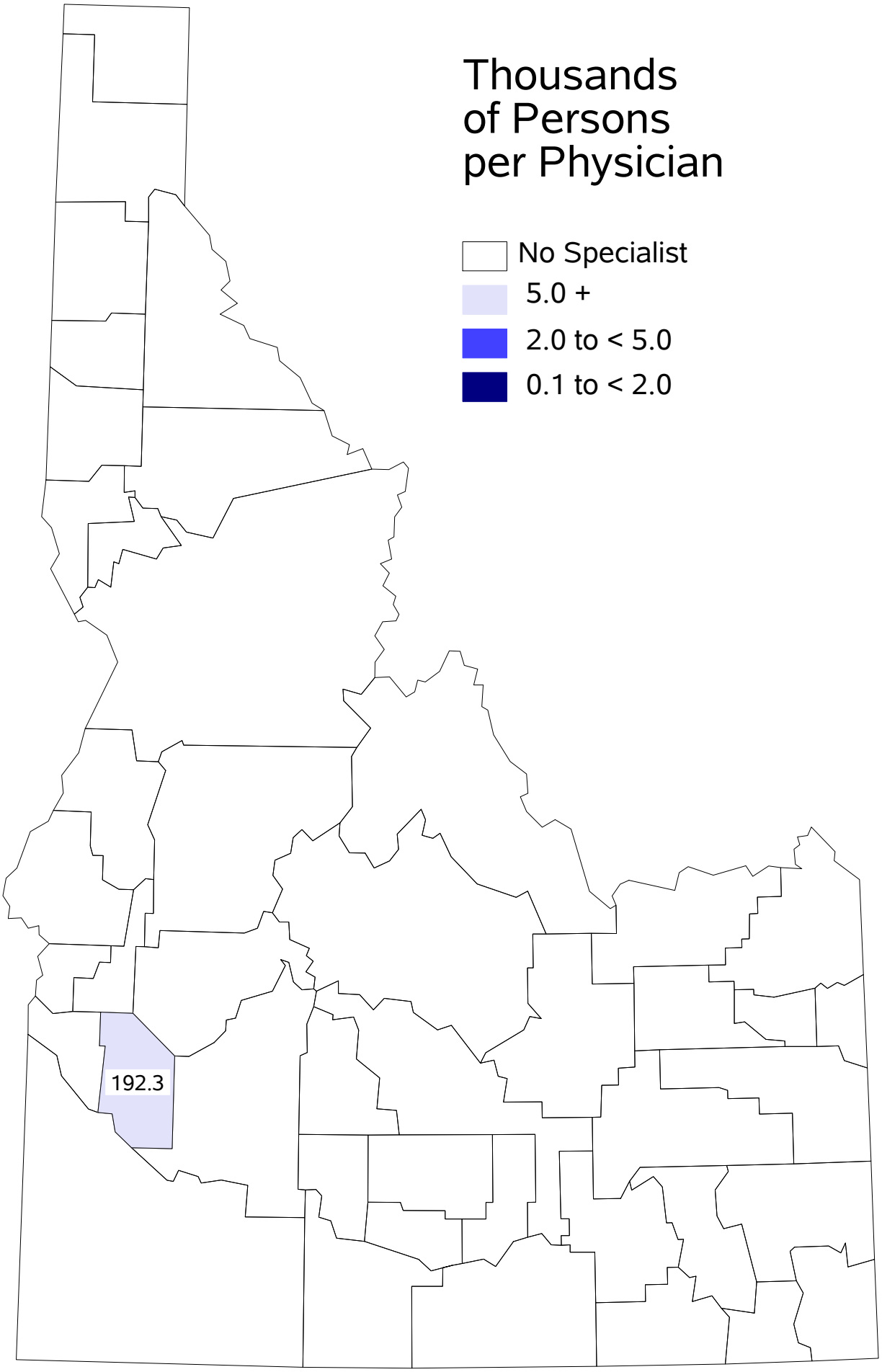
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Gynecological Oncology

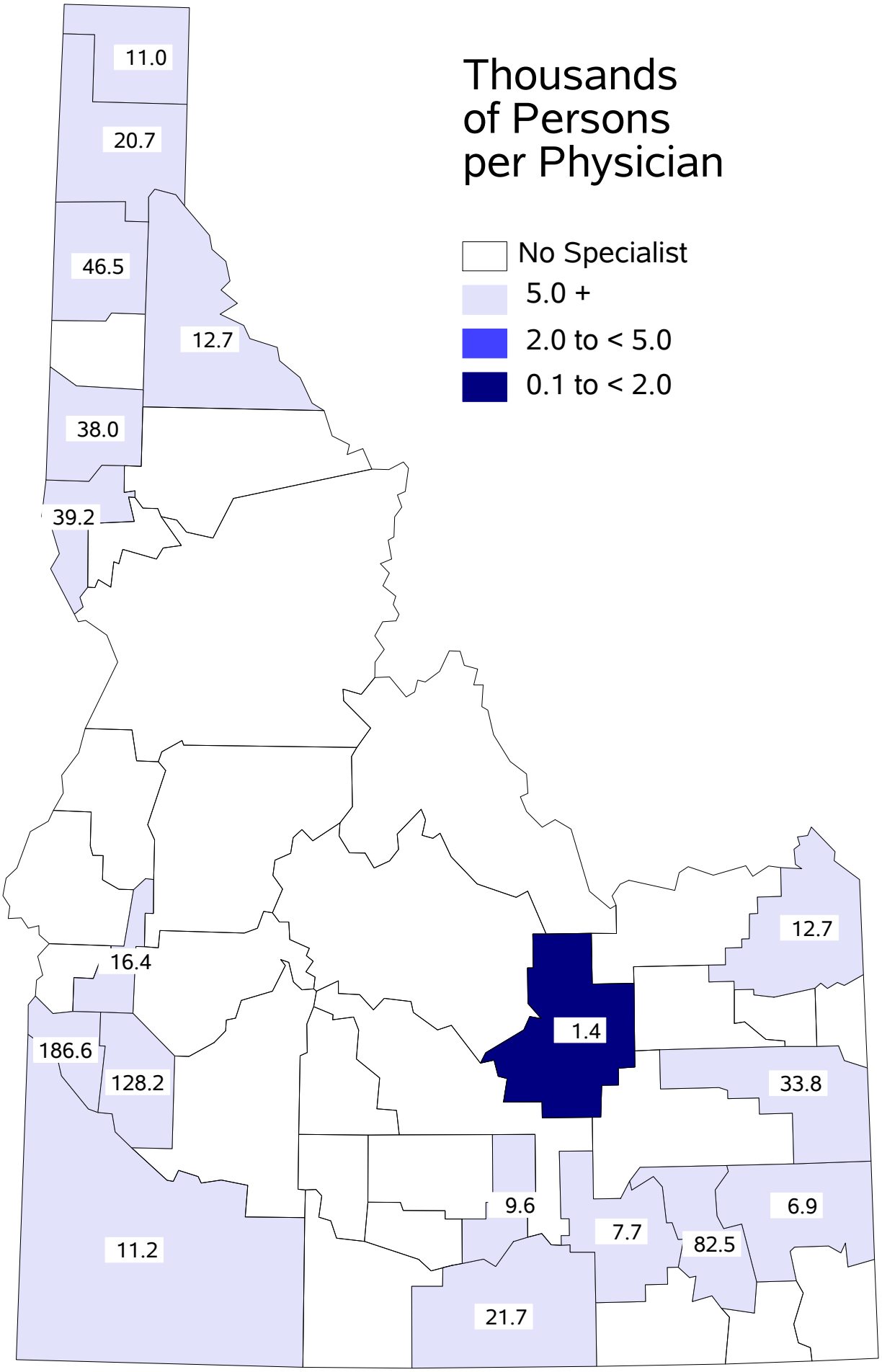
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=General Practice

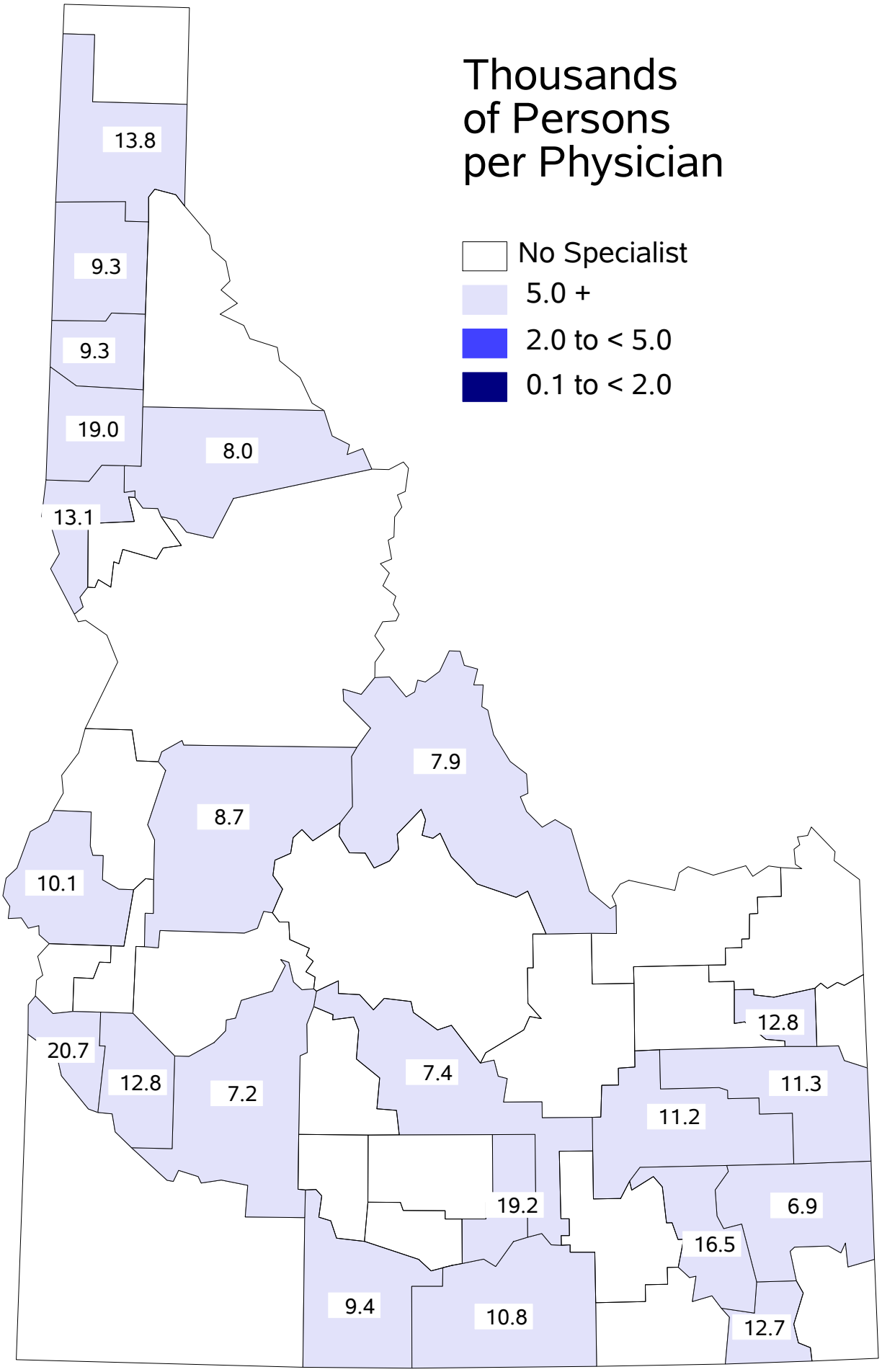
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=General Surgery

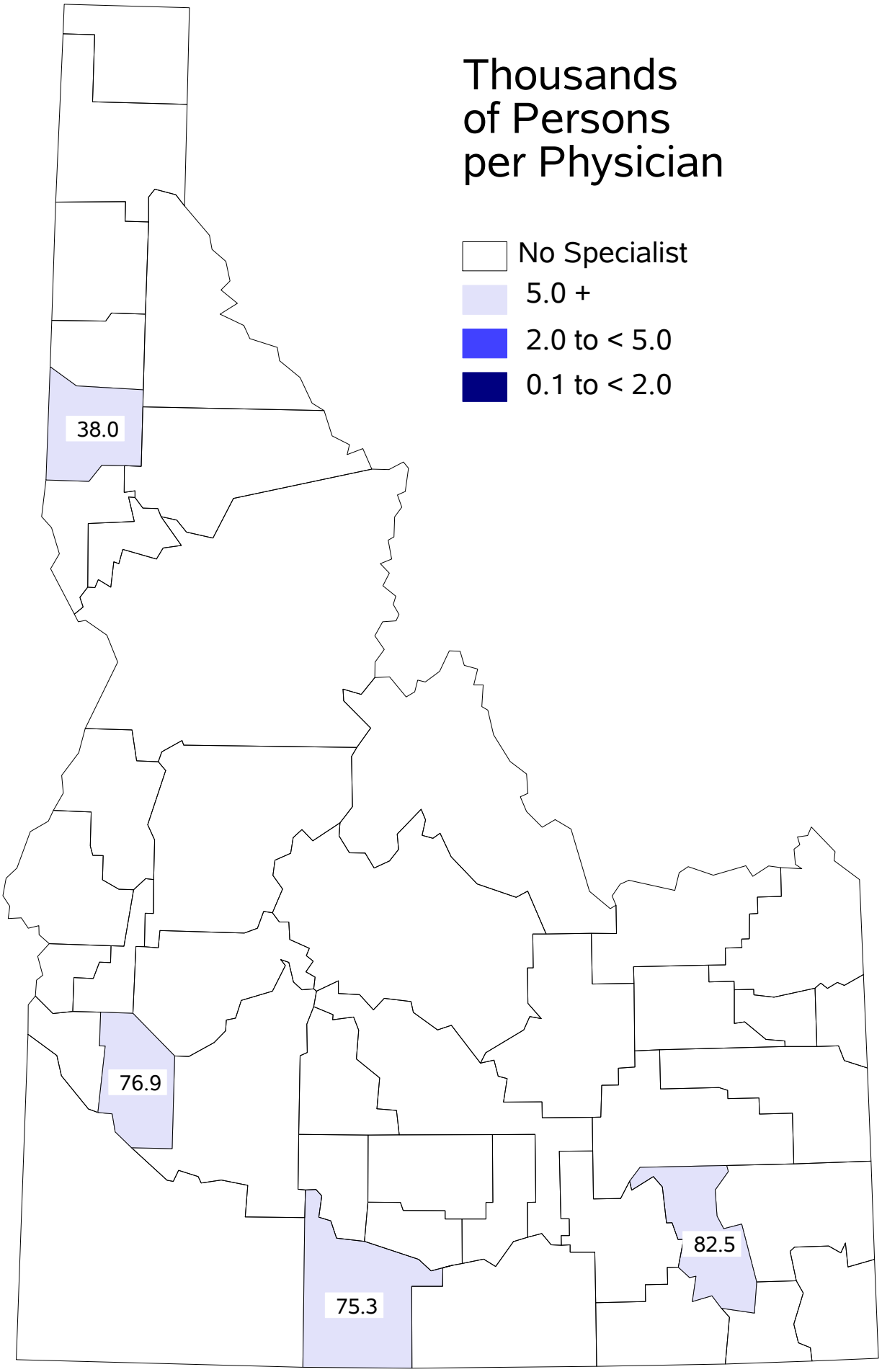
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Gynecology

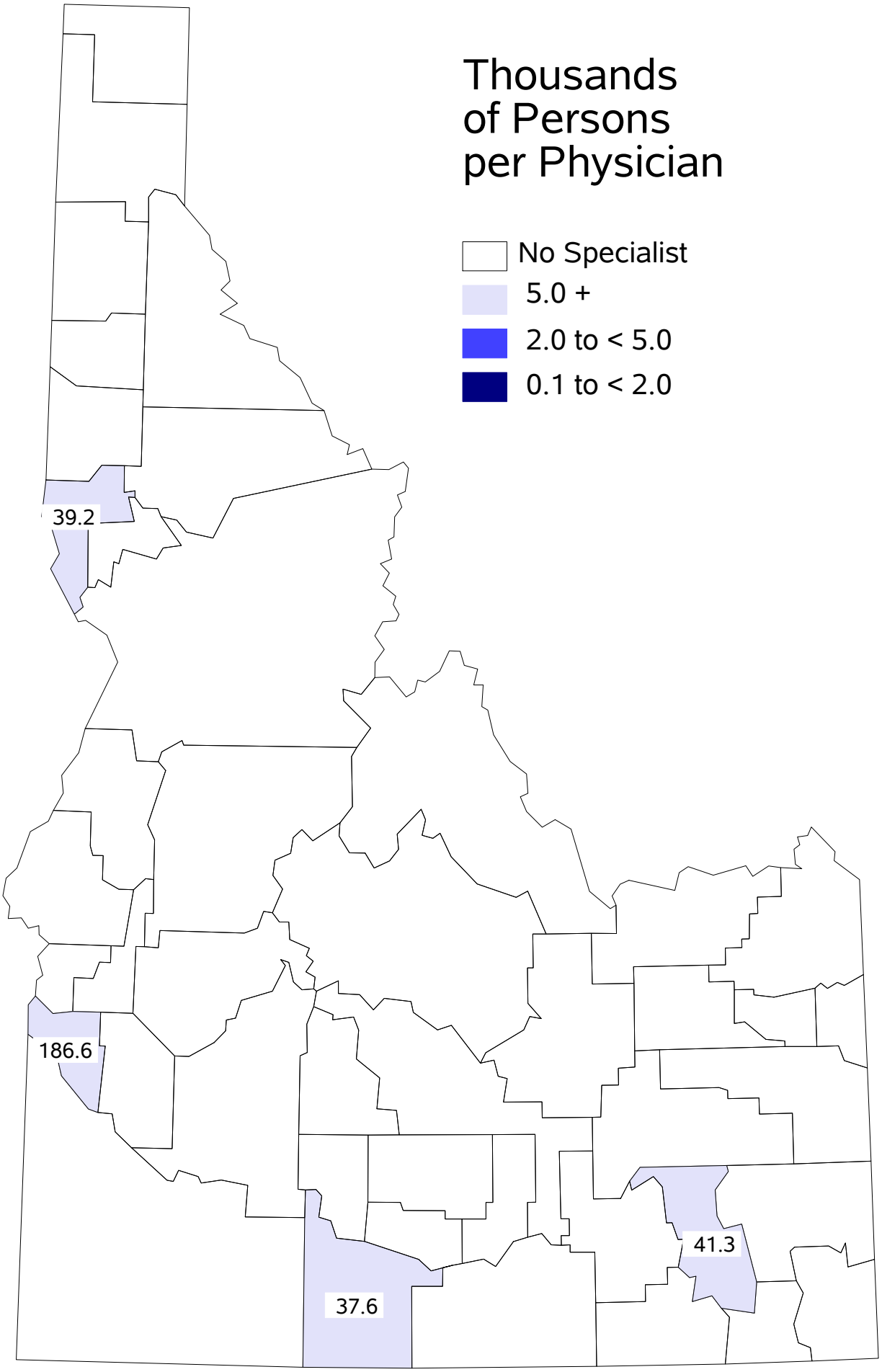
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Hematology (Internal Medicine)

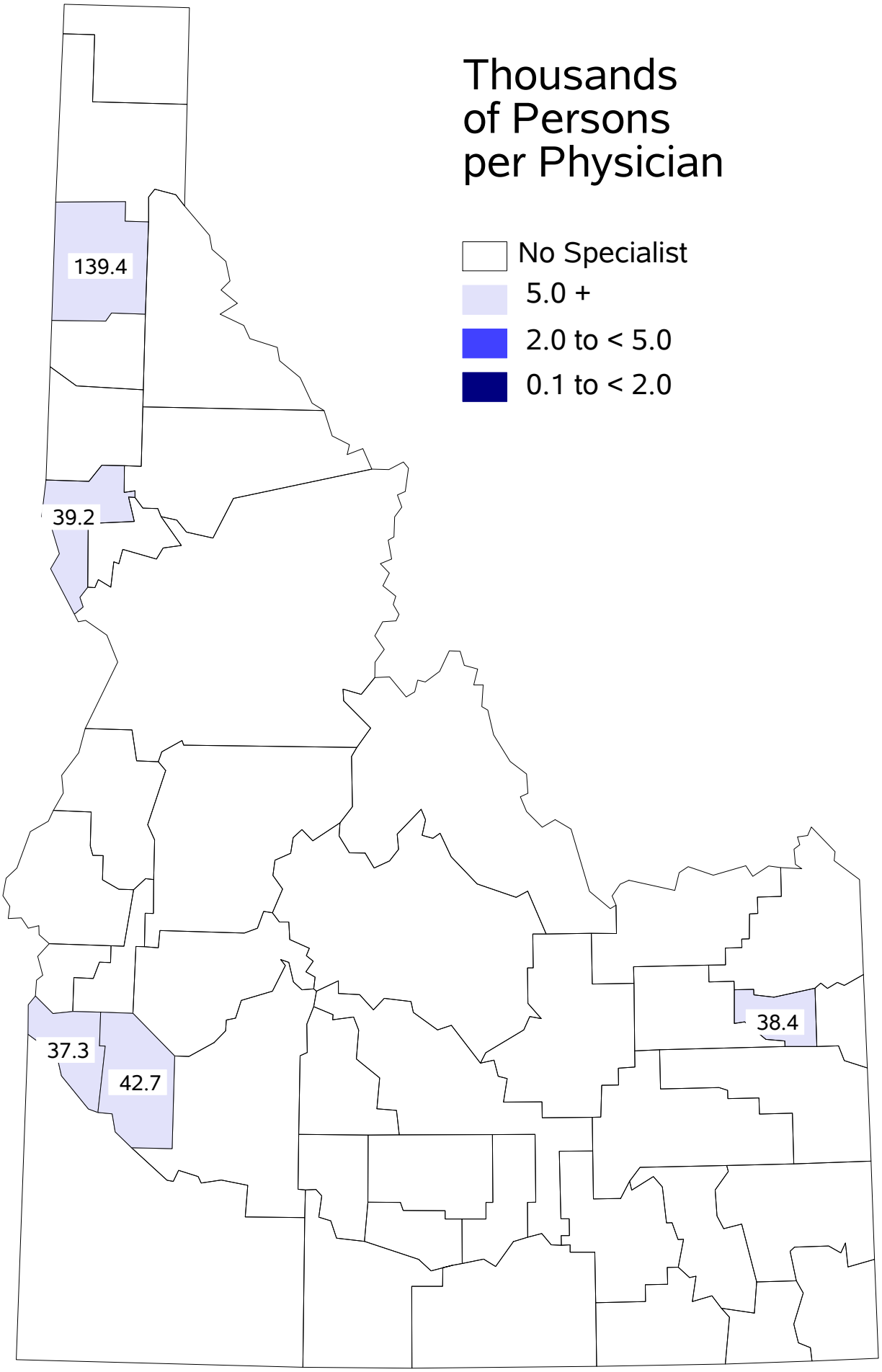
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Hematology/Oncology

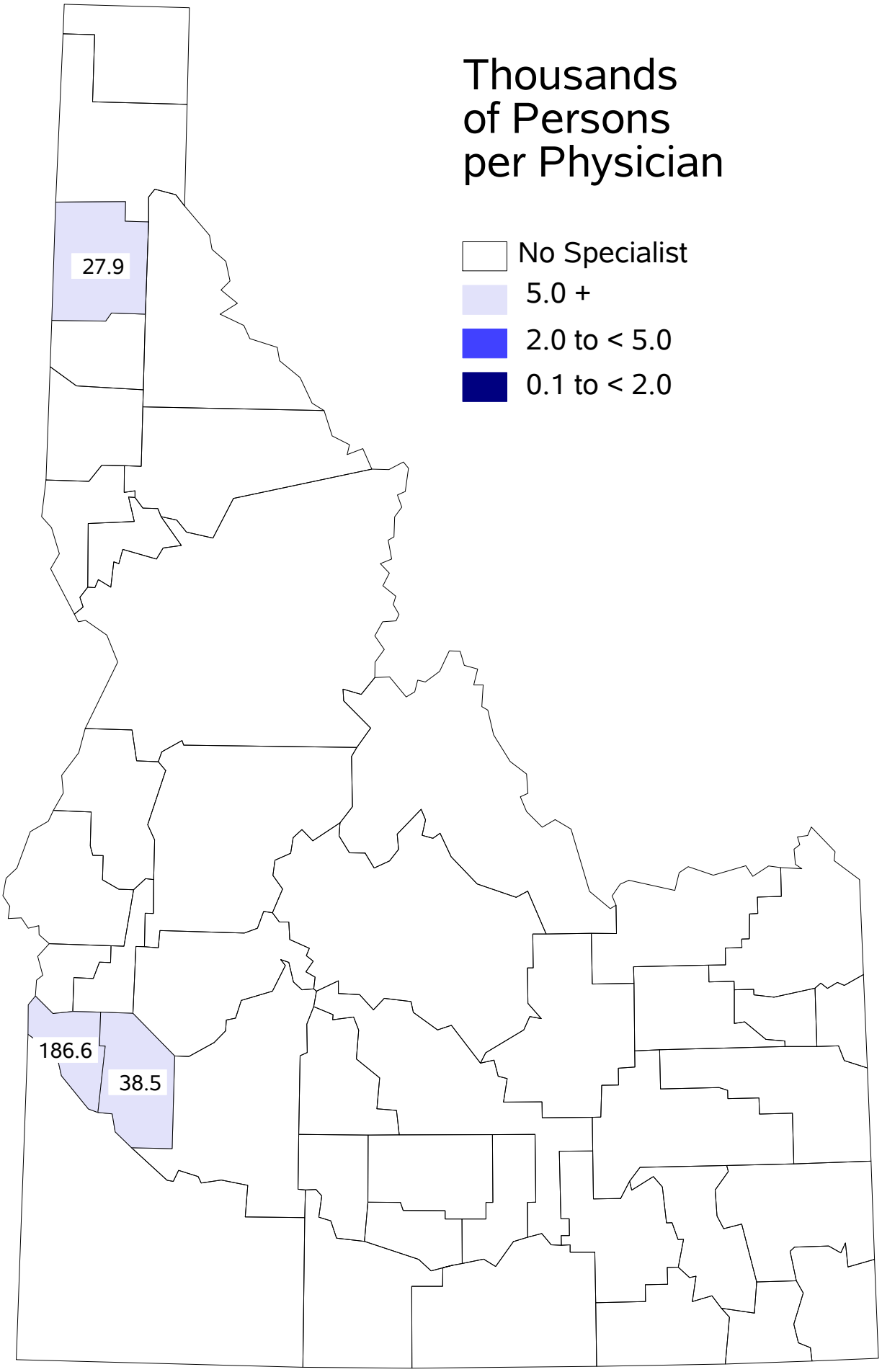
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Hospitalist

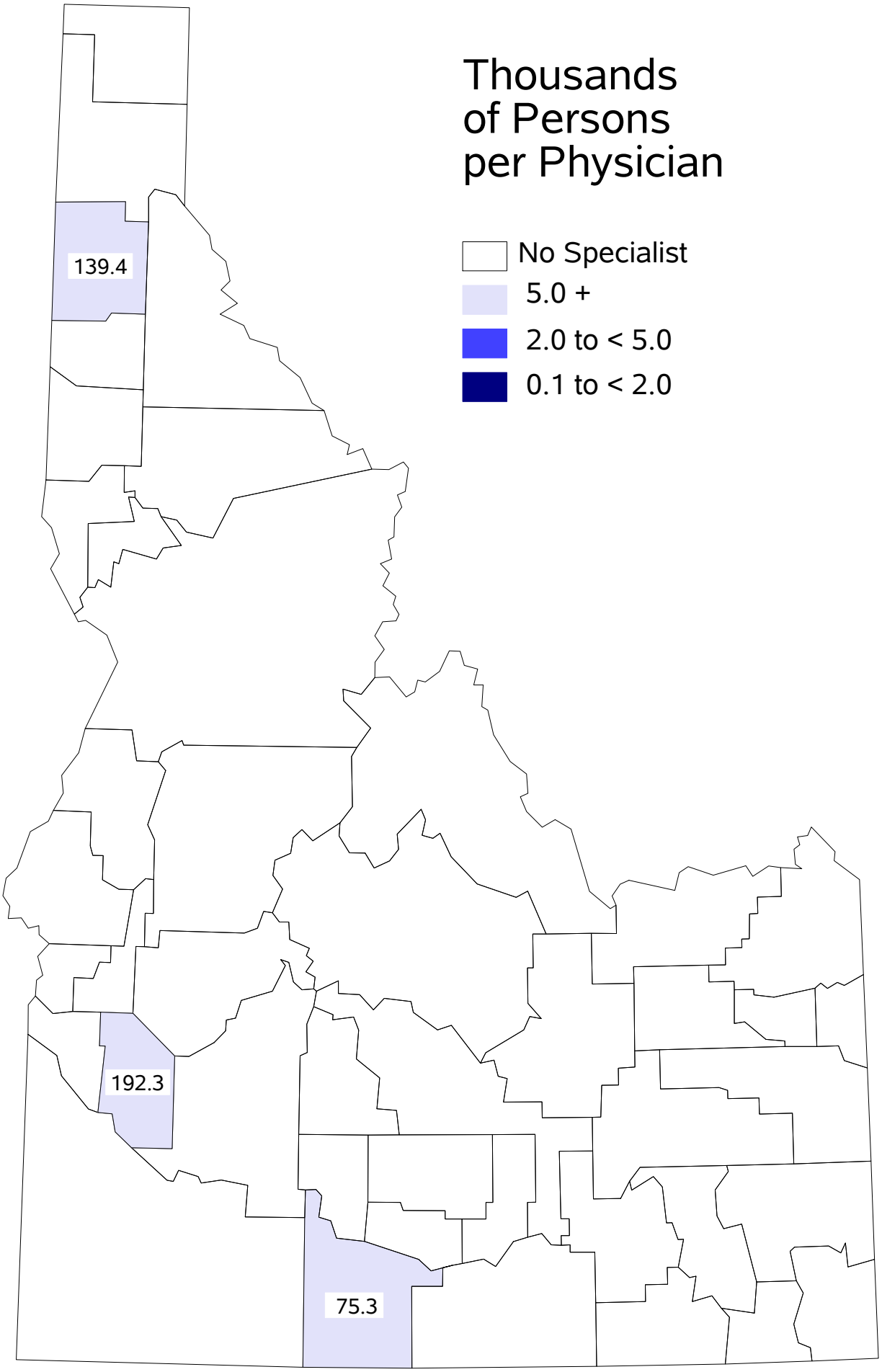
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Hand Surgery

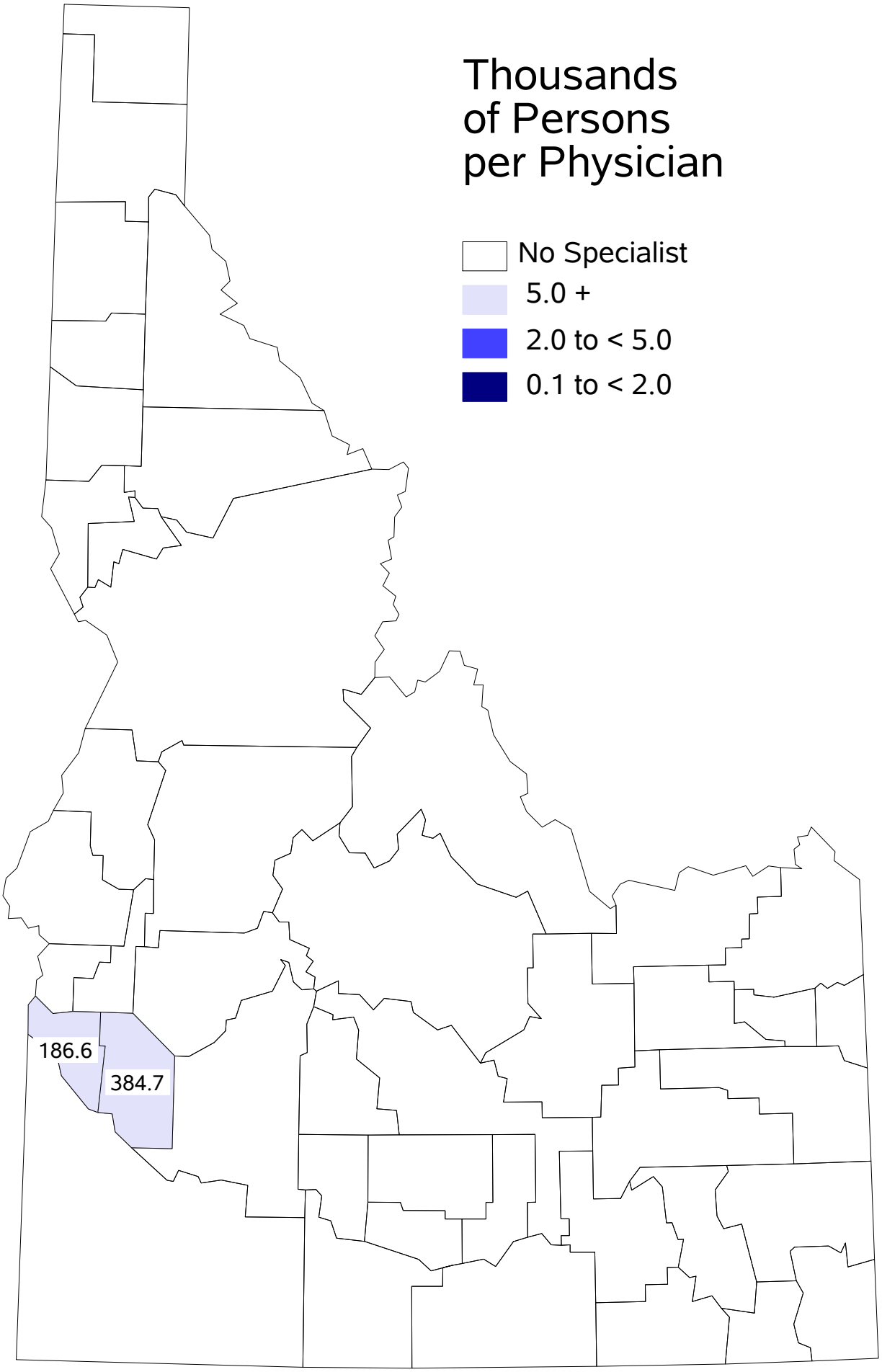
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Interventional Cardiology

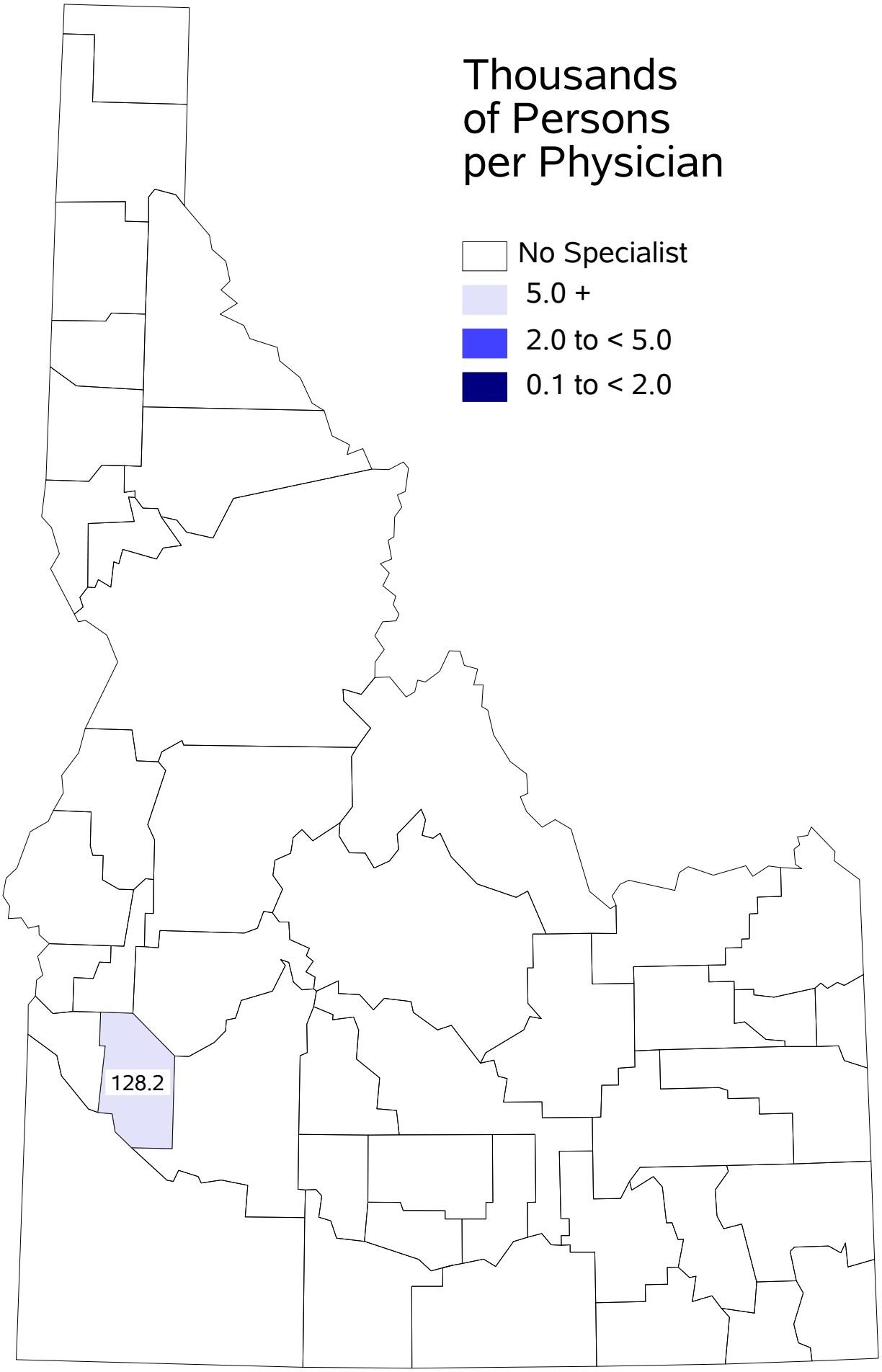
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Clinical Cardiac Electrophysiology

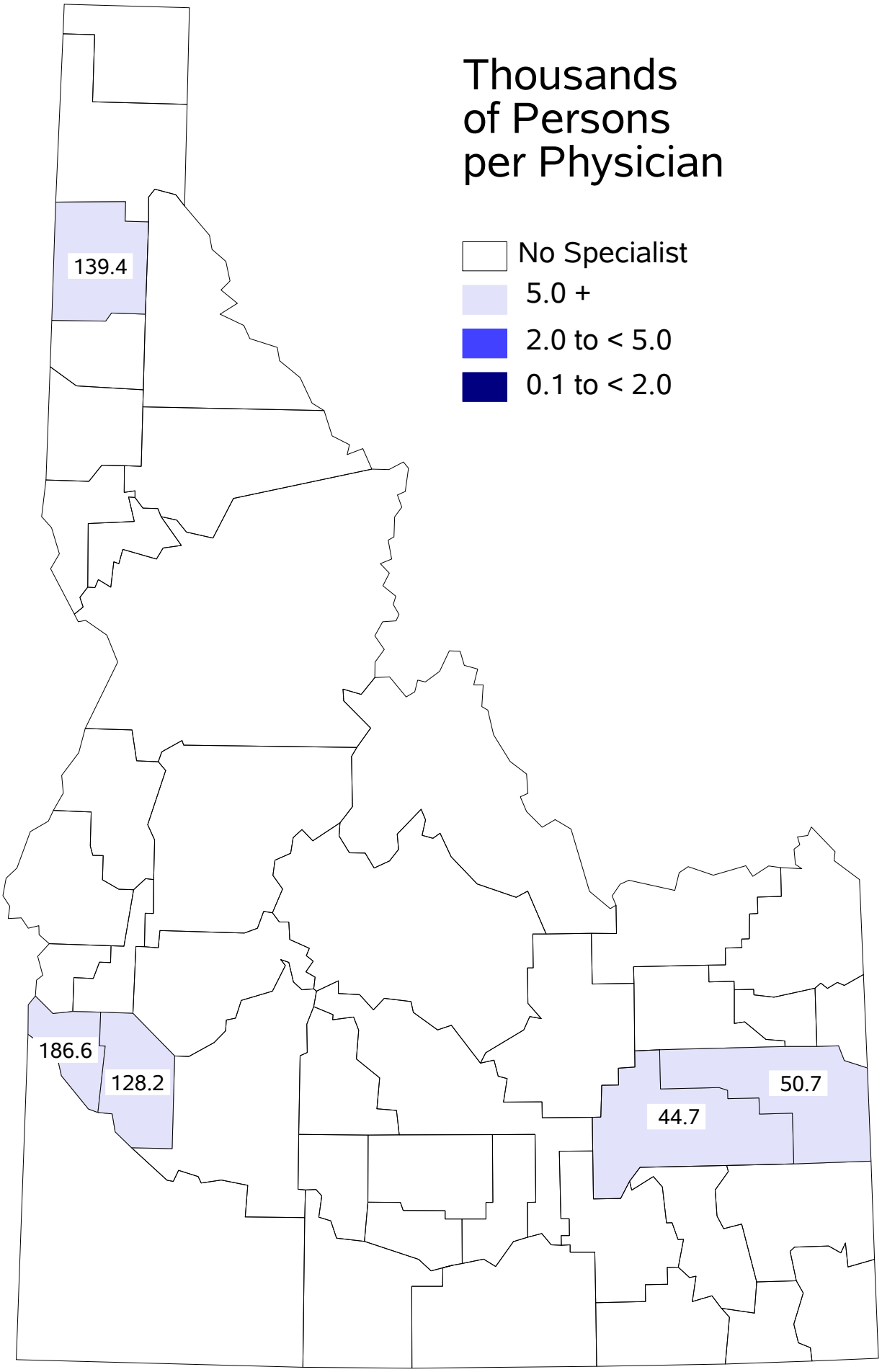
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Infectious Disease

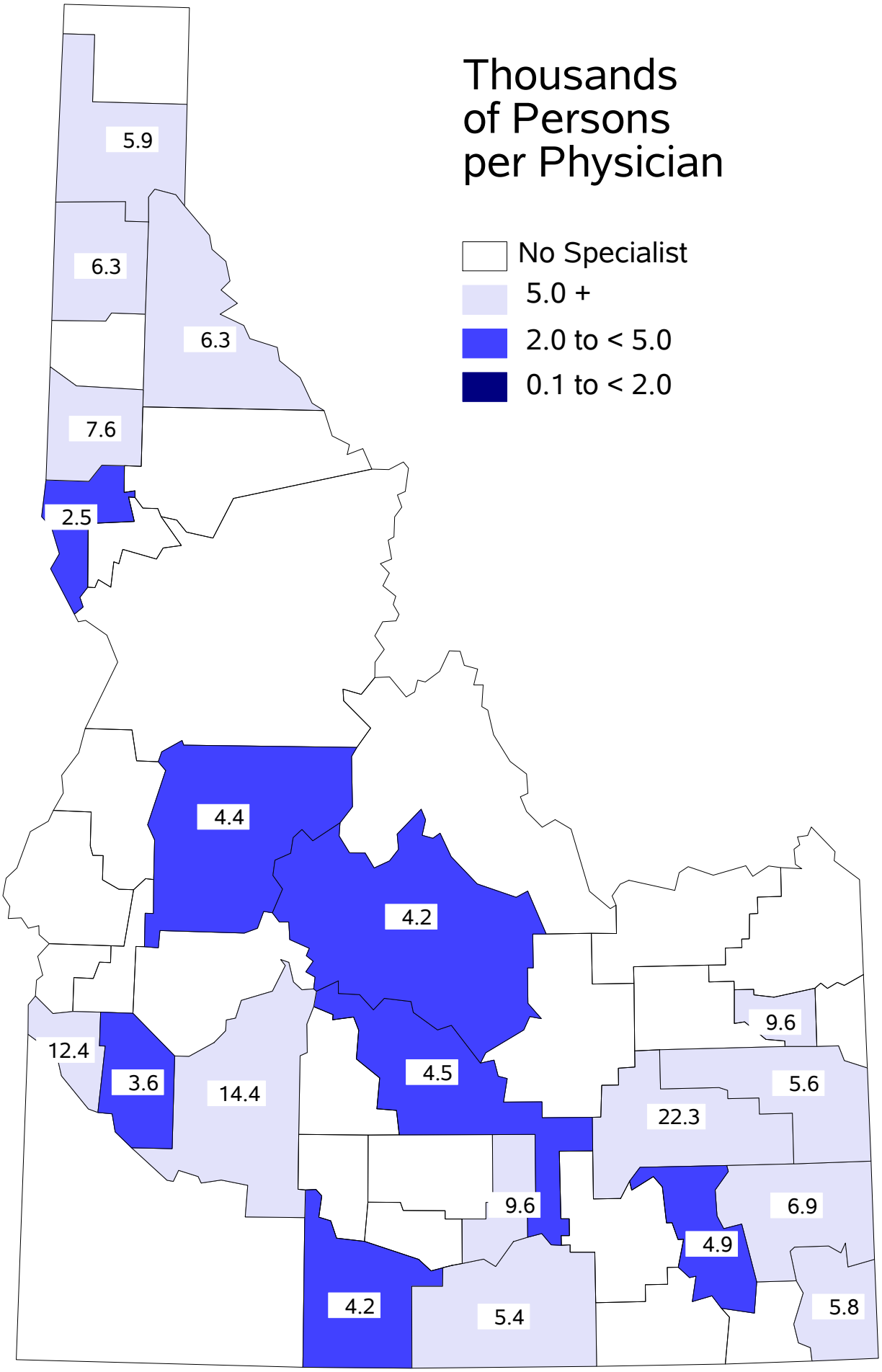
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Internal Medicine

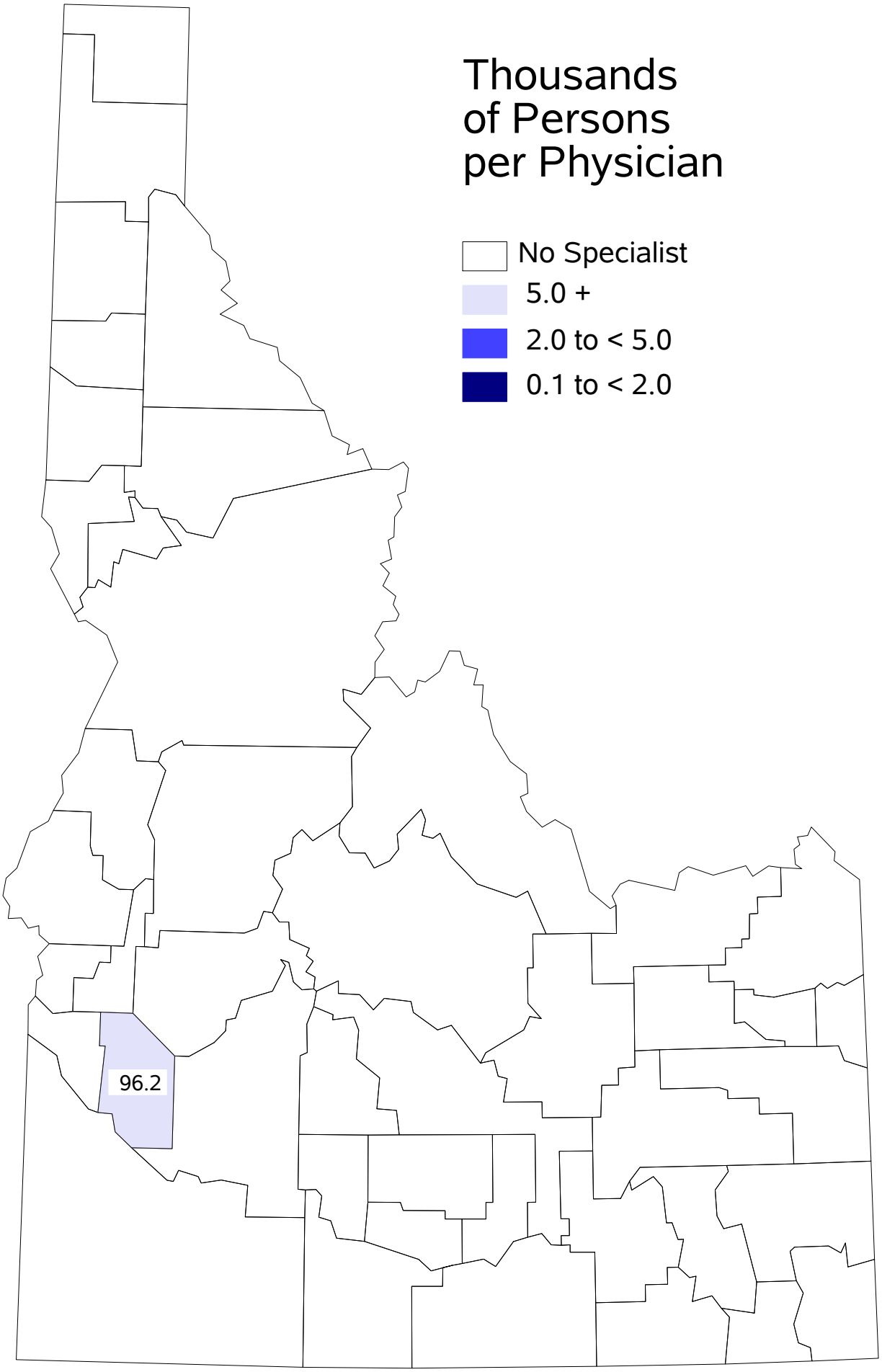
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Maternal & Fetal Medicine

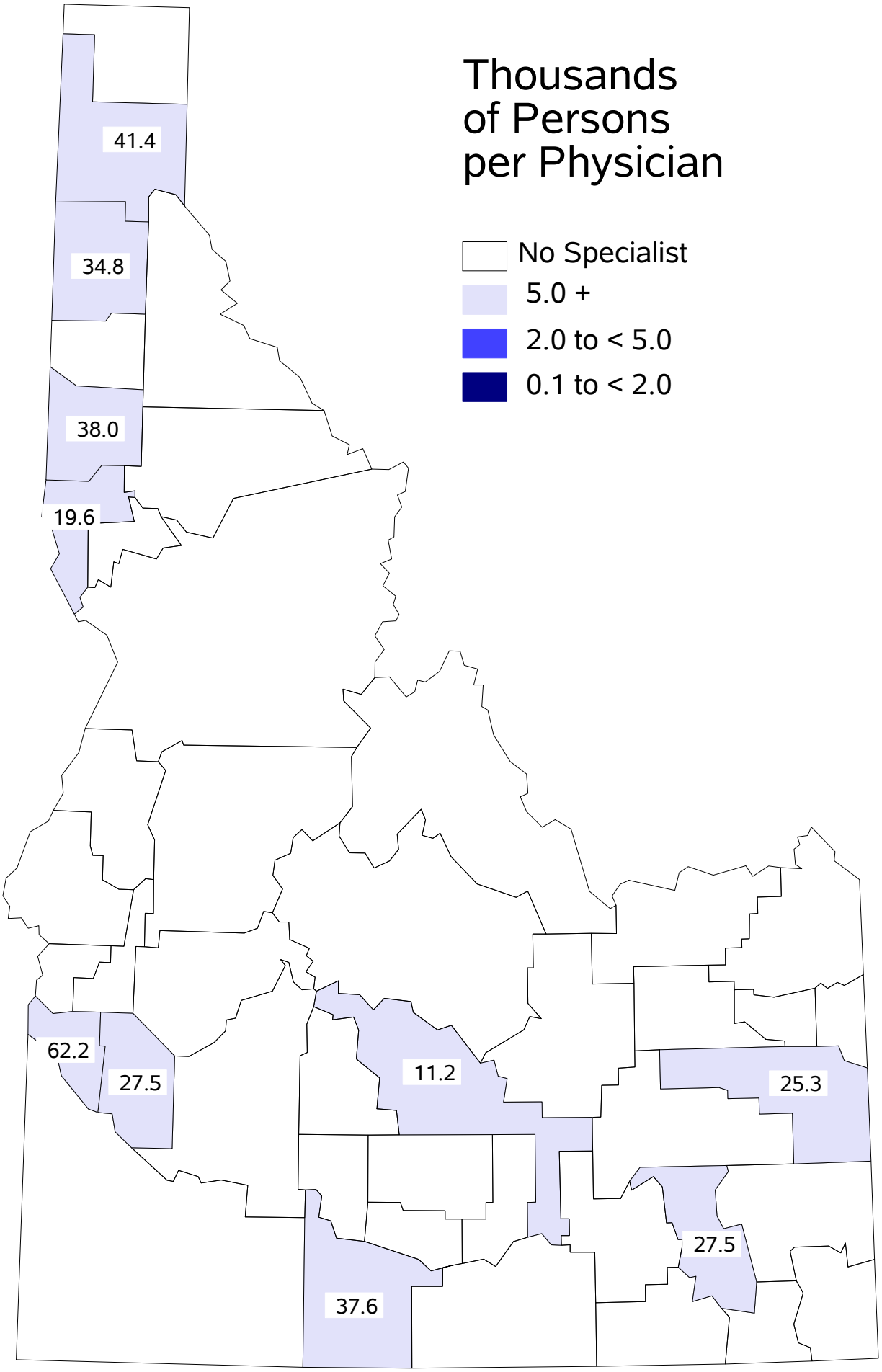
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Neurology

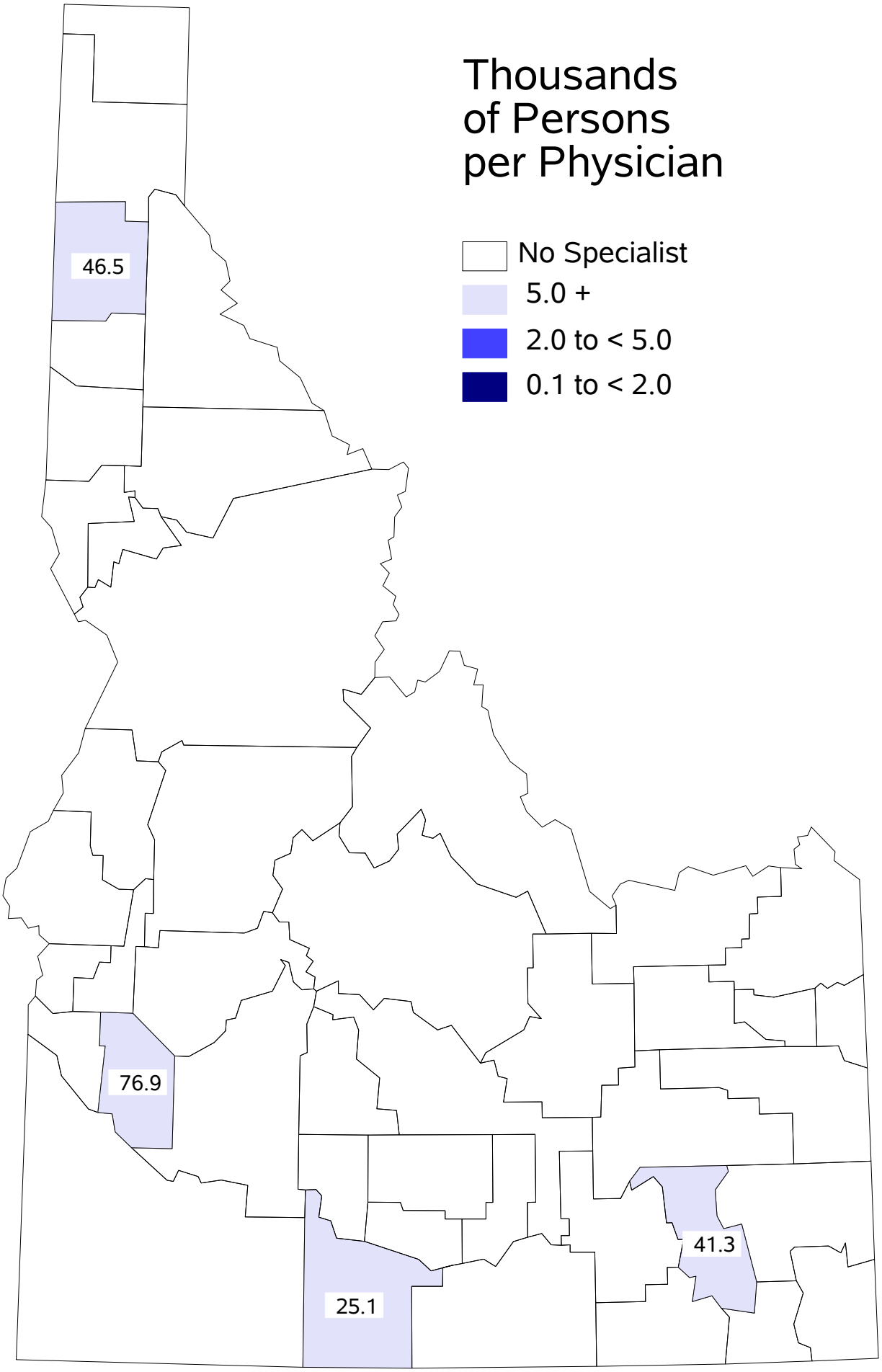
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Nephrology

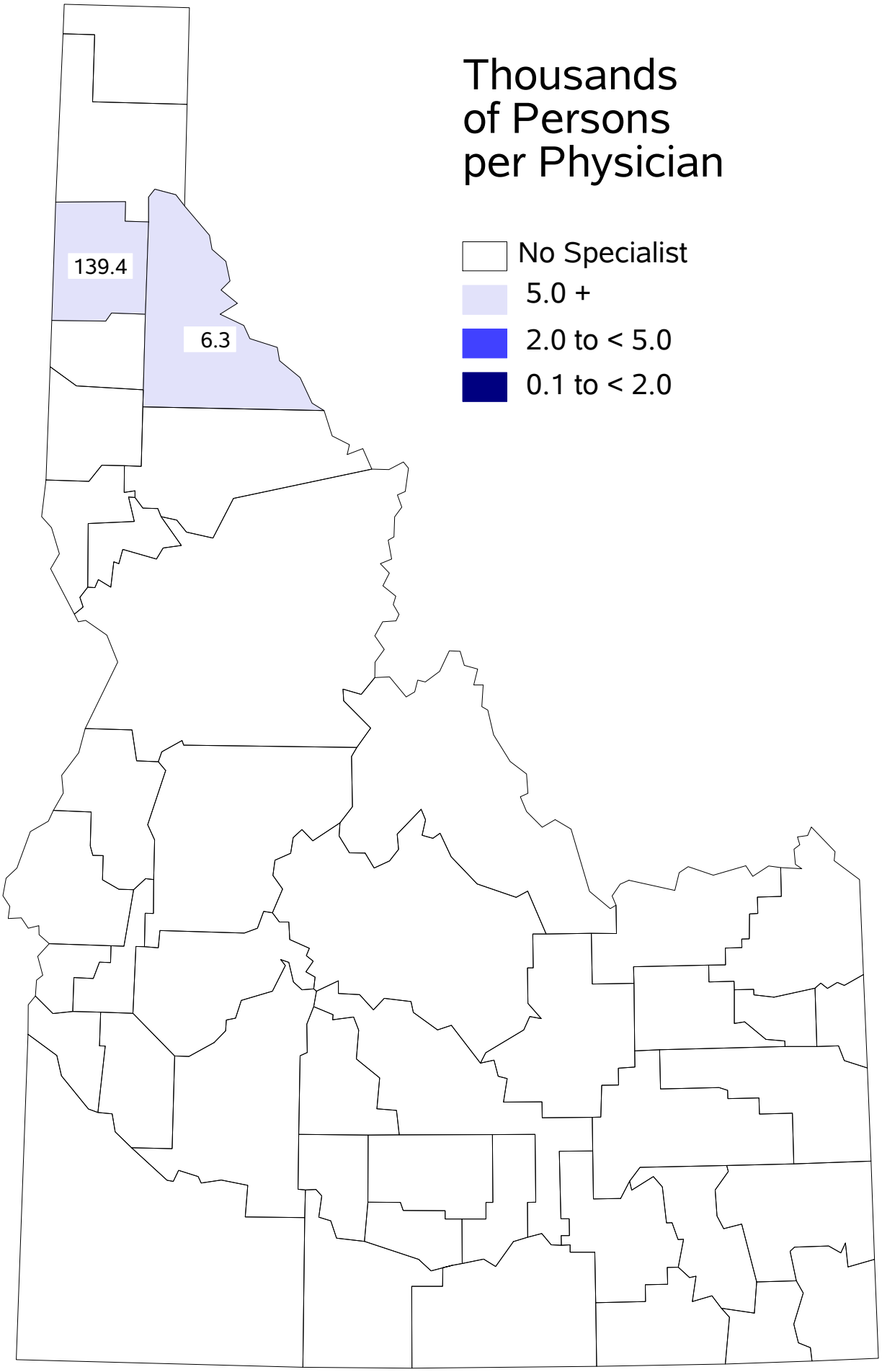
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Nuclear Medicine

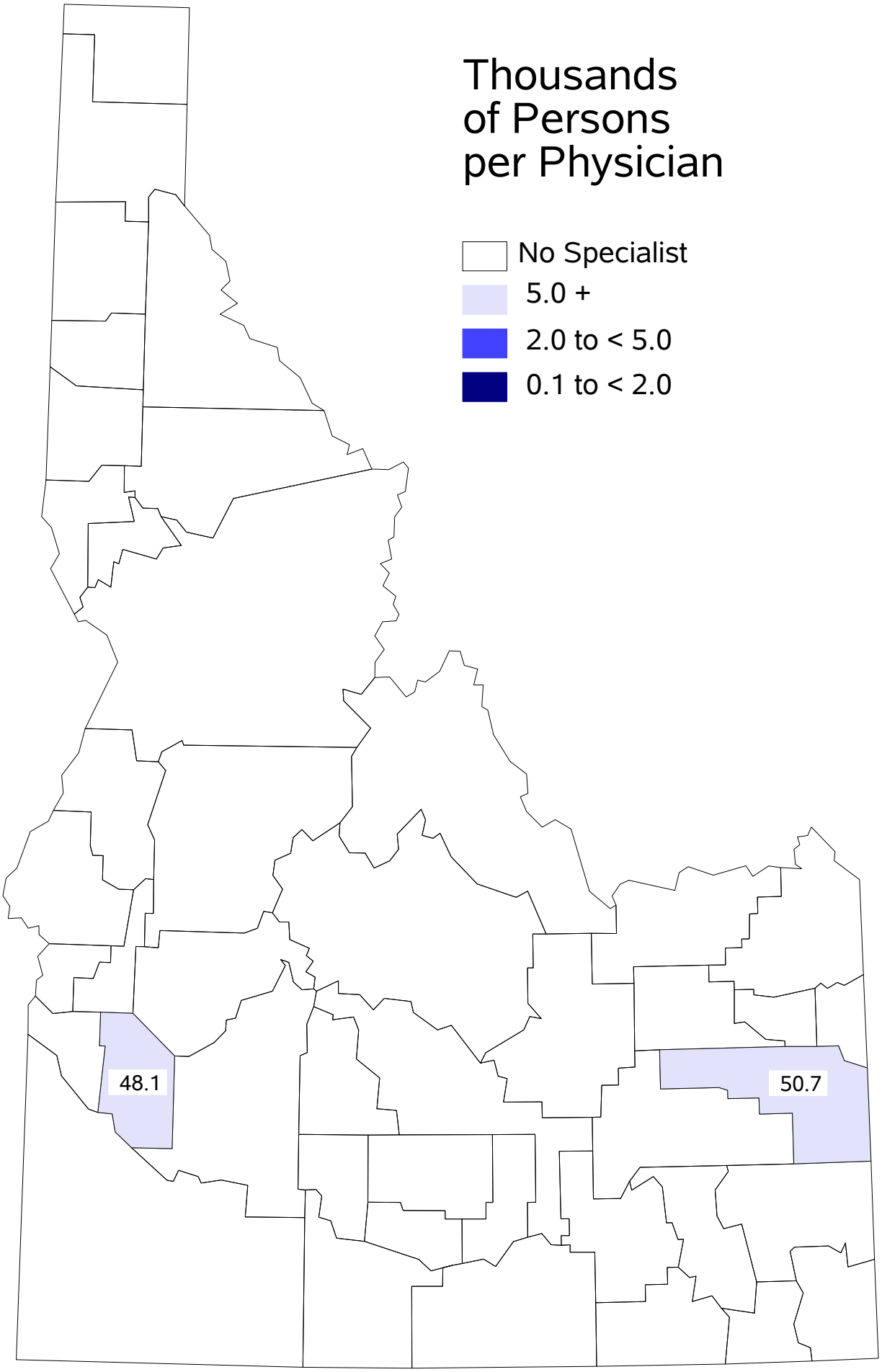
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Neonatal-Perinatal Medicine

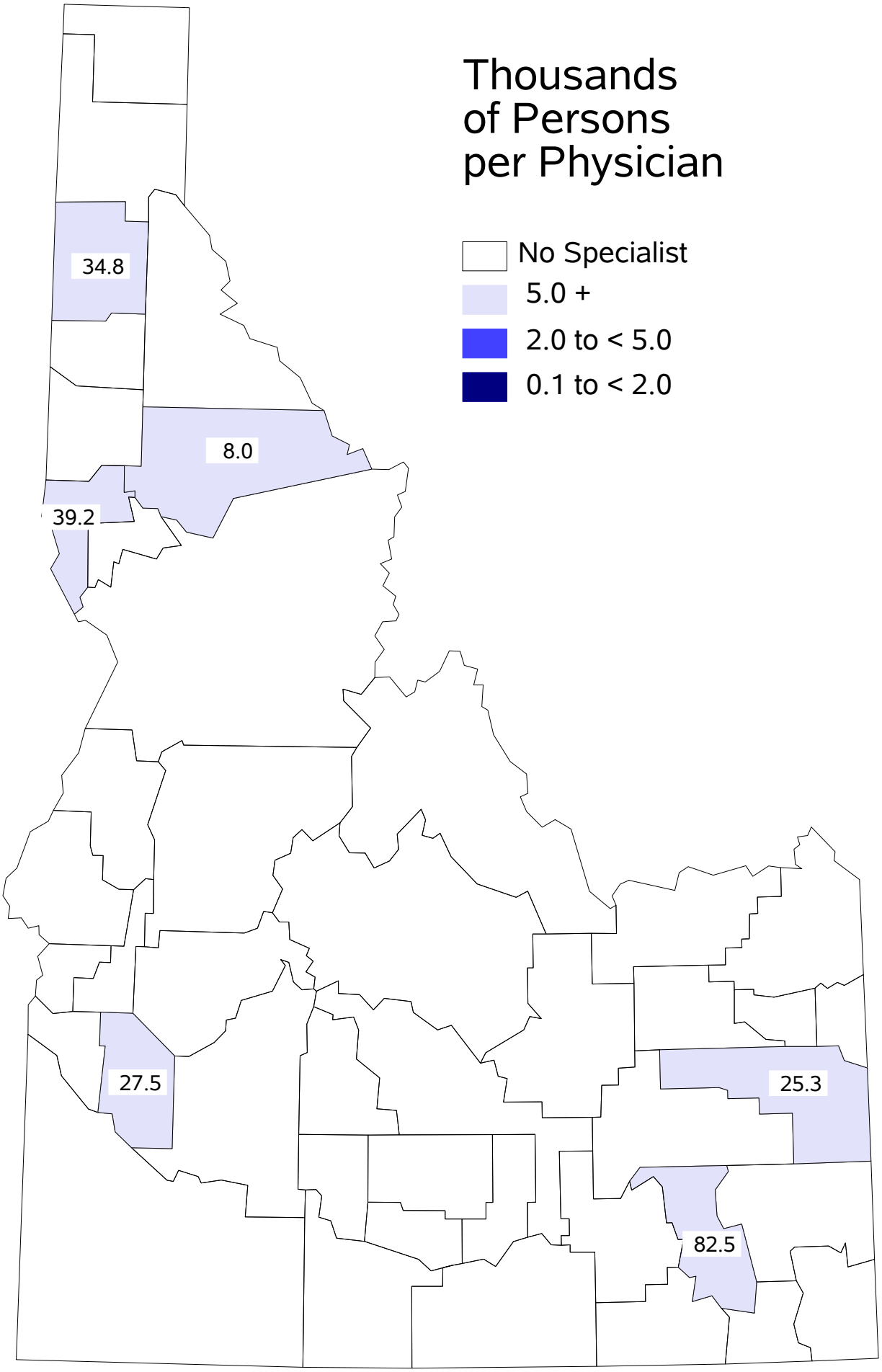
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Neurological Surgery

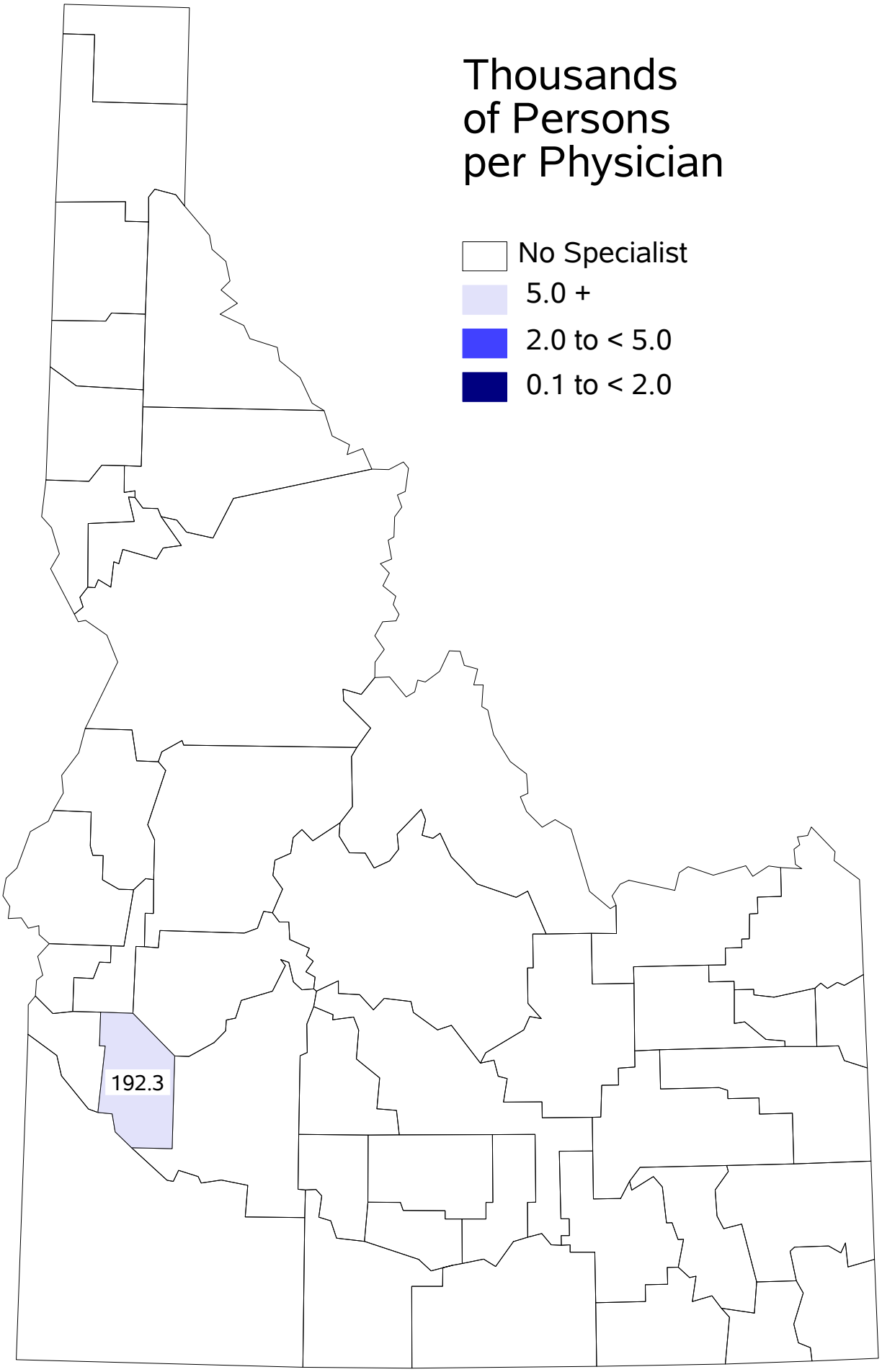
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Pediatric Surgery (Neurology)

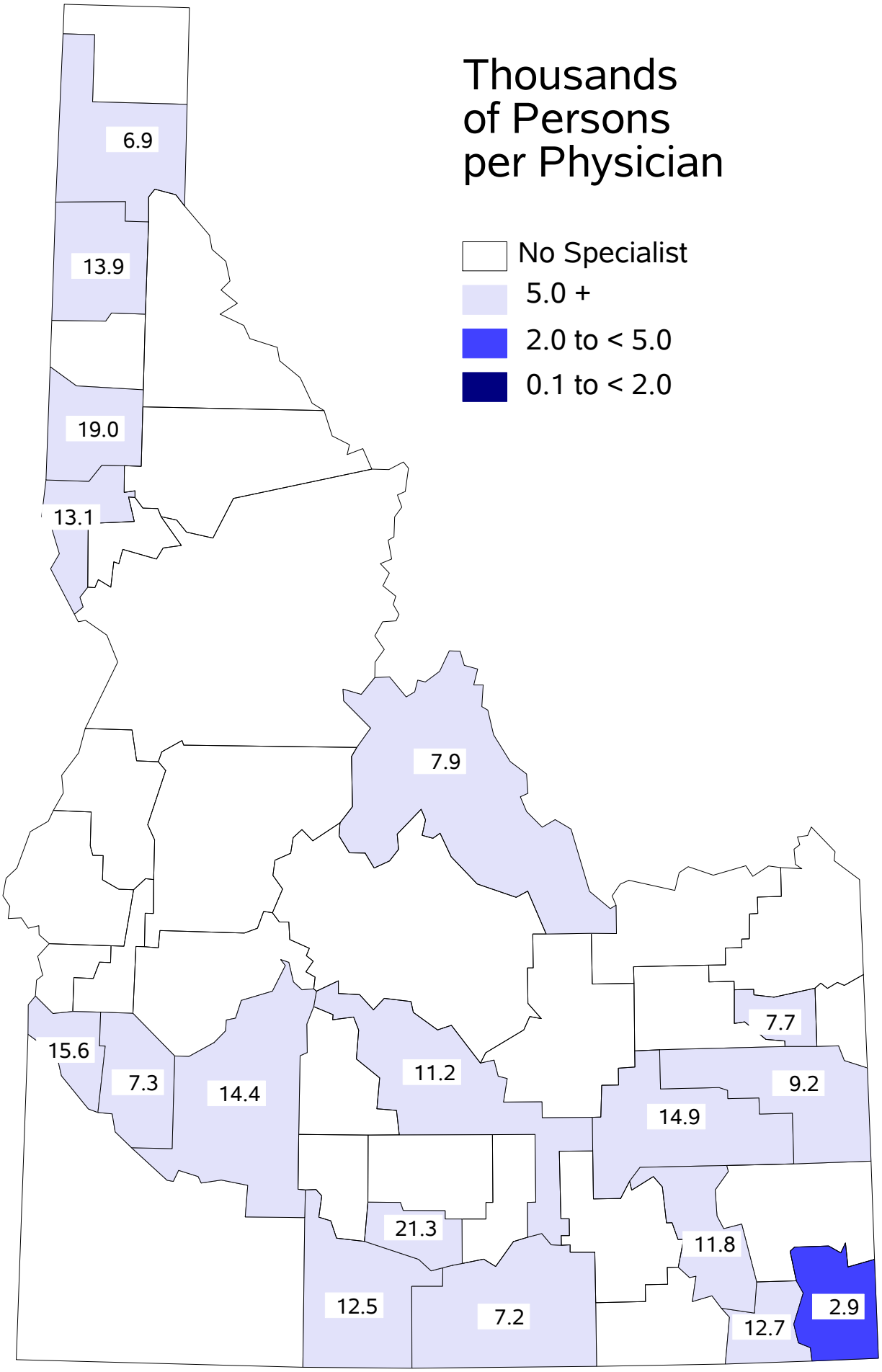
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Obstetrics & Gynecology

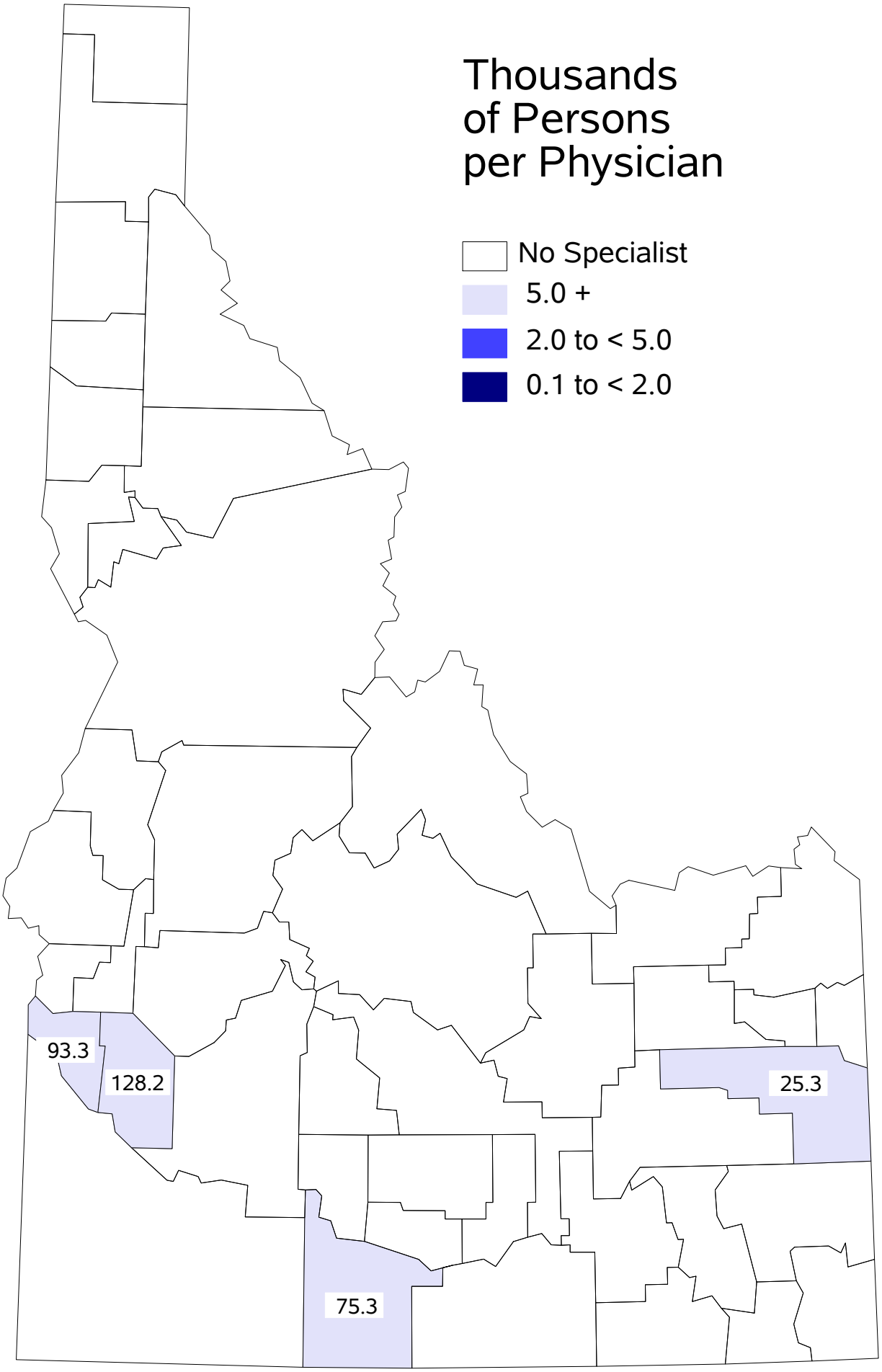
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Occupational Medicine

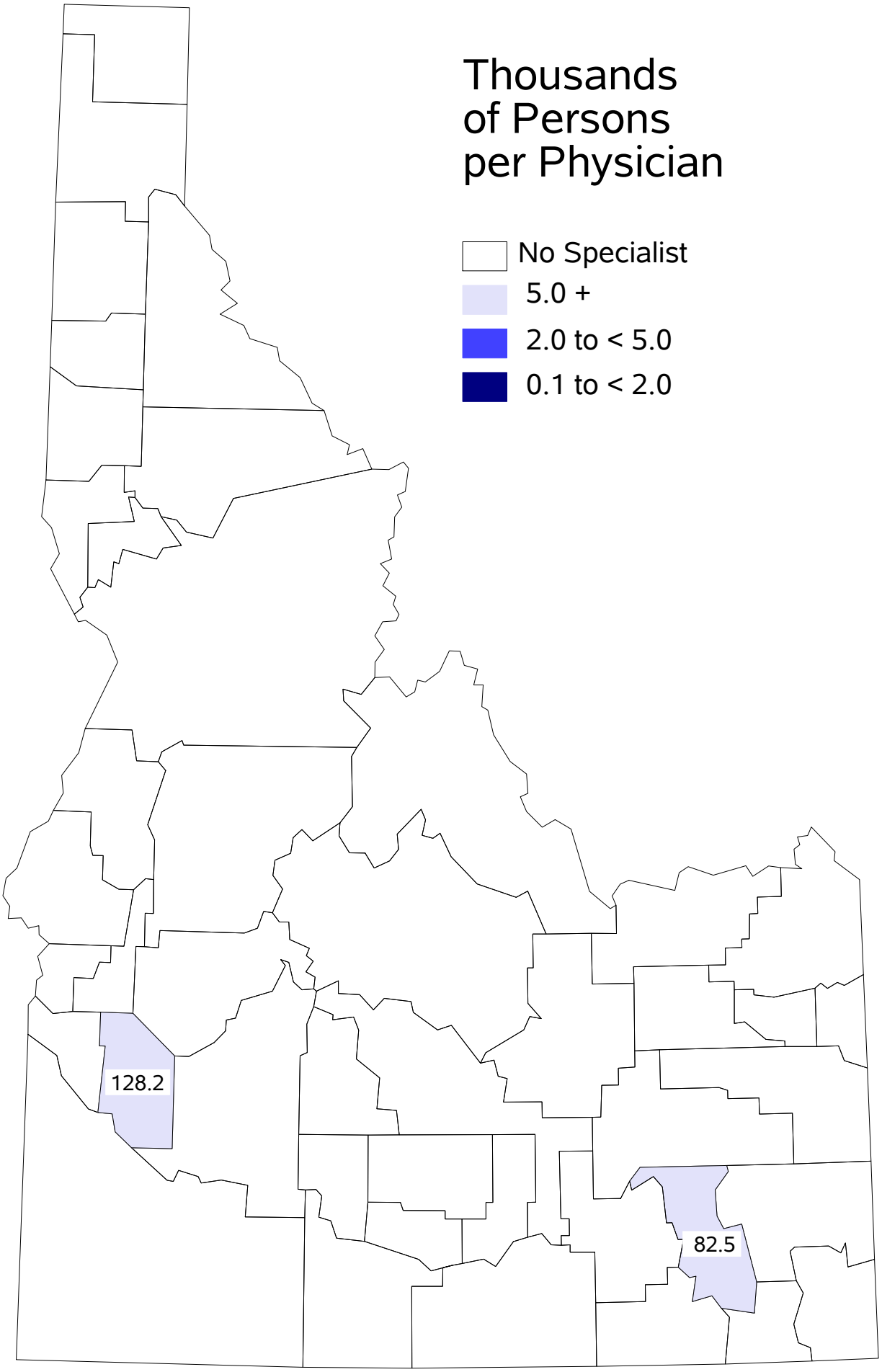
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Oral & Maxillofacial Surgery

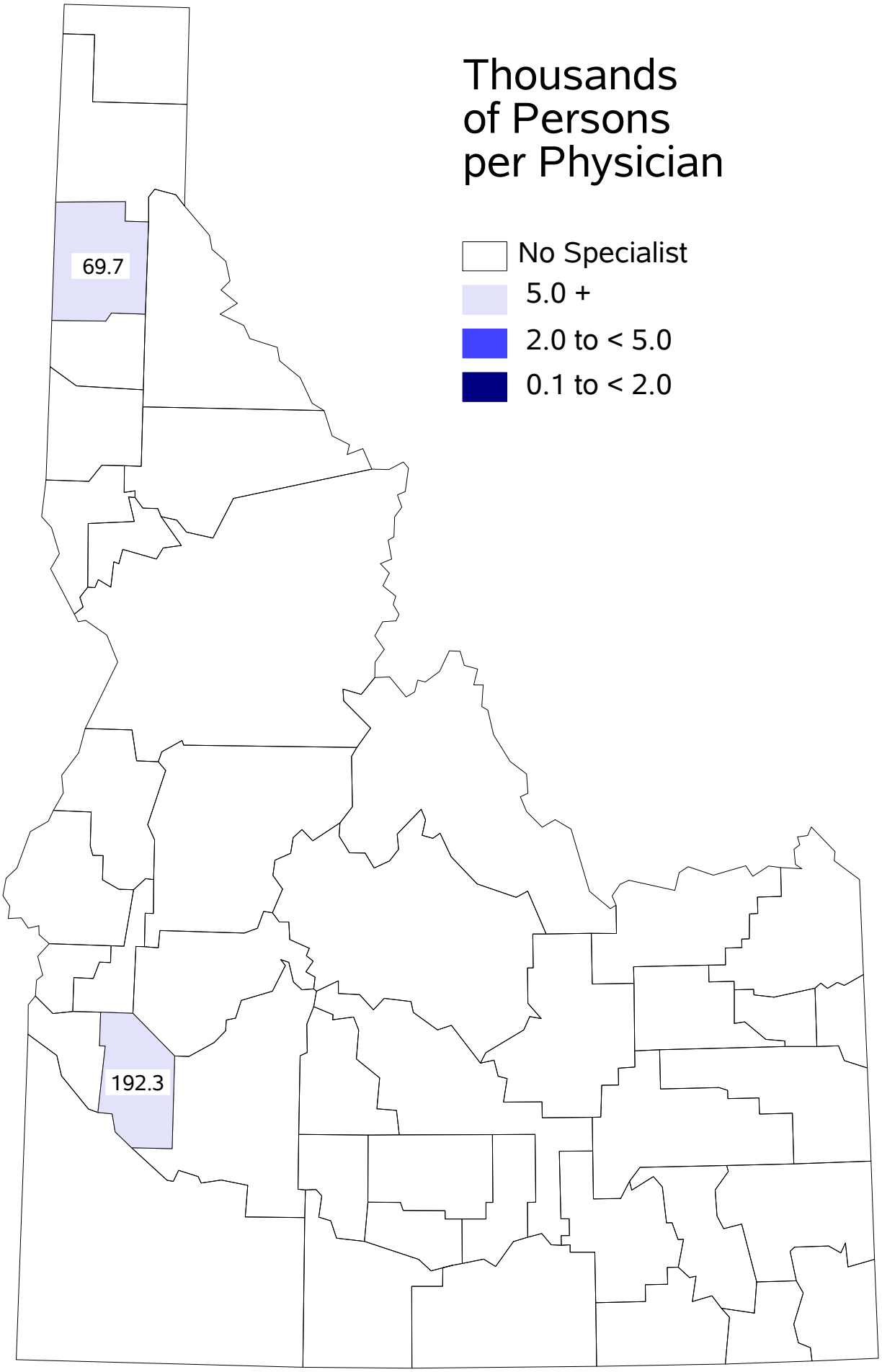
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Medical Oncology

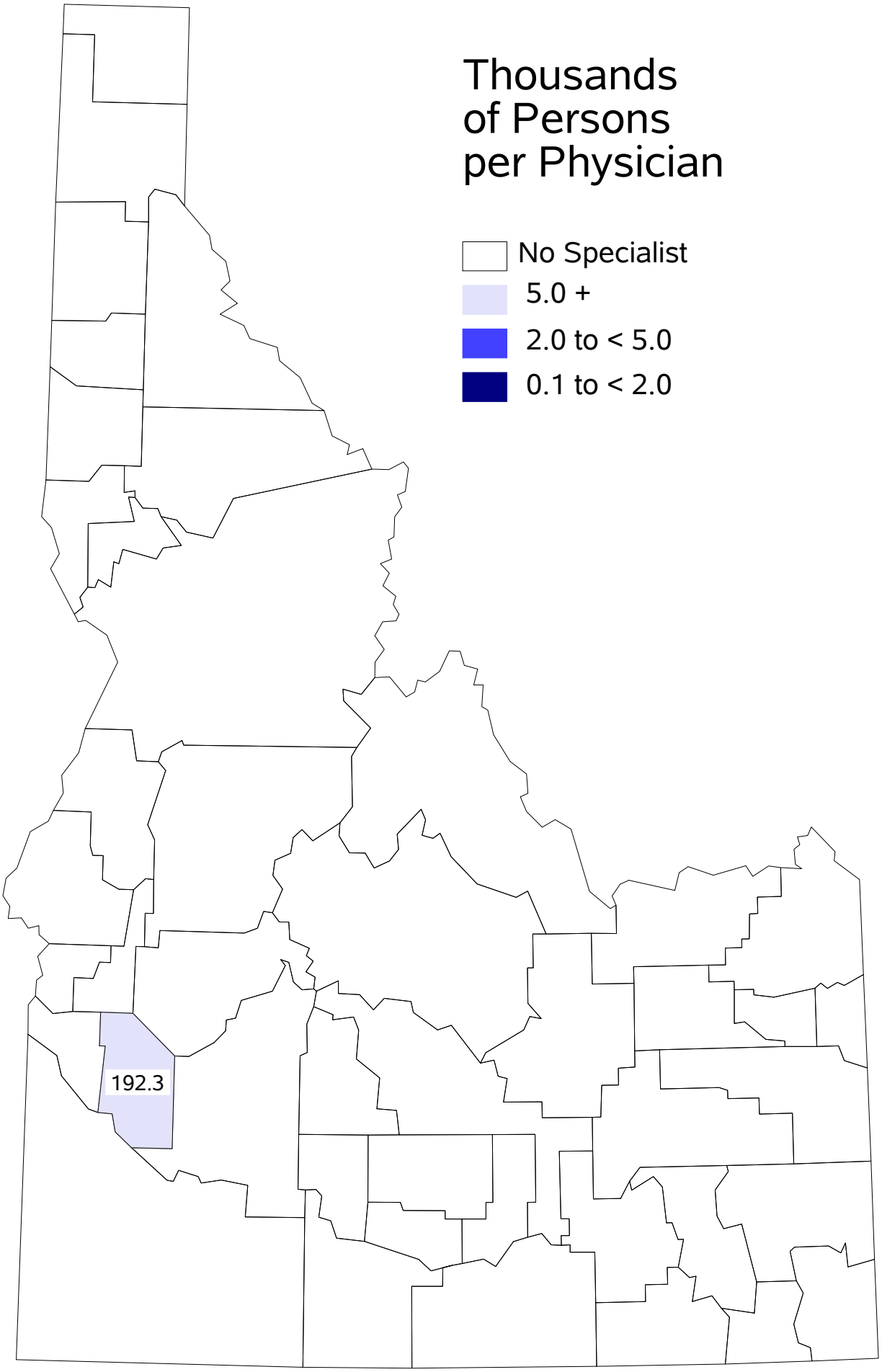
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Pediatric Orthopedics

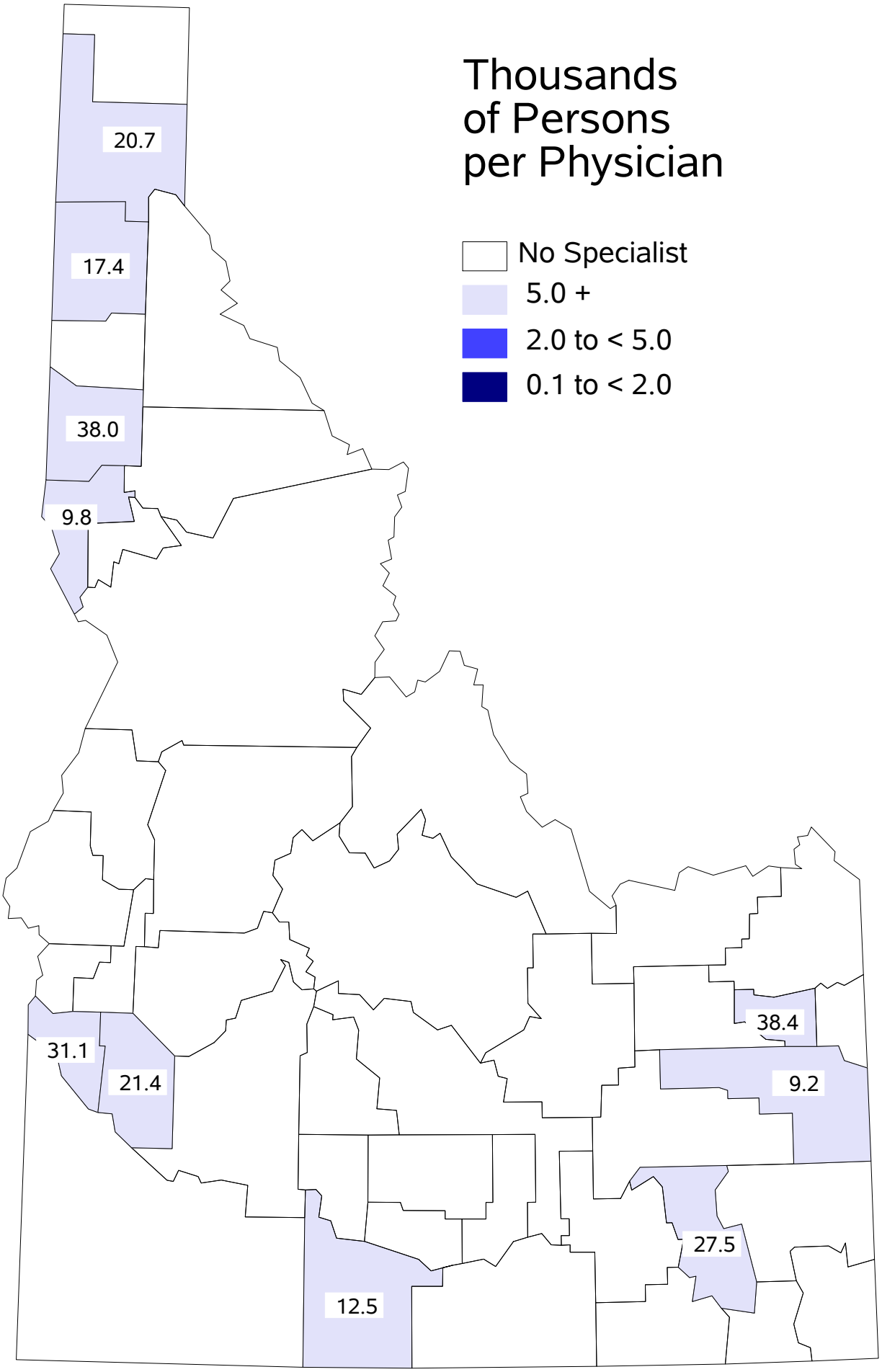
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Ophthalmology

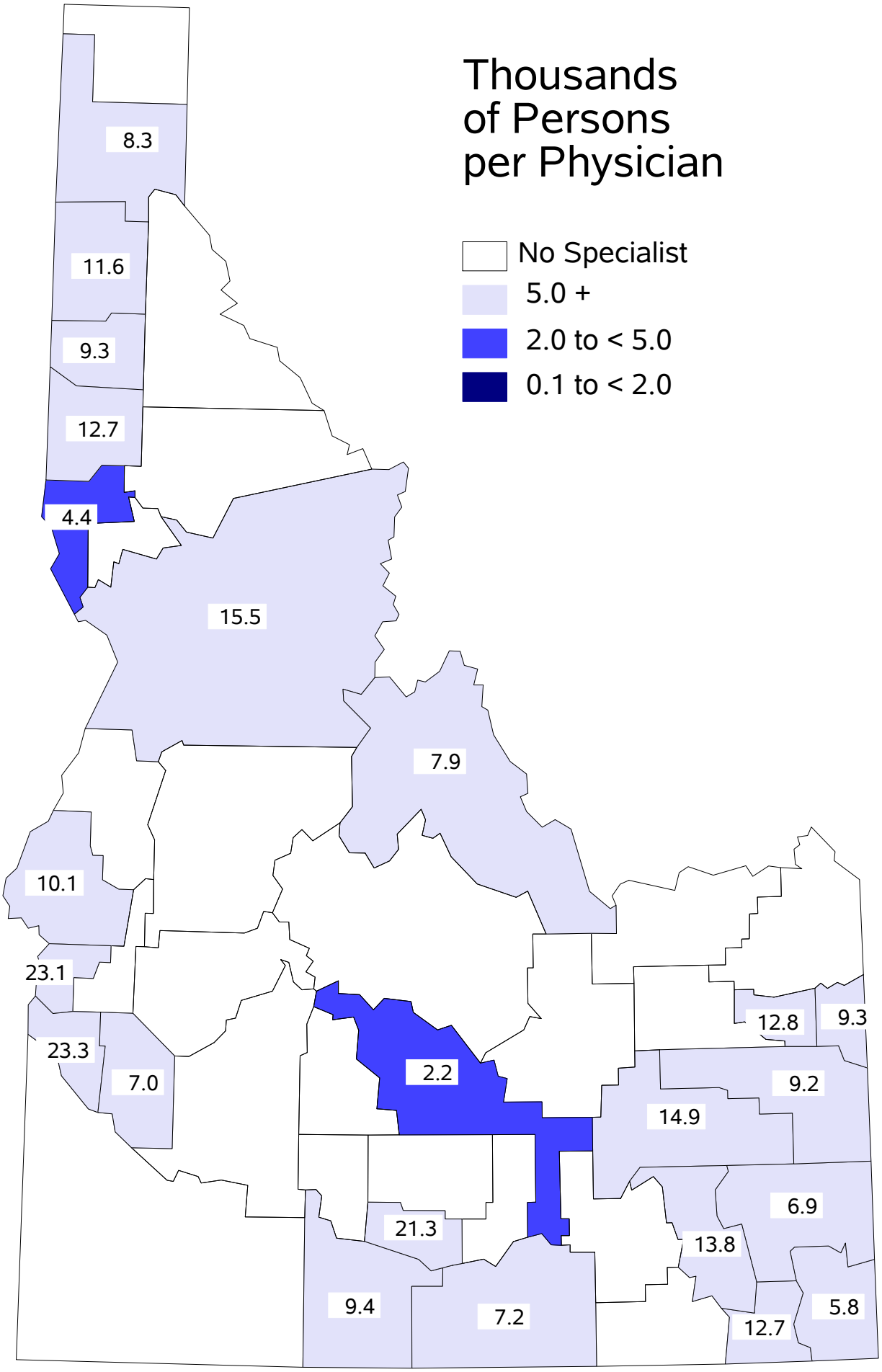
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Orthopedic Surgery

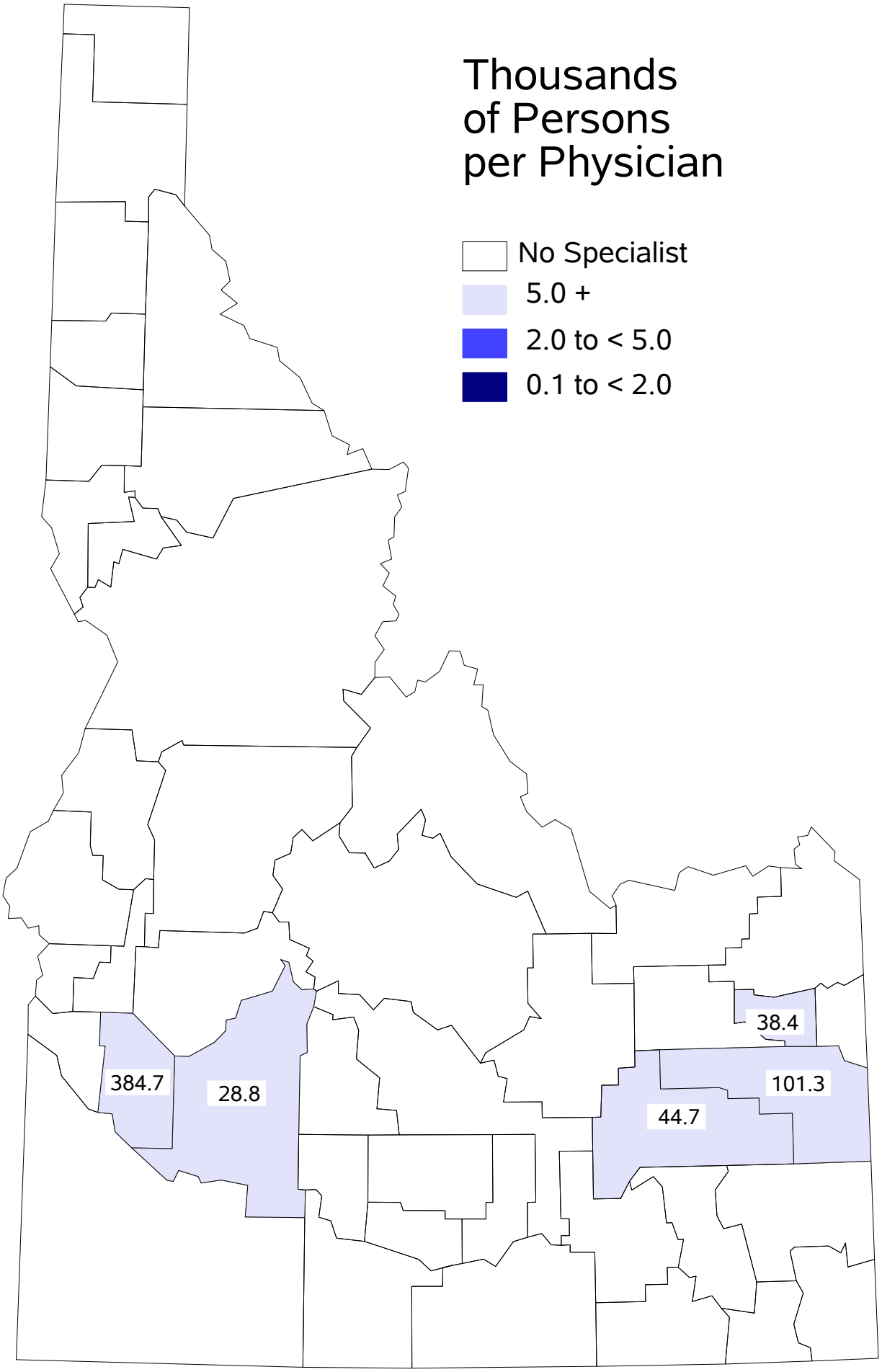
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Other Specialty

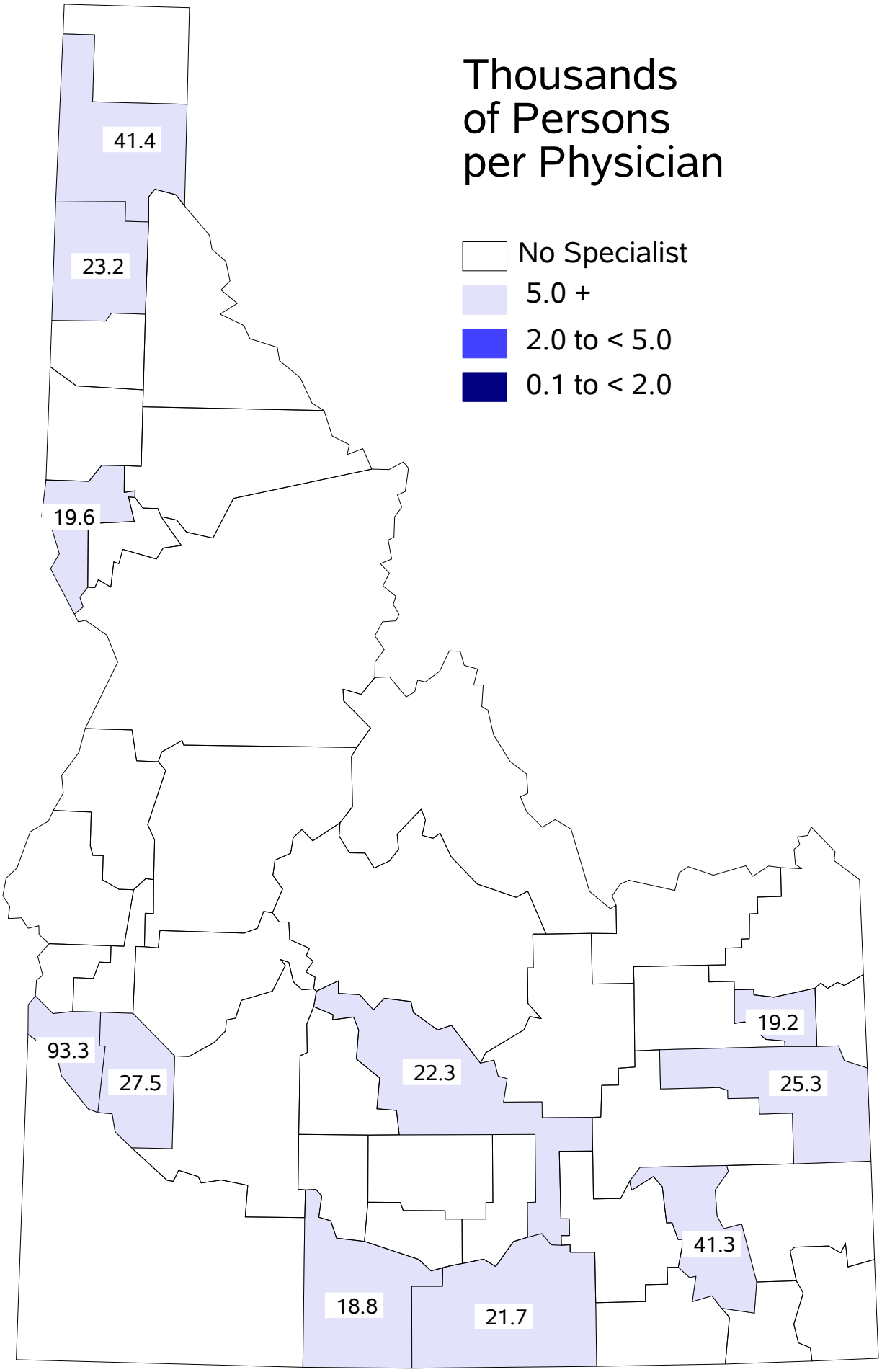
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Otolaryngology

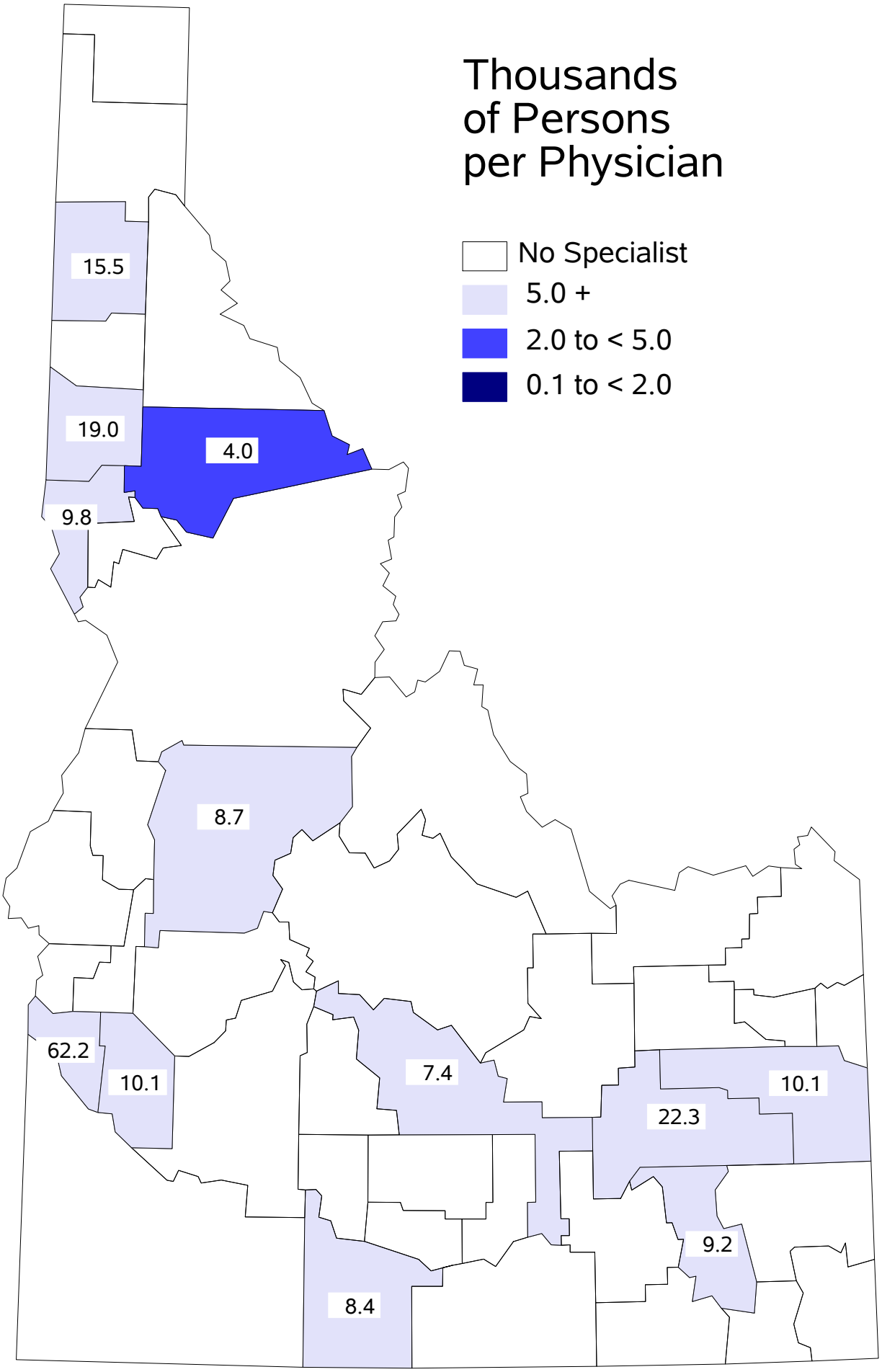
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Psychiatry

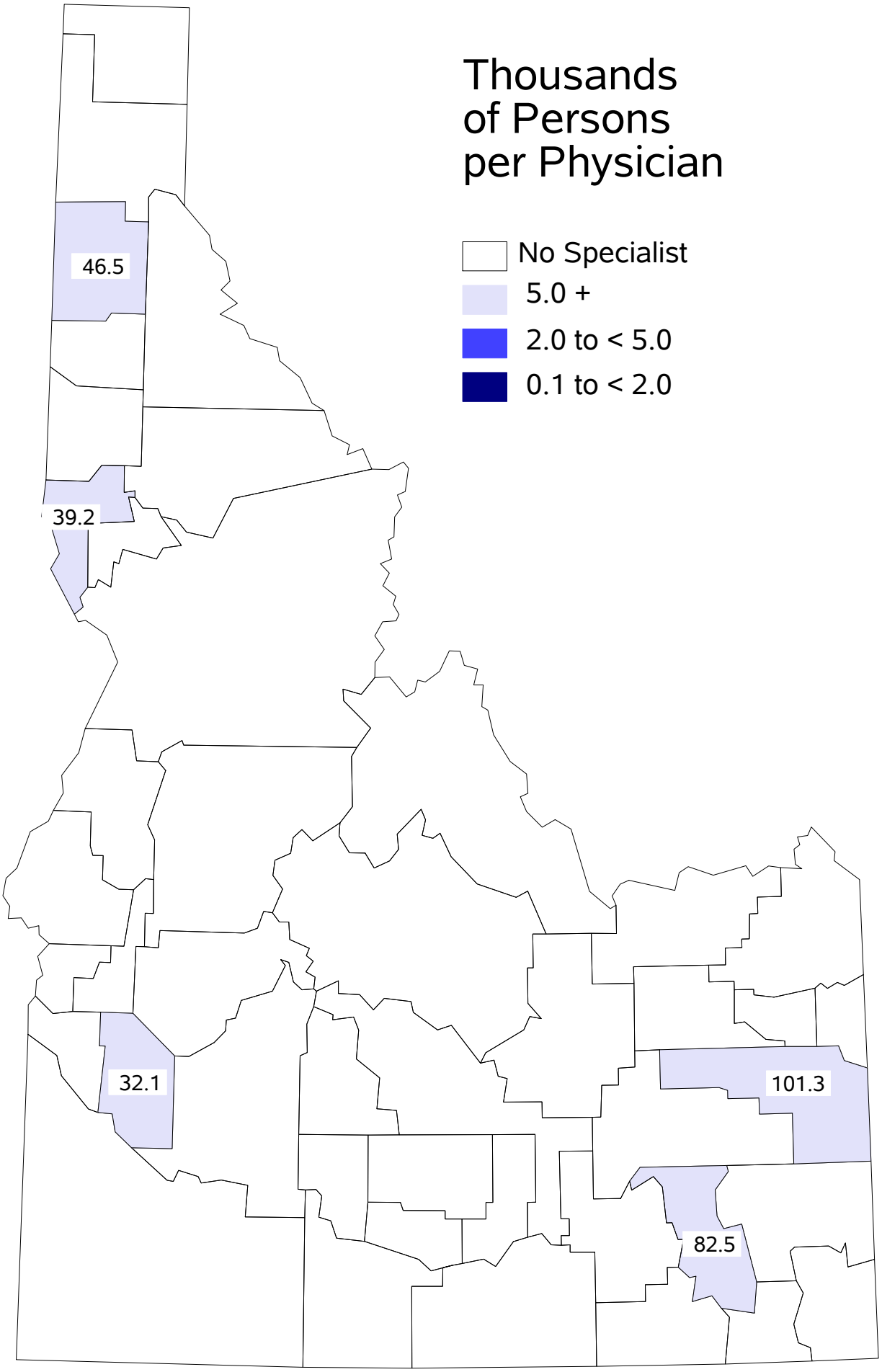
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Pulmonary Critical Care Medicine

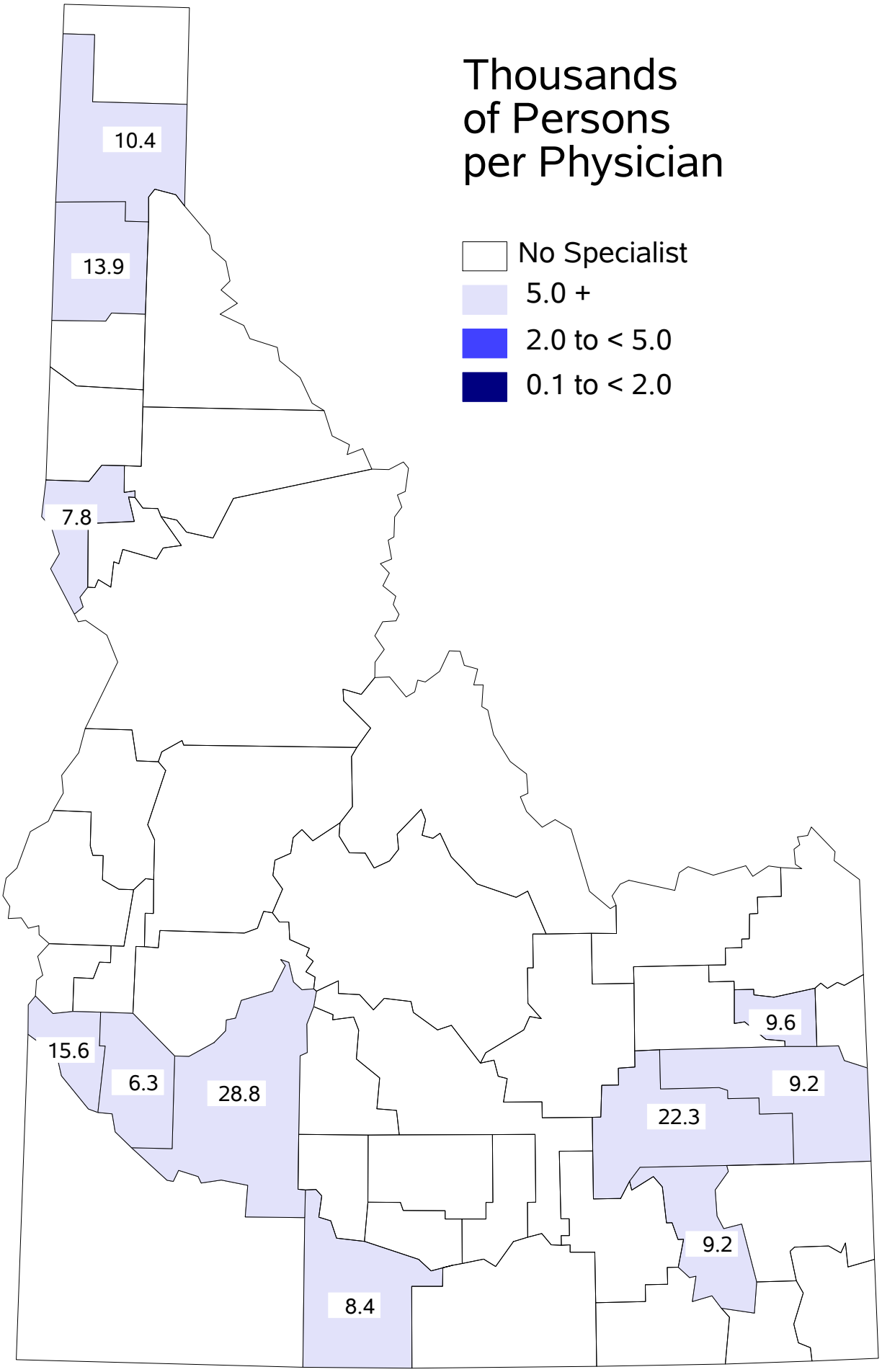
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Pediatrics

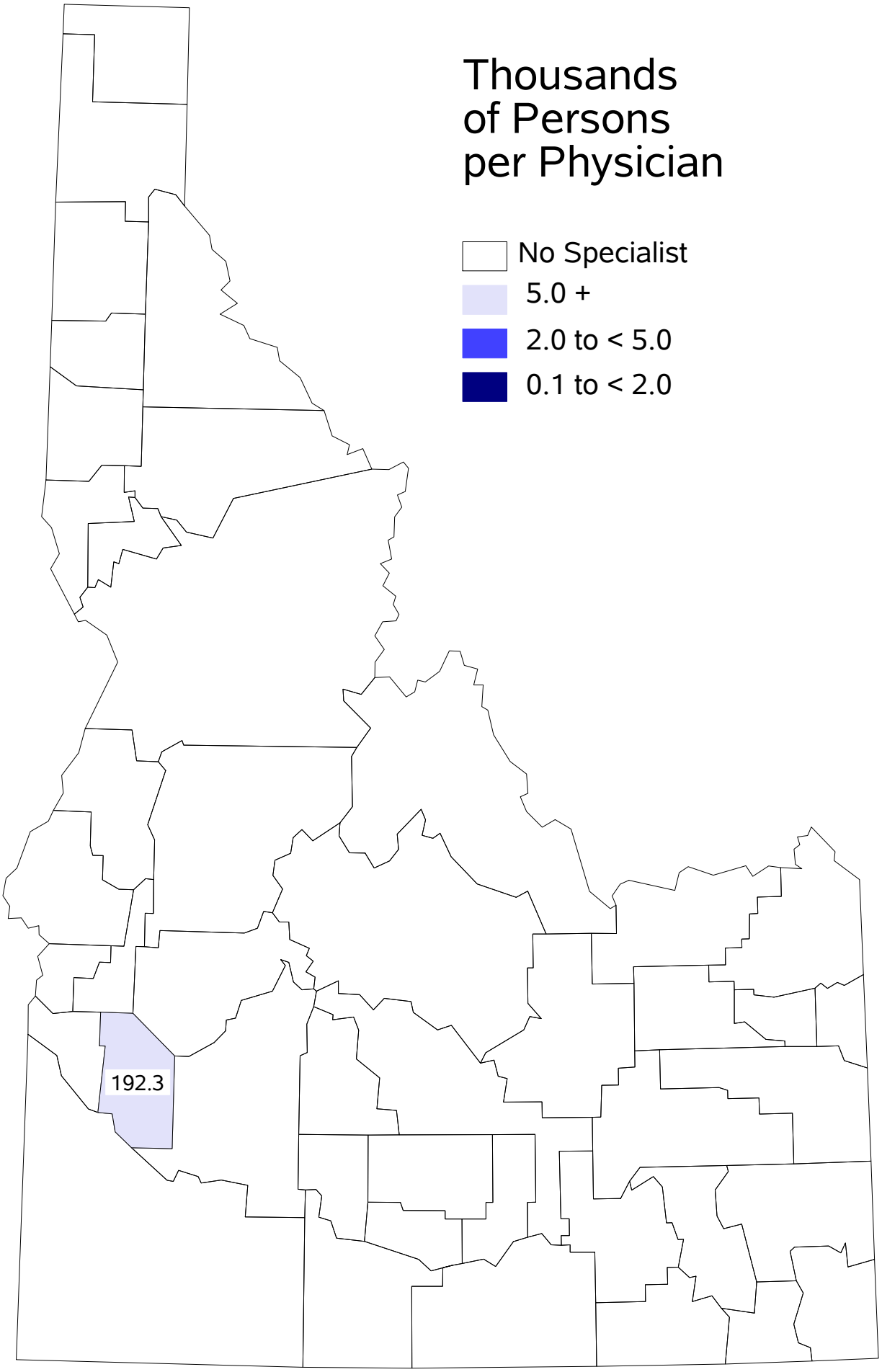
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Pediatric Cardiology

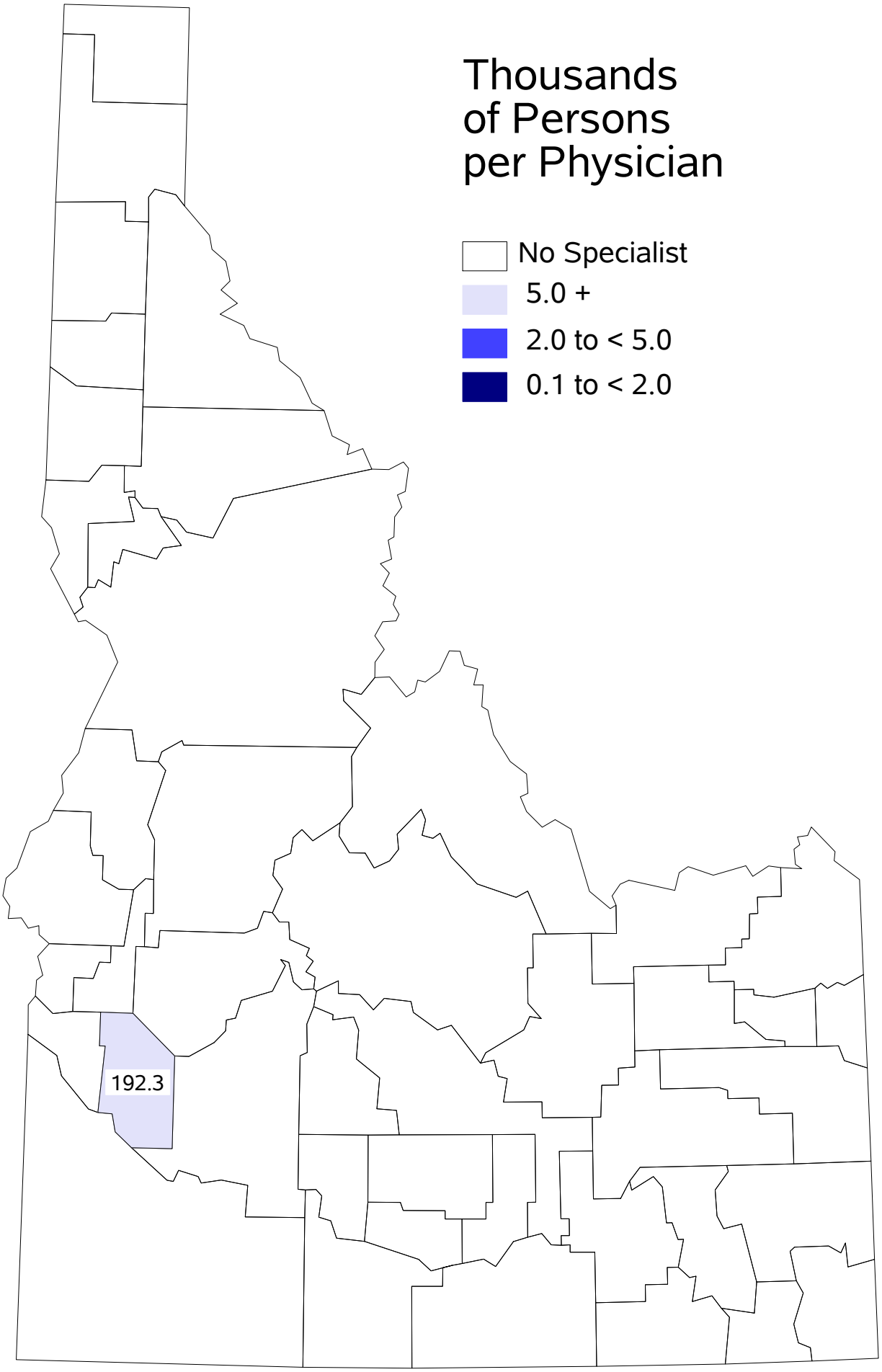
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Pediatric Enocrinology

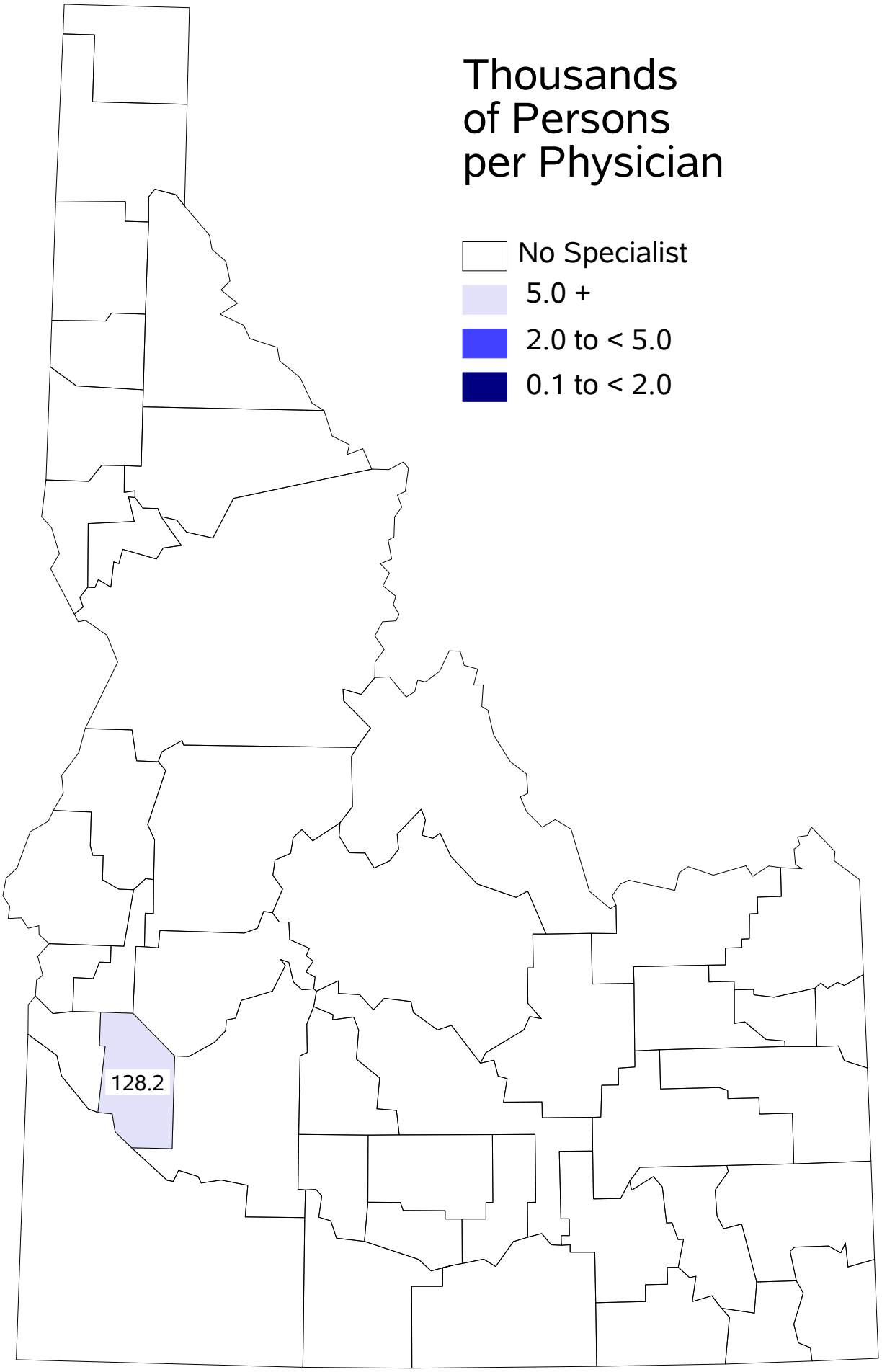
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Pediatric Surgery (Surgery)

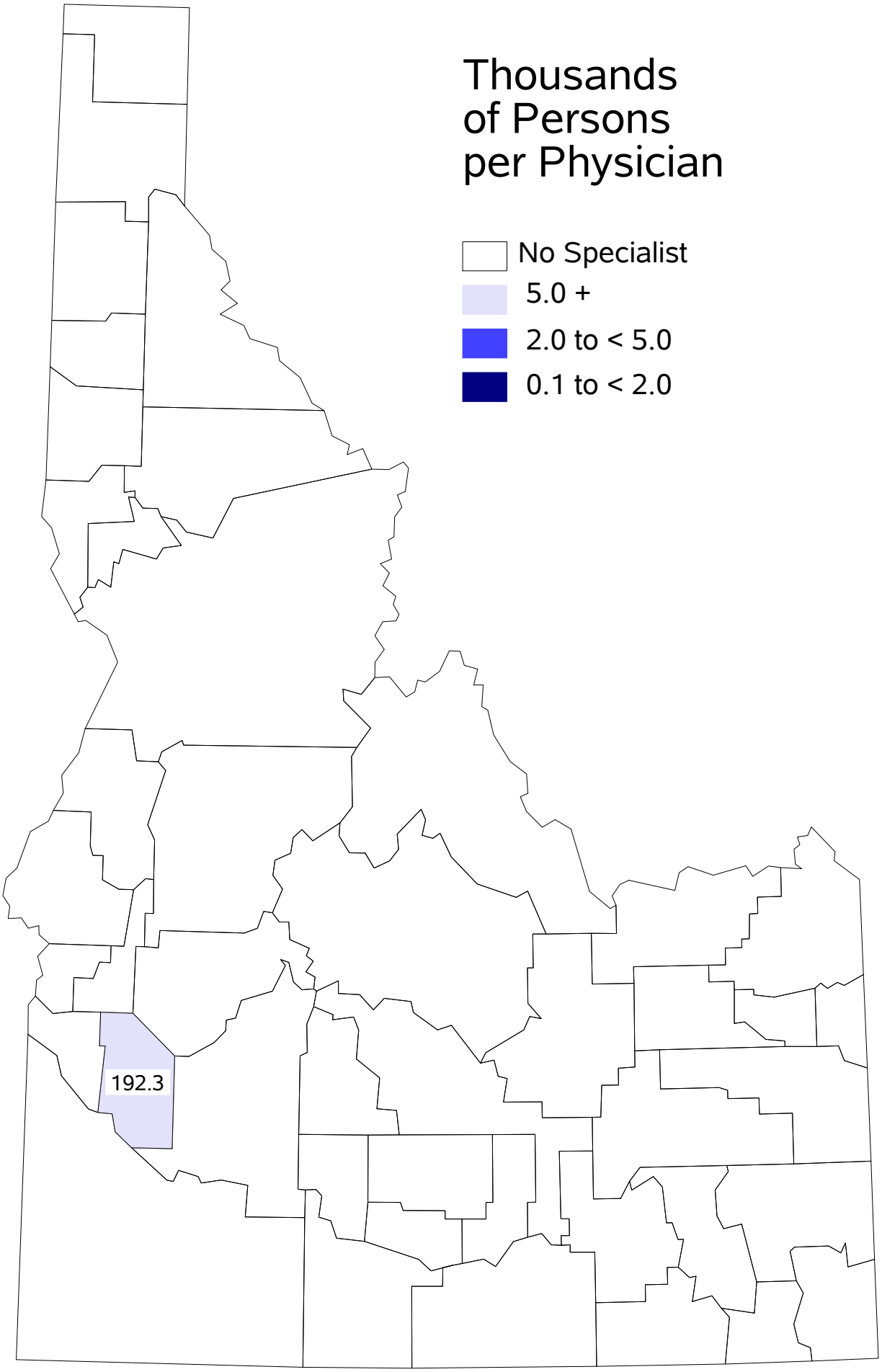
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Phlebology

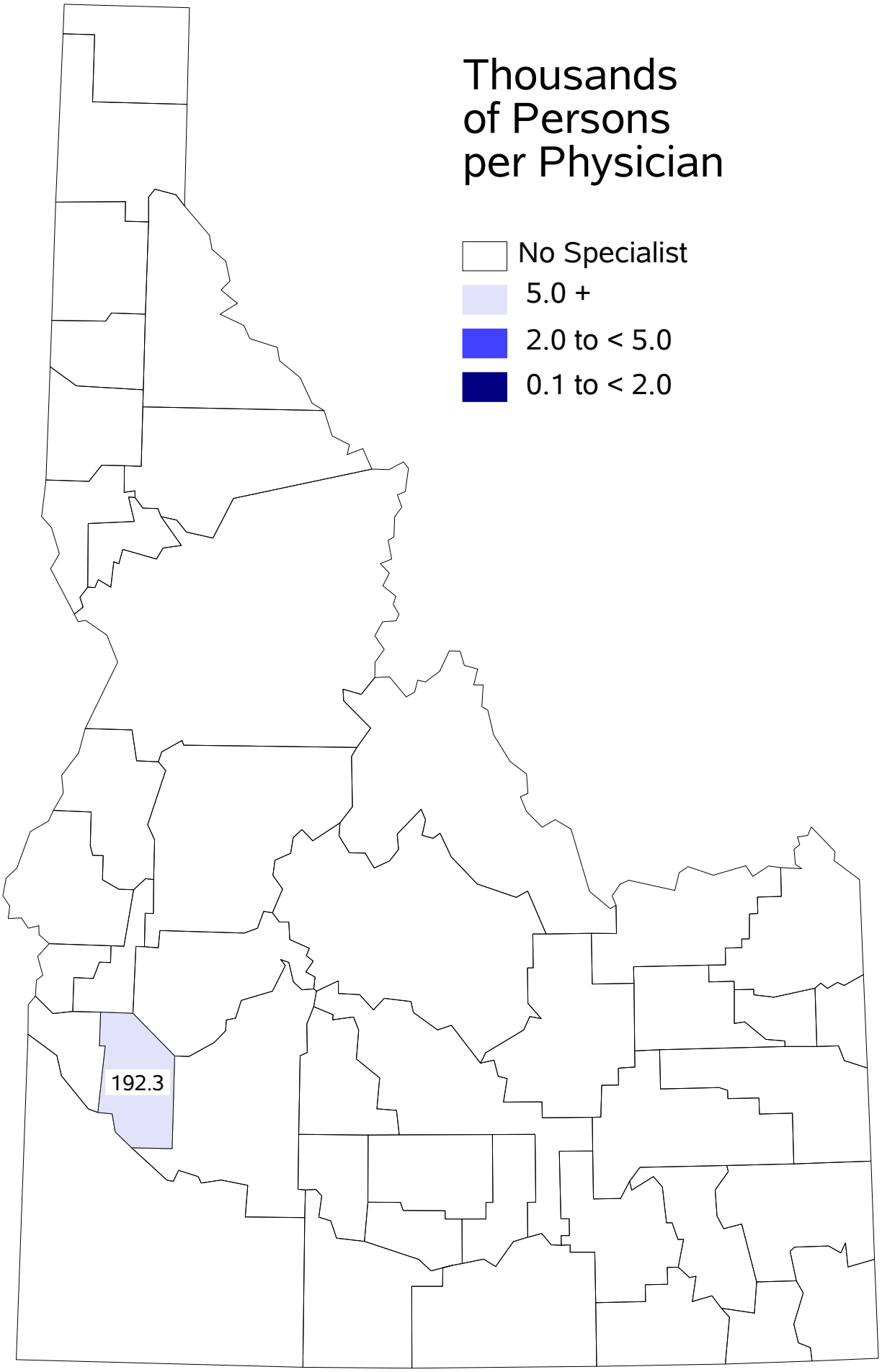
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Pediatric Hematology/Oncology

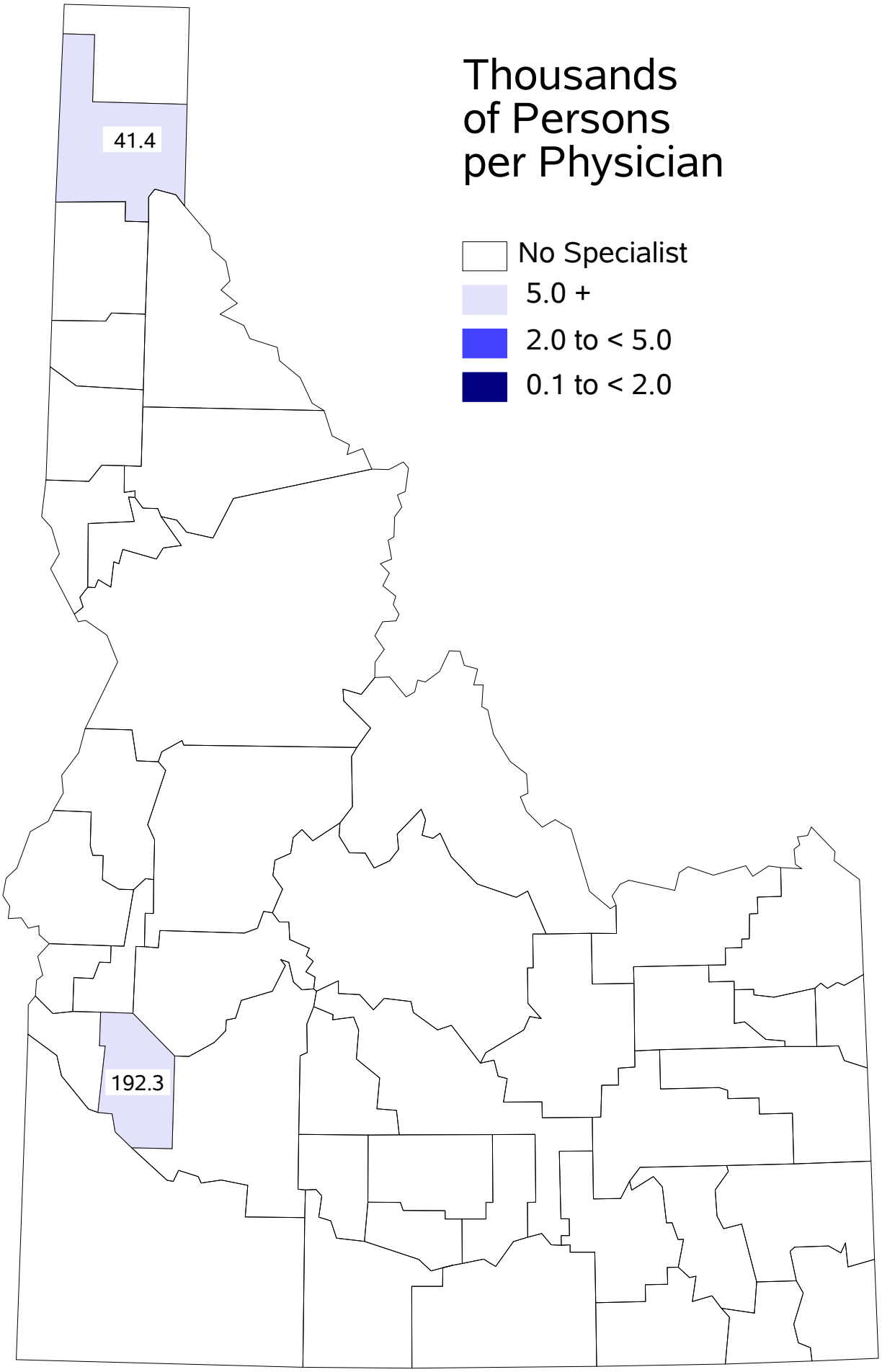
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Public Health & General Preventive Medicine

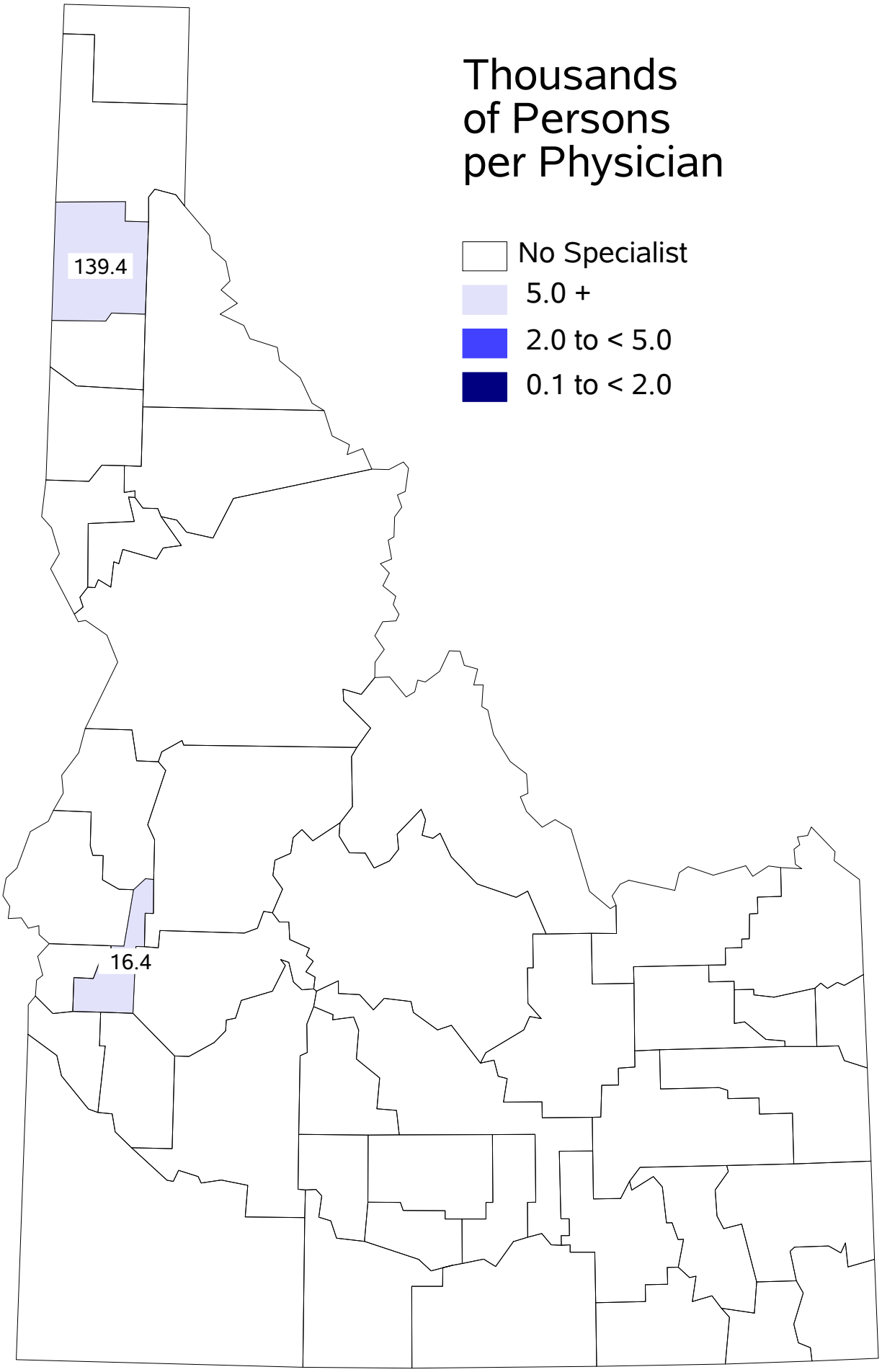
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Palliative Medicine

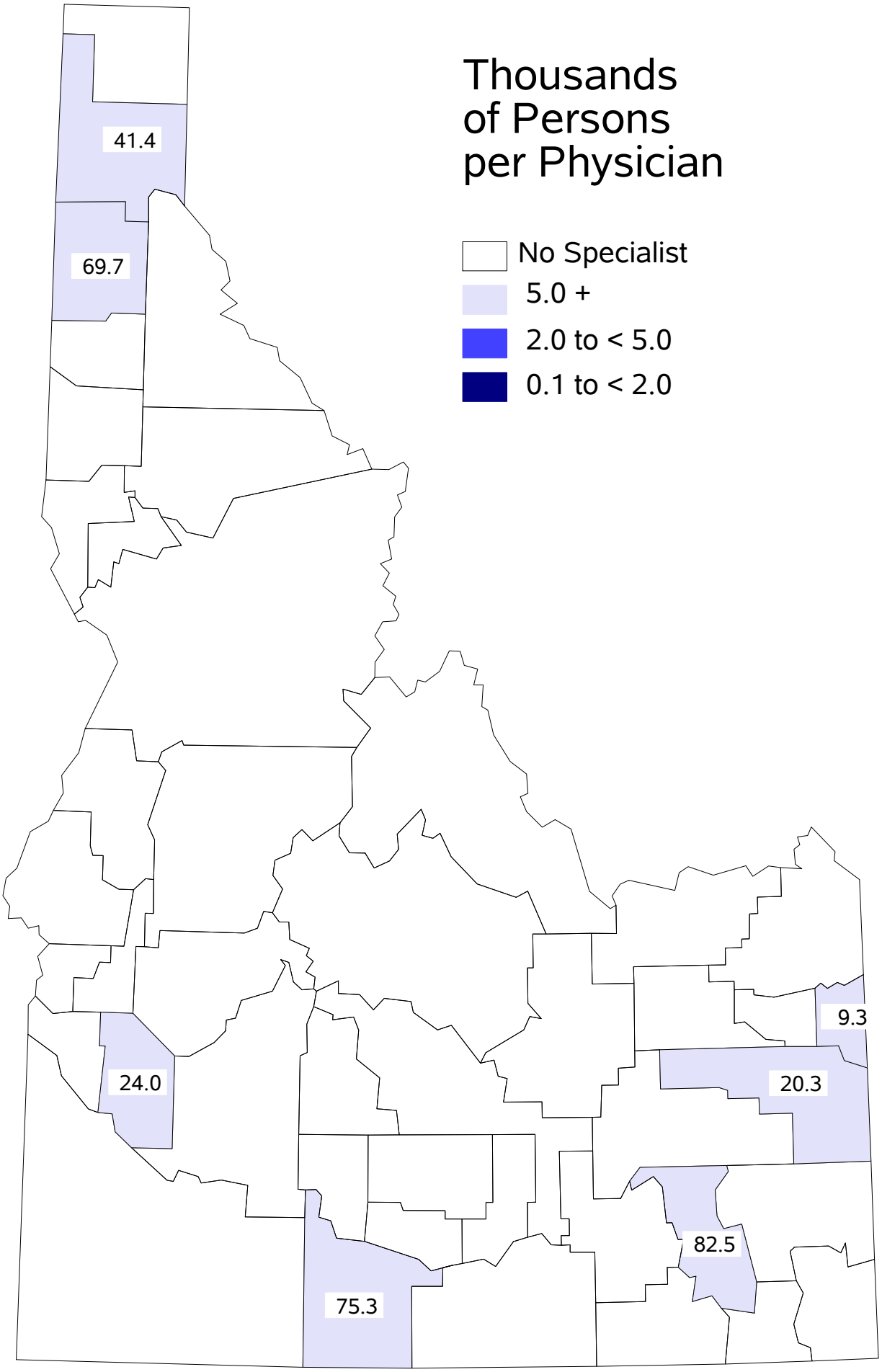
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Physical Medicine & Rehabilitation

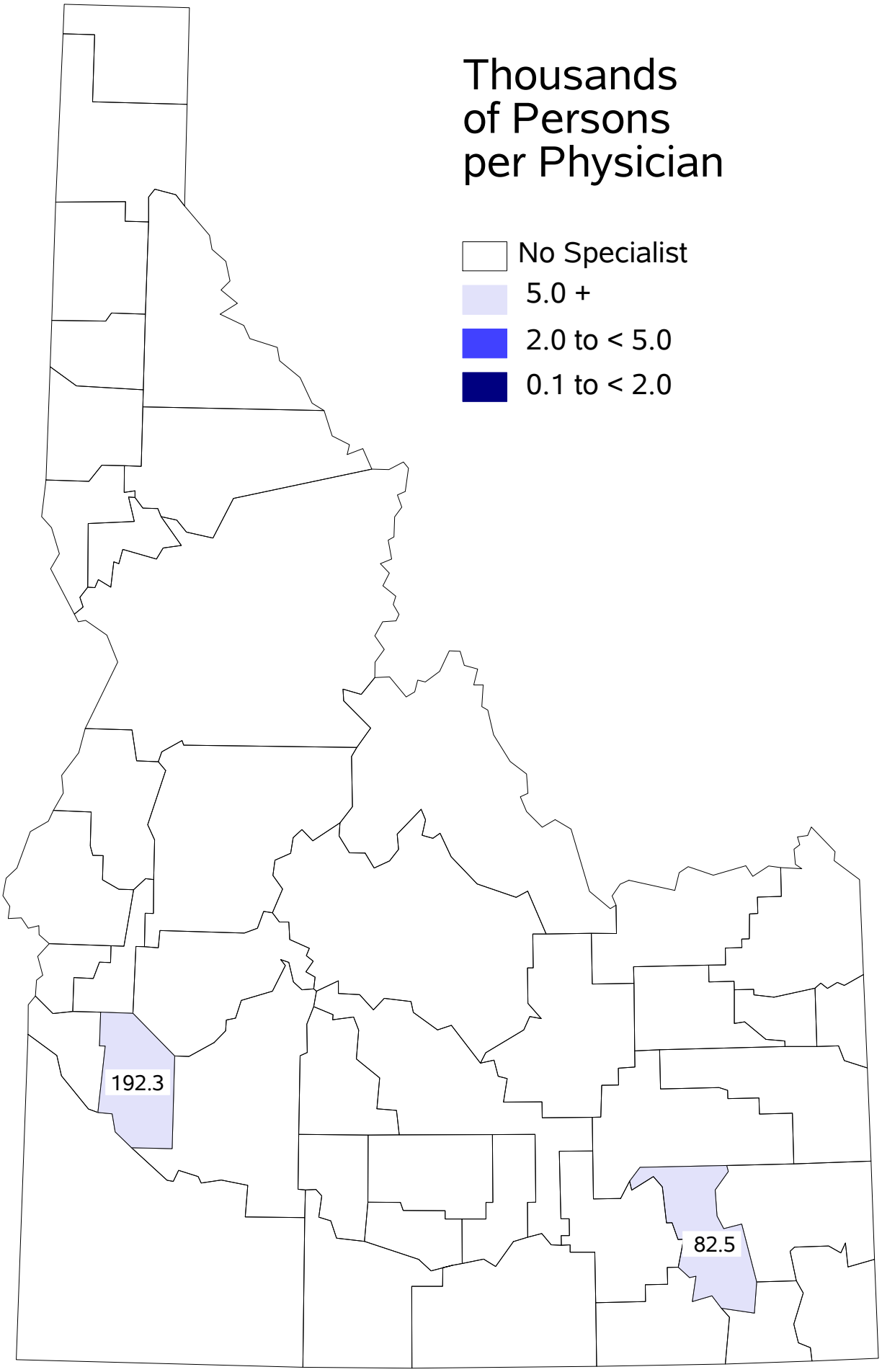
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Pediatric Ophthalmology

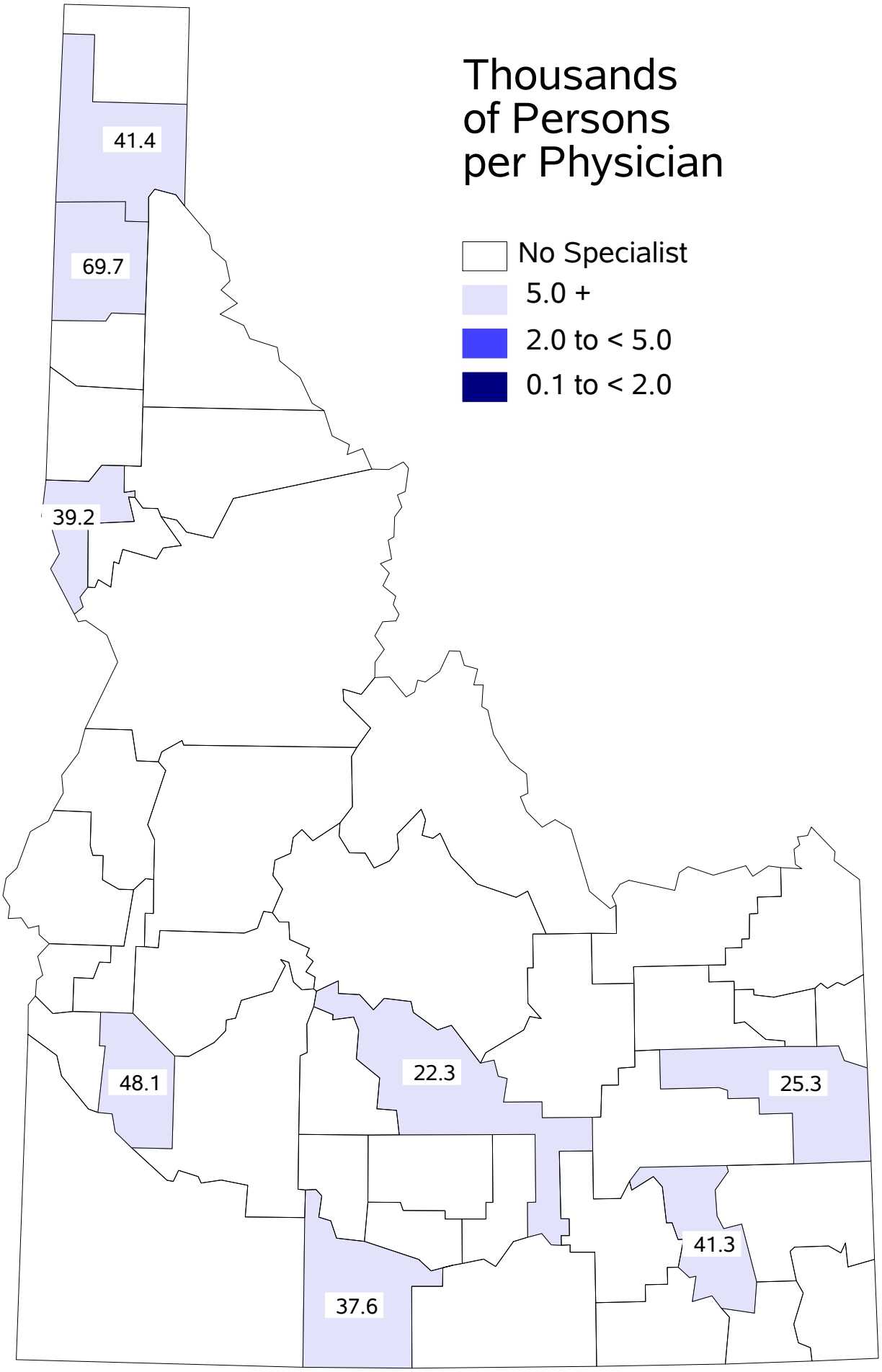
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Plastic Surgery

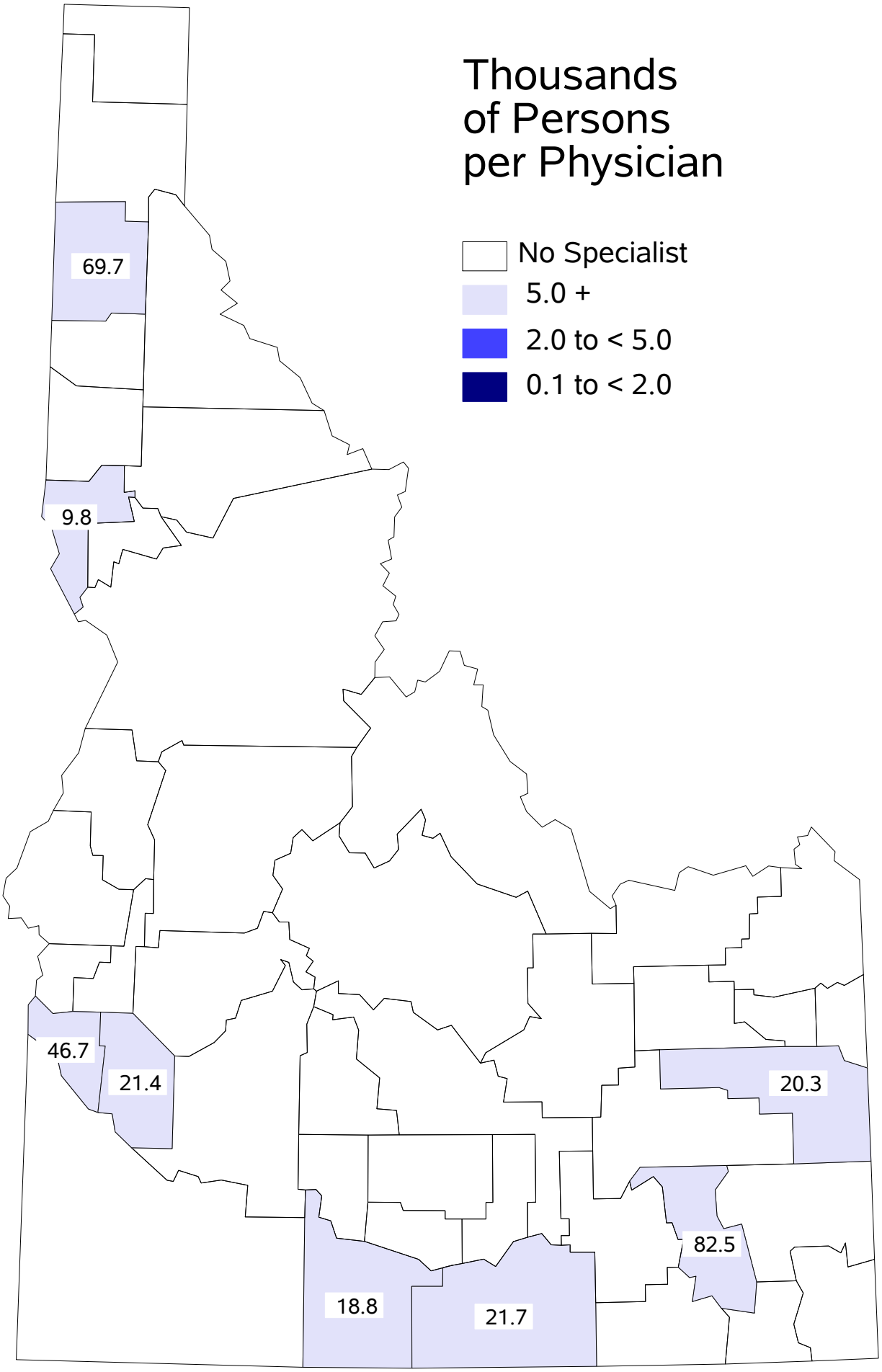
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Anatomic/Clinical Pathology

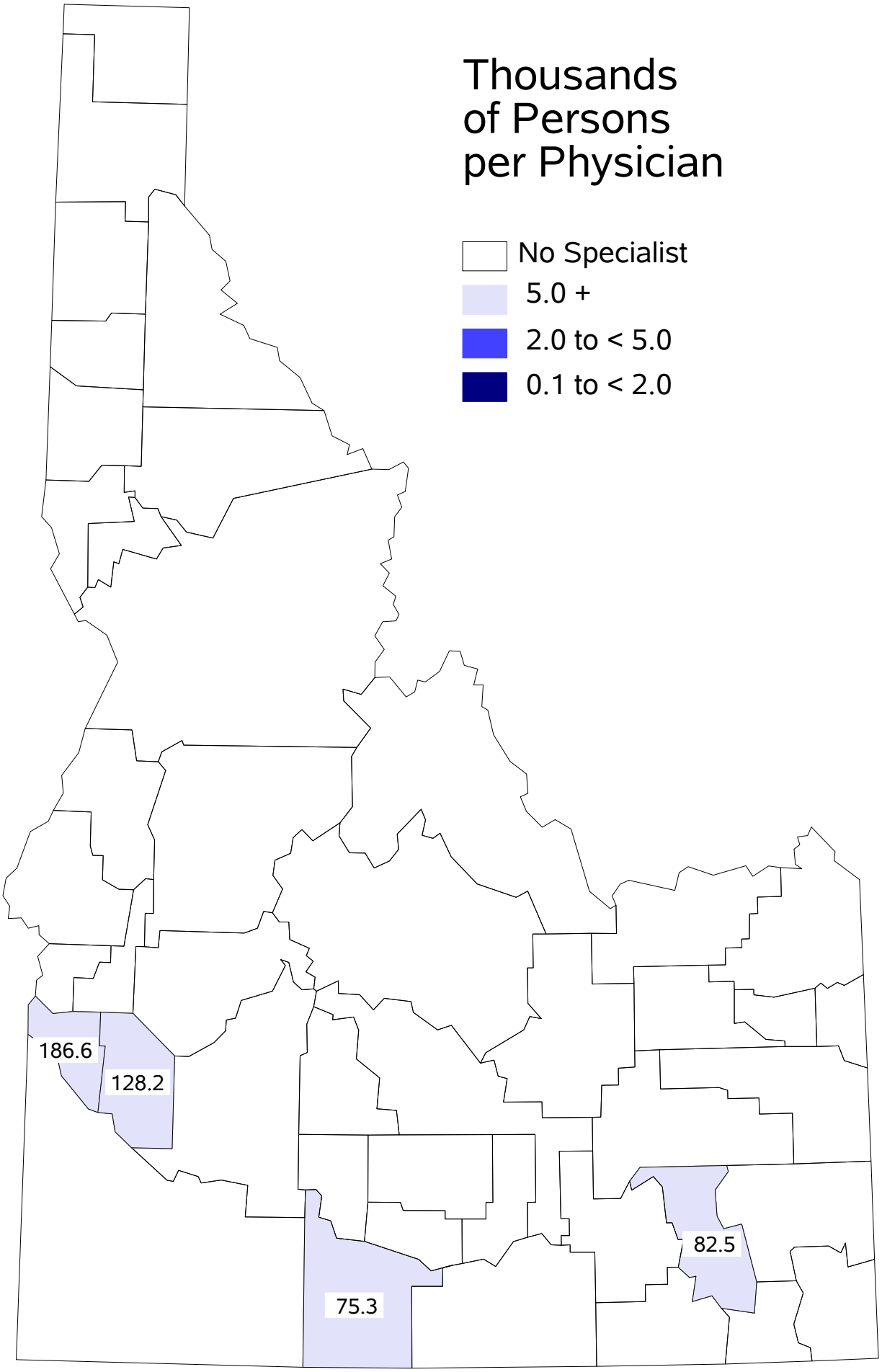
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Pulmonary Disease

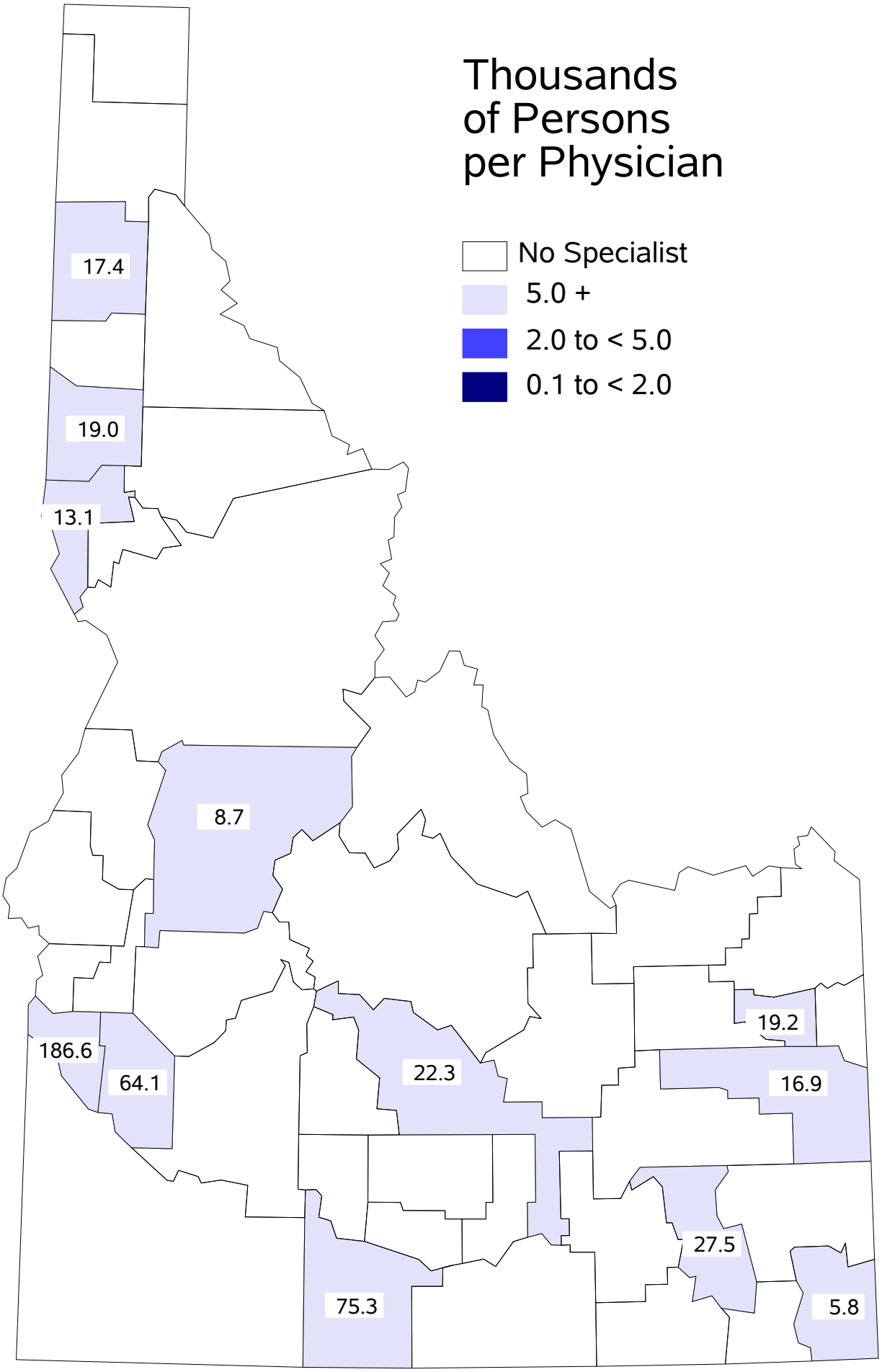
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

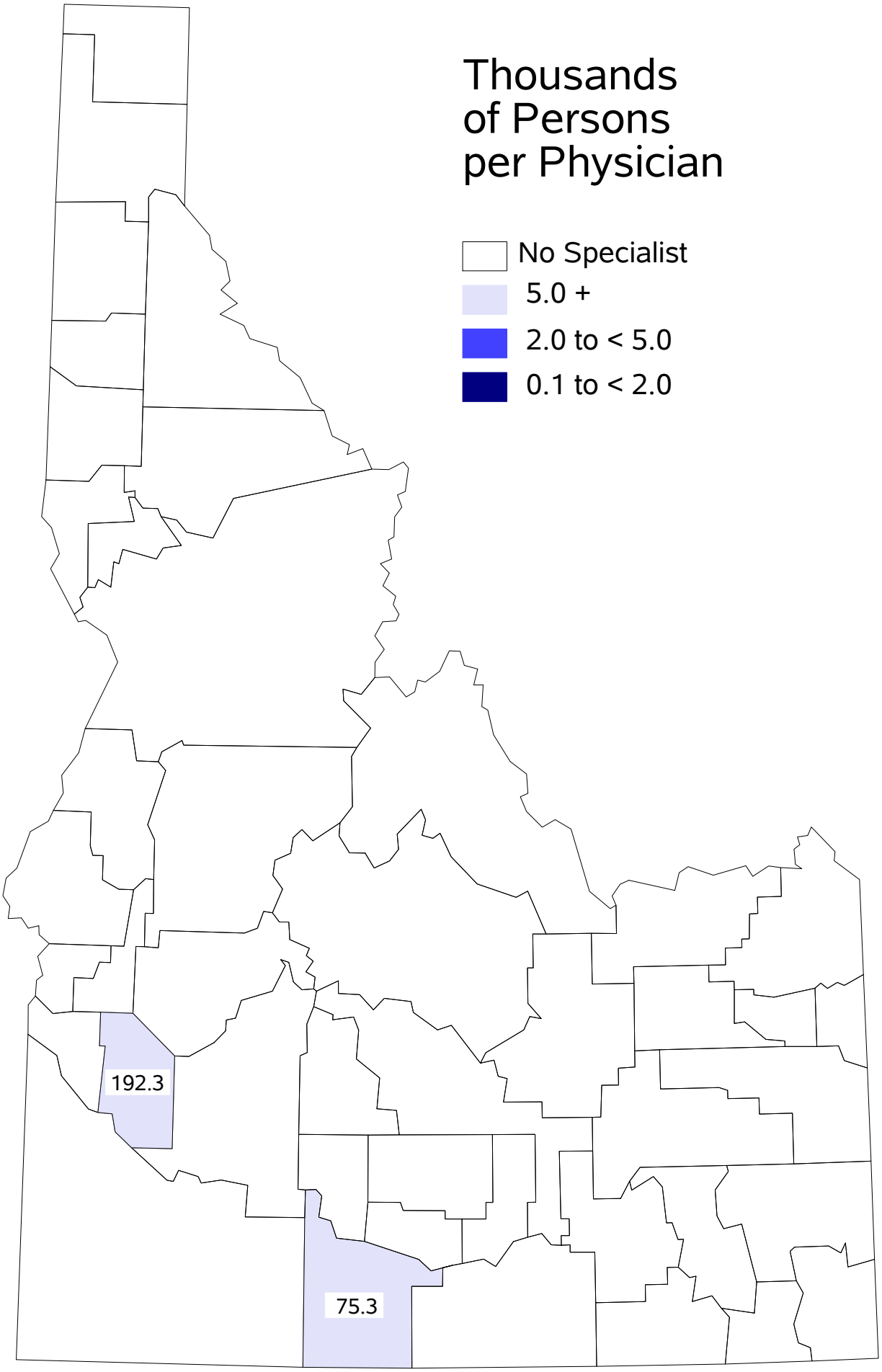
Medical Specialty=Radiology

Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

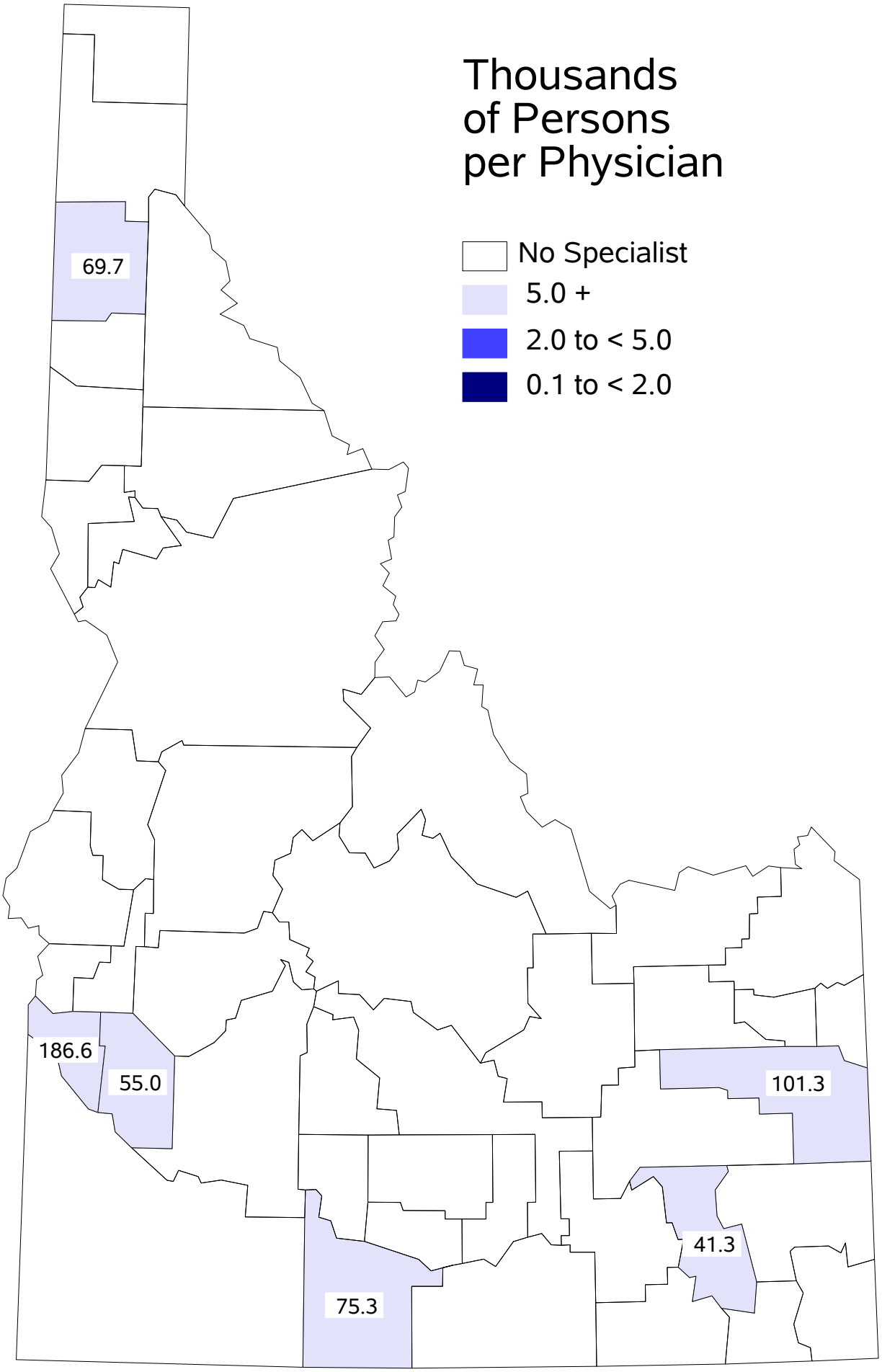
Medical Specialty=Reproductive Endocrinology & Infertility Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Rheumatology

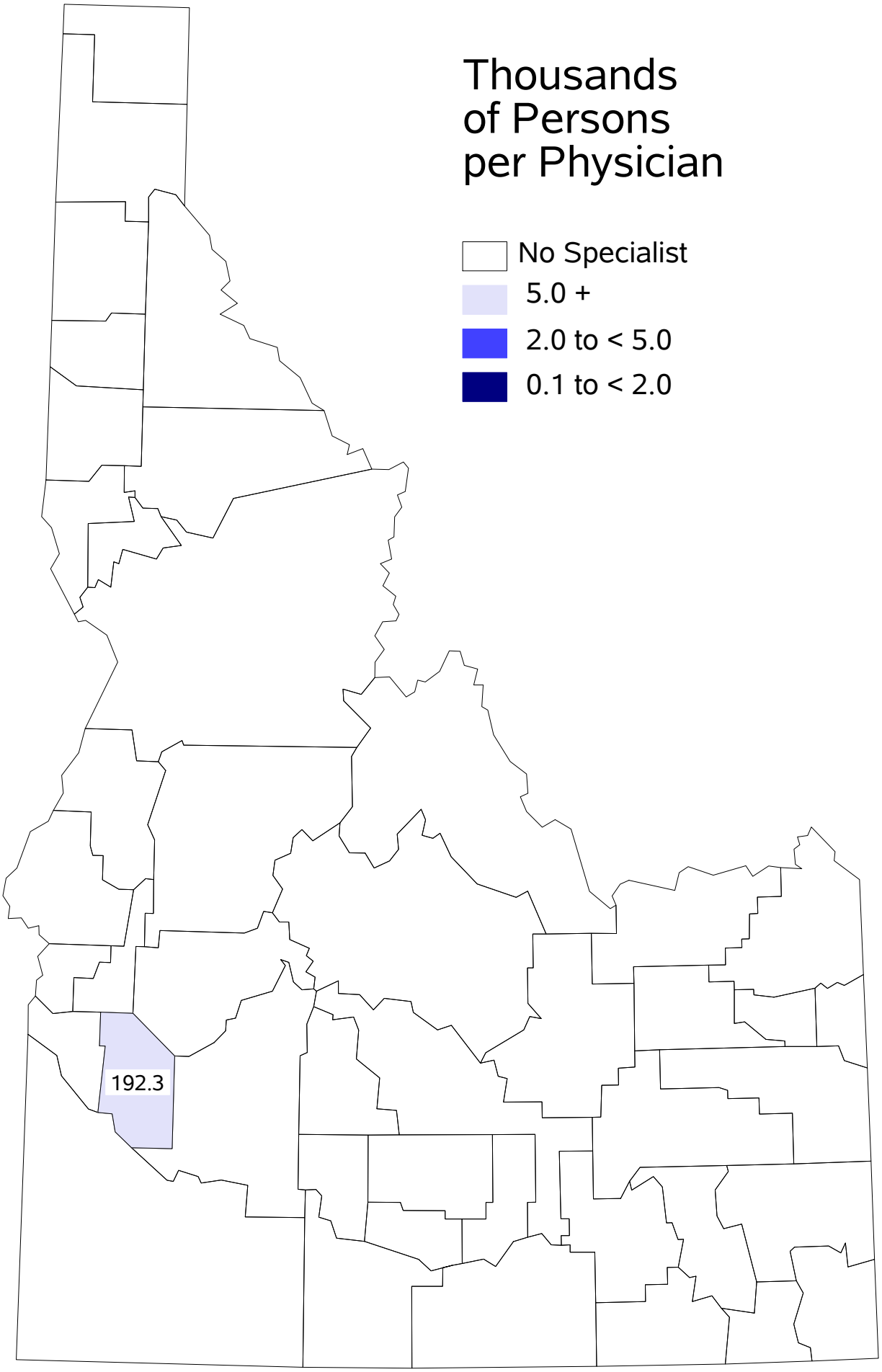
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Neuroradiology

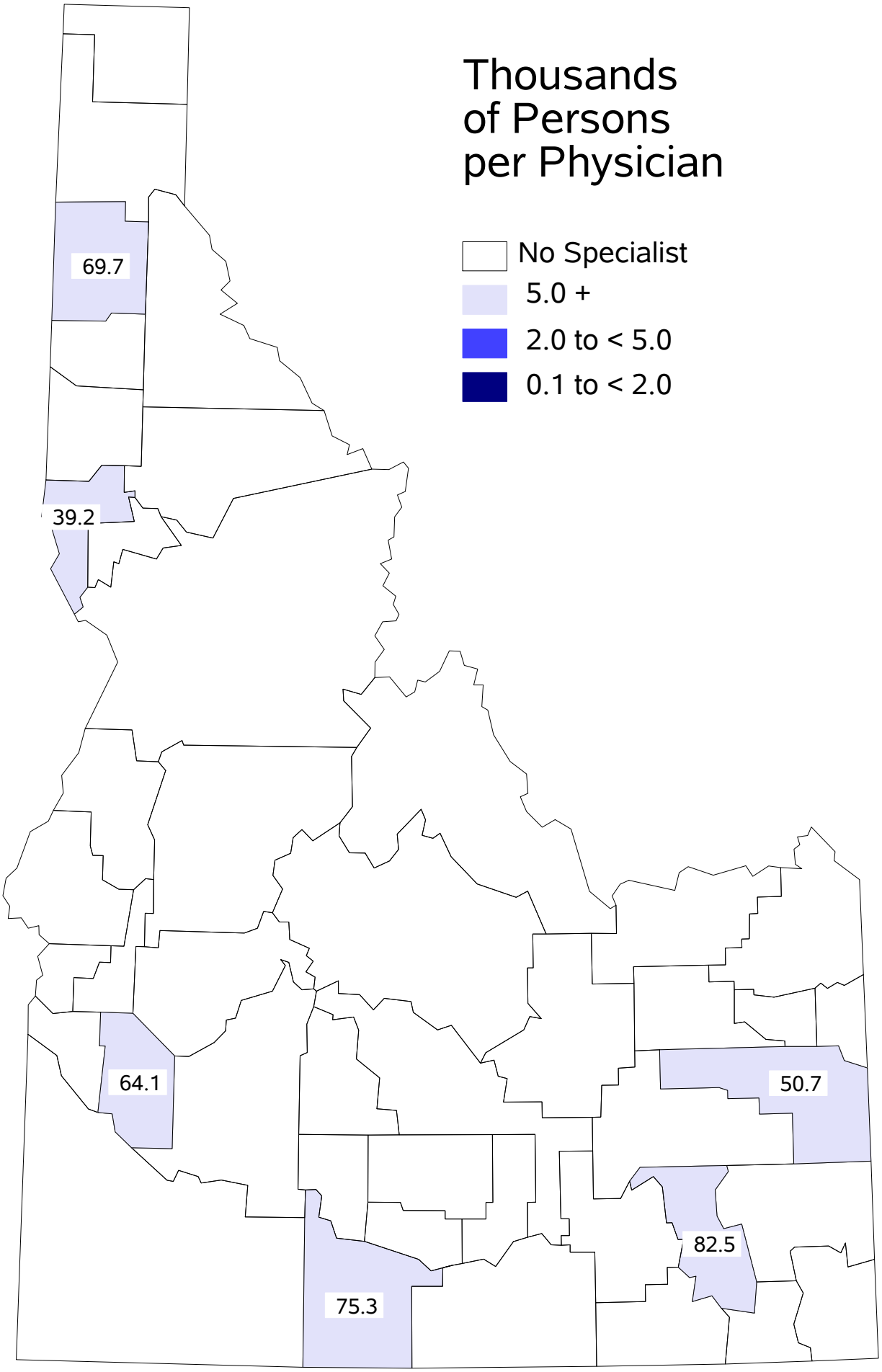
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Radiation Oncology

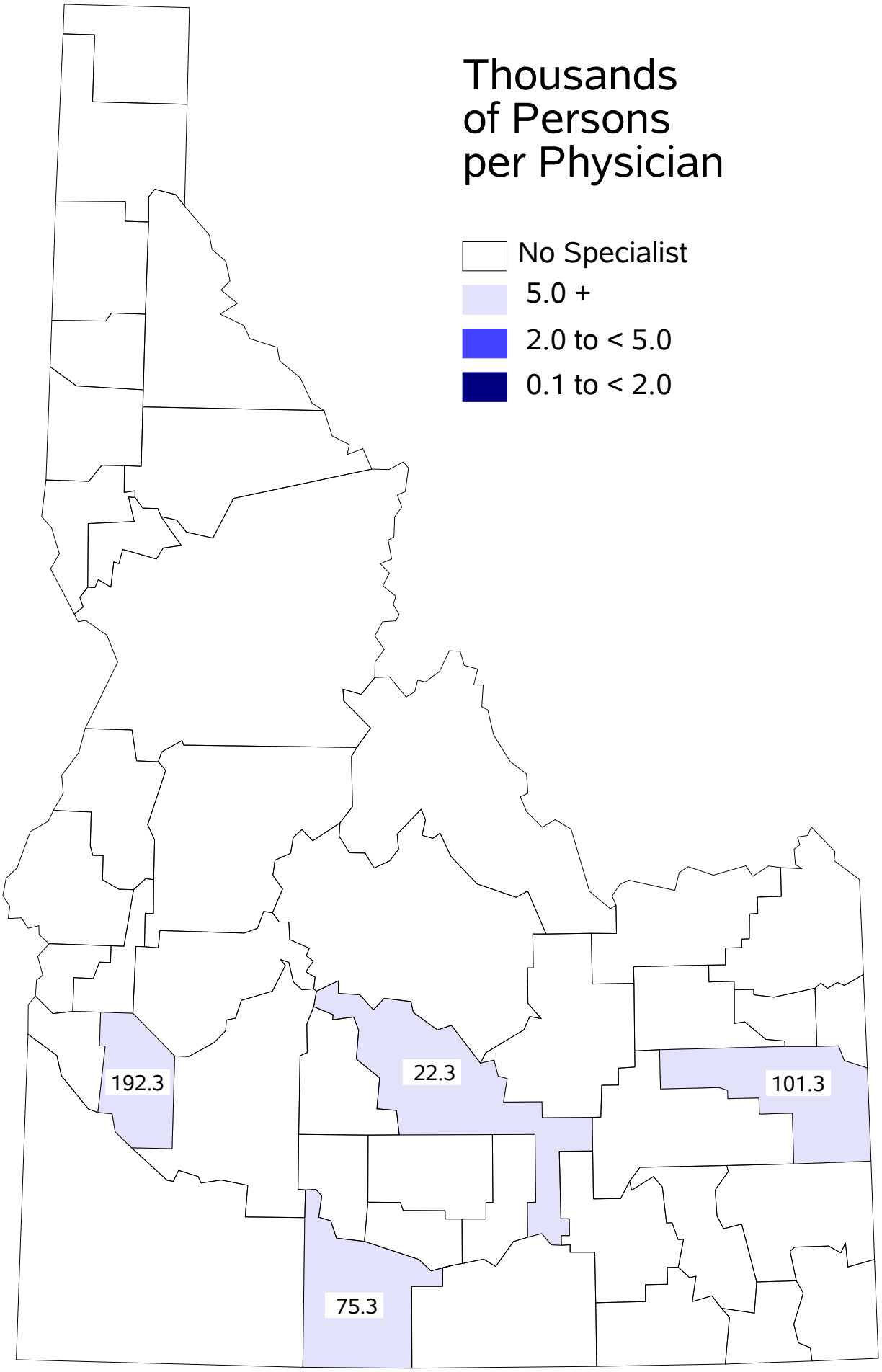
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Sleep Medicine

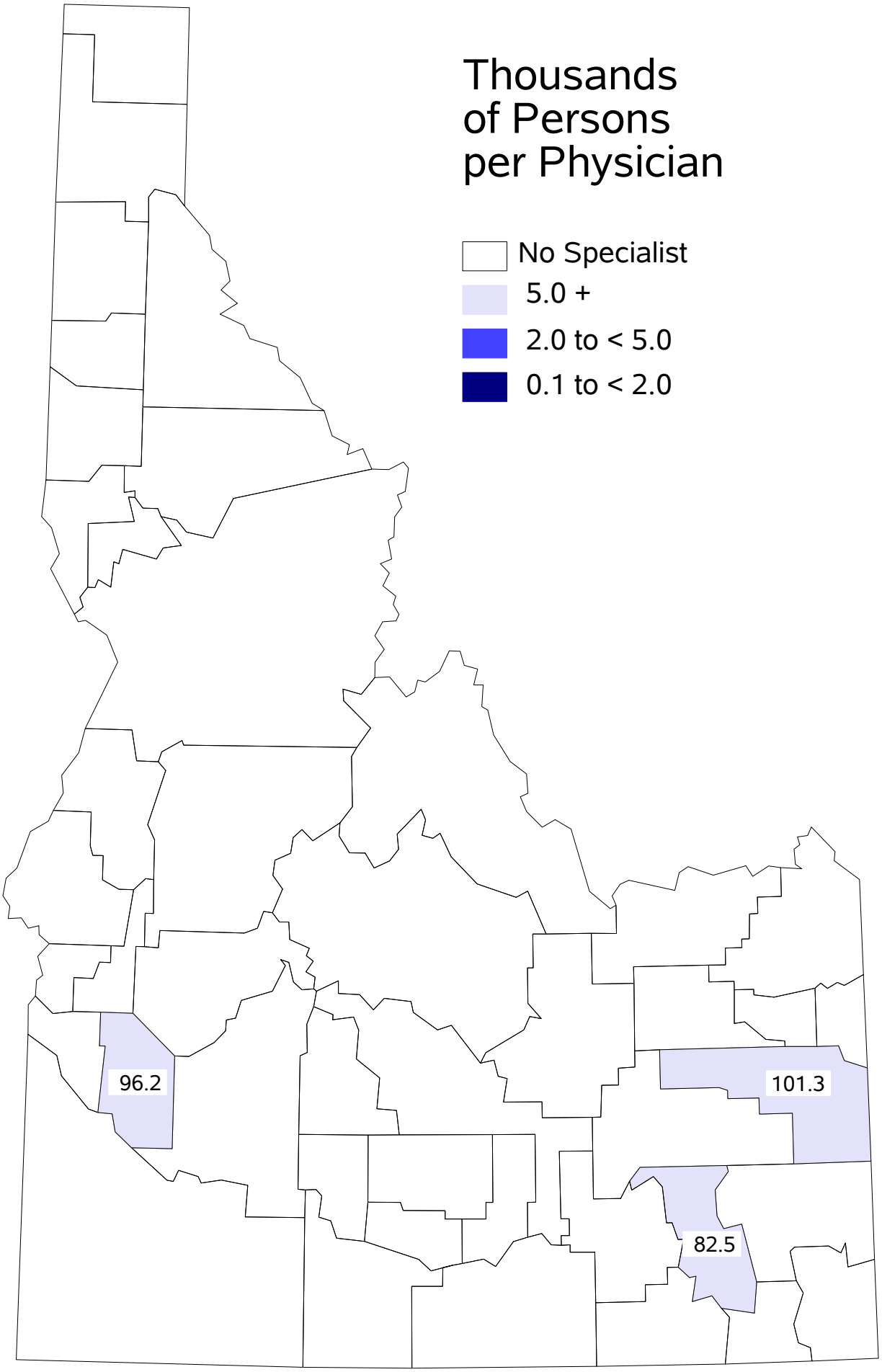
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Thoracic Surgery

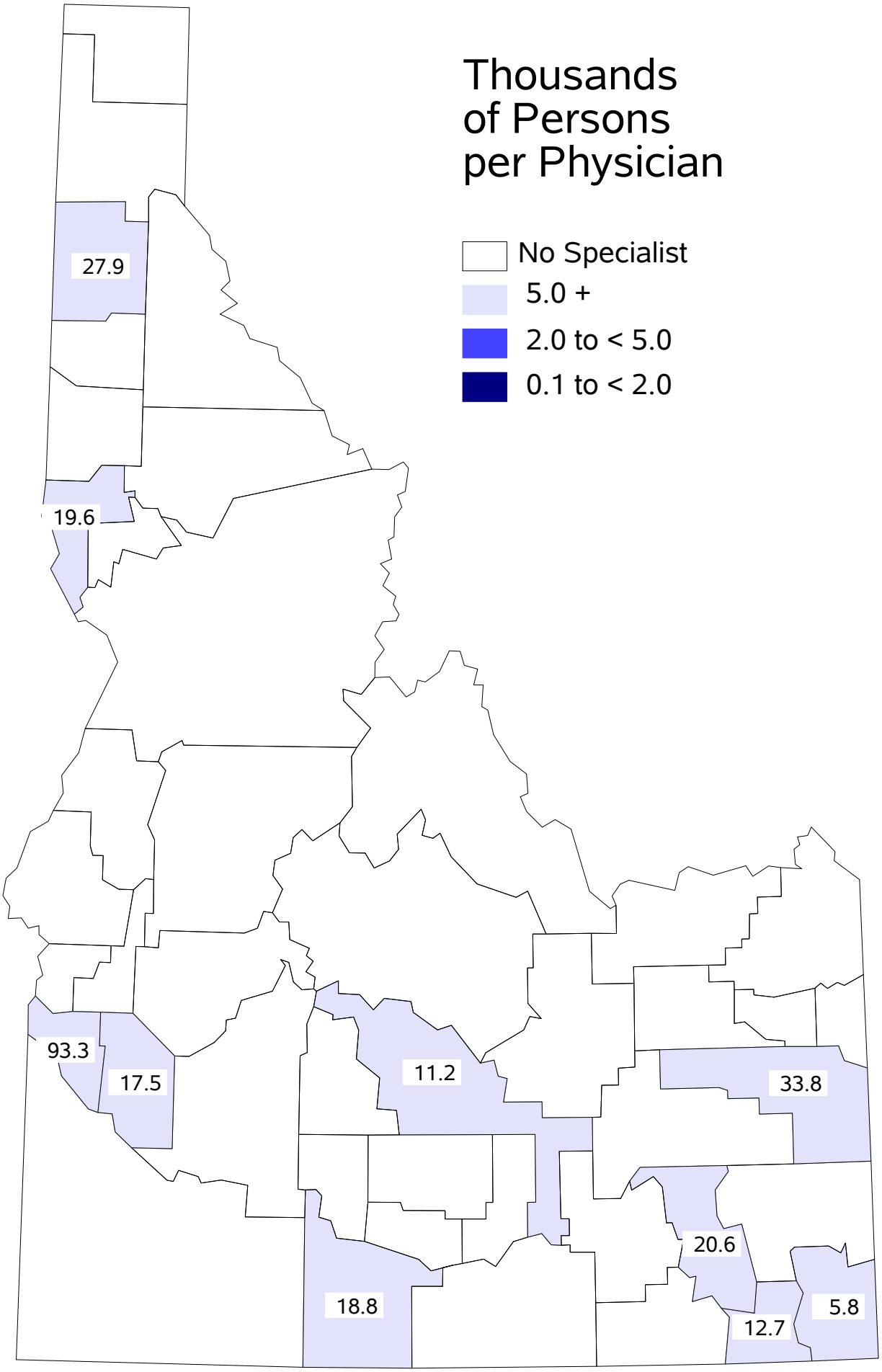
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Urology

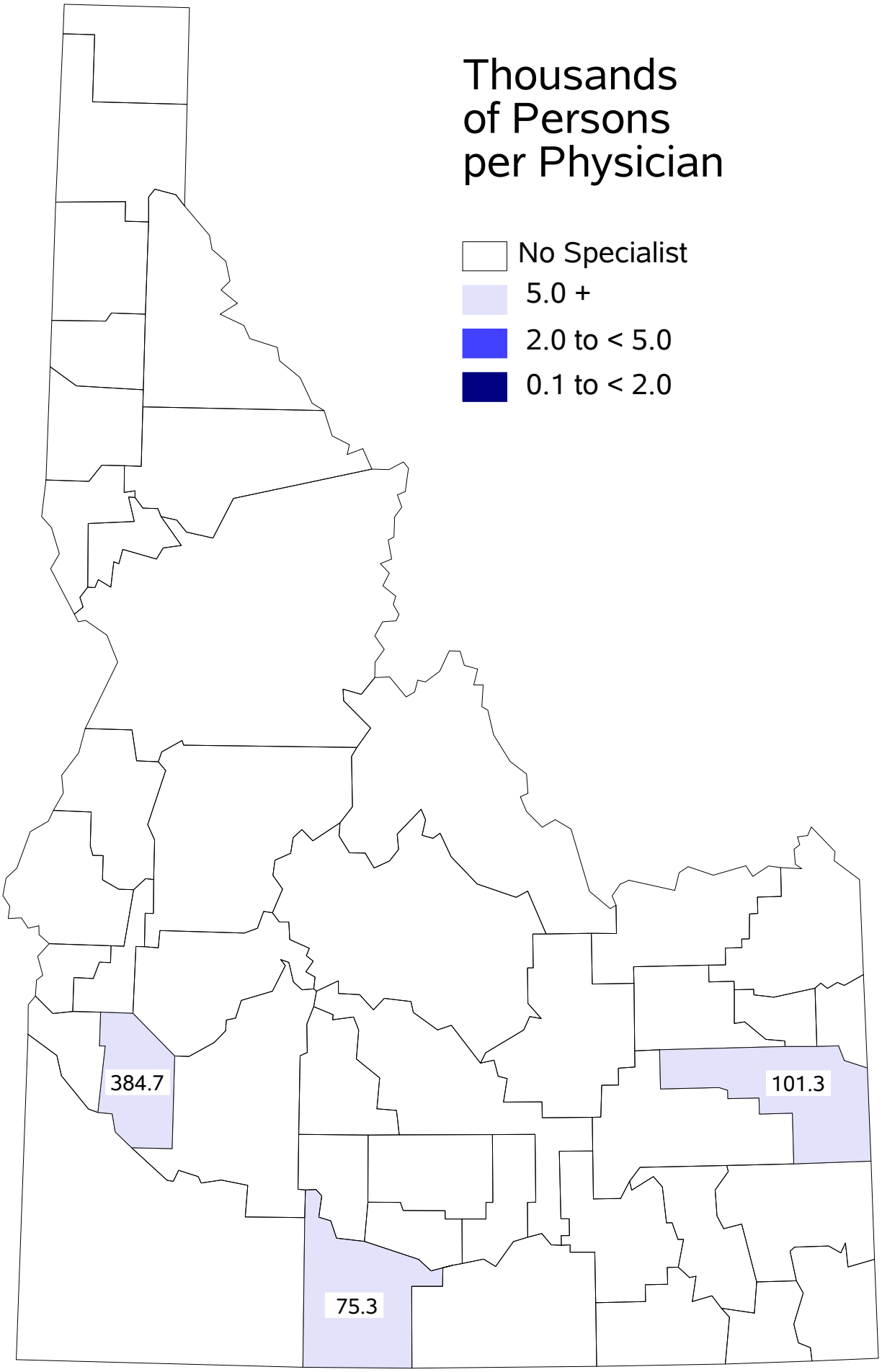
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Urgent Care Medicine

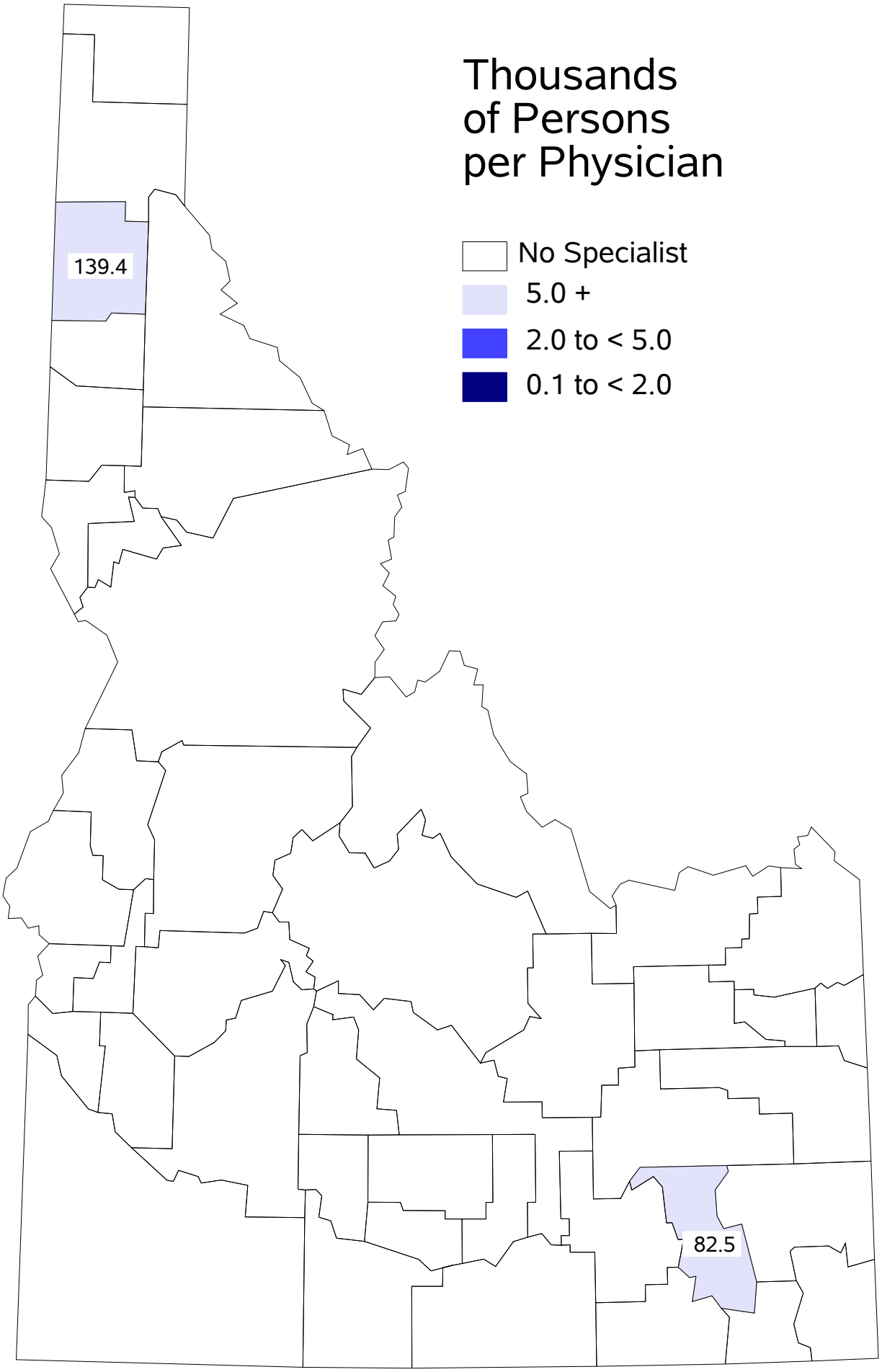
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Vascular & Interventional Radiology

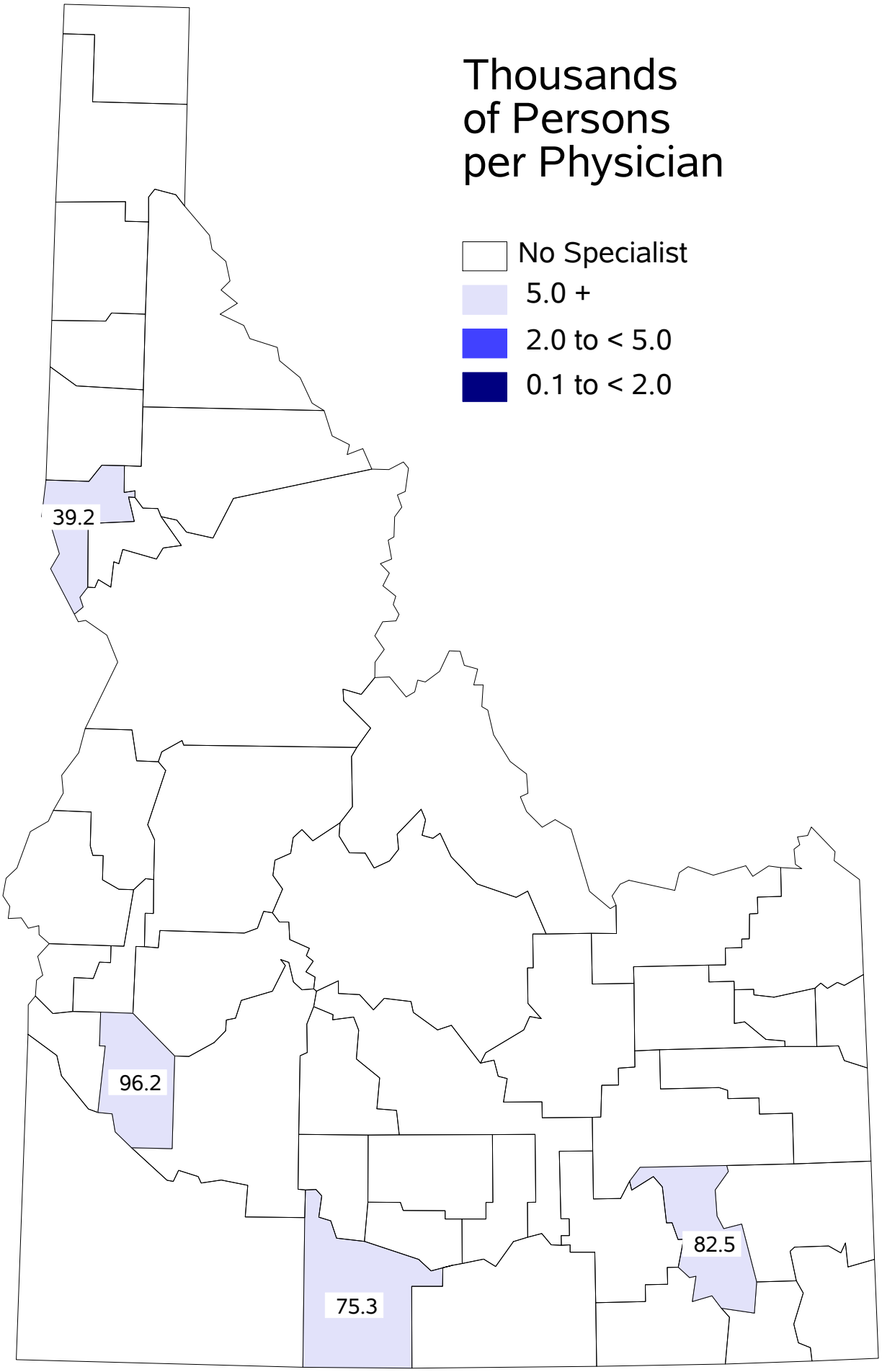
Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Medical Specialty=Vasular Surgery

Attachment F



Source: Idaho Medical Association, May 2010, includes non-member physicians

Specialties with No Physicians in Idaho

Attachment F

Specialty
Addiction Medicine
Addiction Psychiatry
Adolescent Medicine (Internal Medicine)
Anatomic Pathology
Blood Banking/Transfusion Medicine
Pediatric Critical Care Medicine
Clinical Pathology
Diabetes
Dermatologic Surgery
General Preventive Medicine
Hepatology
Hematology (Pathology)
Head & Neck Surgery
Hospice & Palliative Medicine (Family Medicine)
Medical Acupuncture
Medical Genetics
Musculoskeletal Radiology
Neuropathology
Neurology/Diagnostic Radiology/Neuroradiology
Foot & Ankle, Orthopedics
Musculoskeletal Oncology
Orthopedic Trauma
Clinical Pharmacology
Pediatric Allergy
Pediatric Emergency Medicine (Pediatrics)
Geriatric Psychiatry
Psychosomatic Medicine
Spinal Cord Injury Medicine
Surgical Oncology
Pediatric Urology
Vascular Medicine

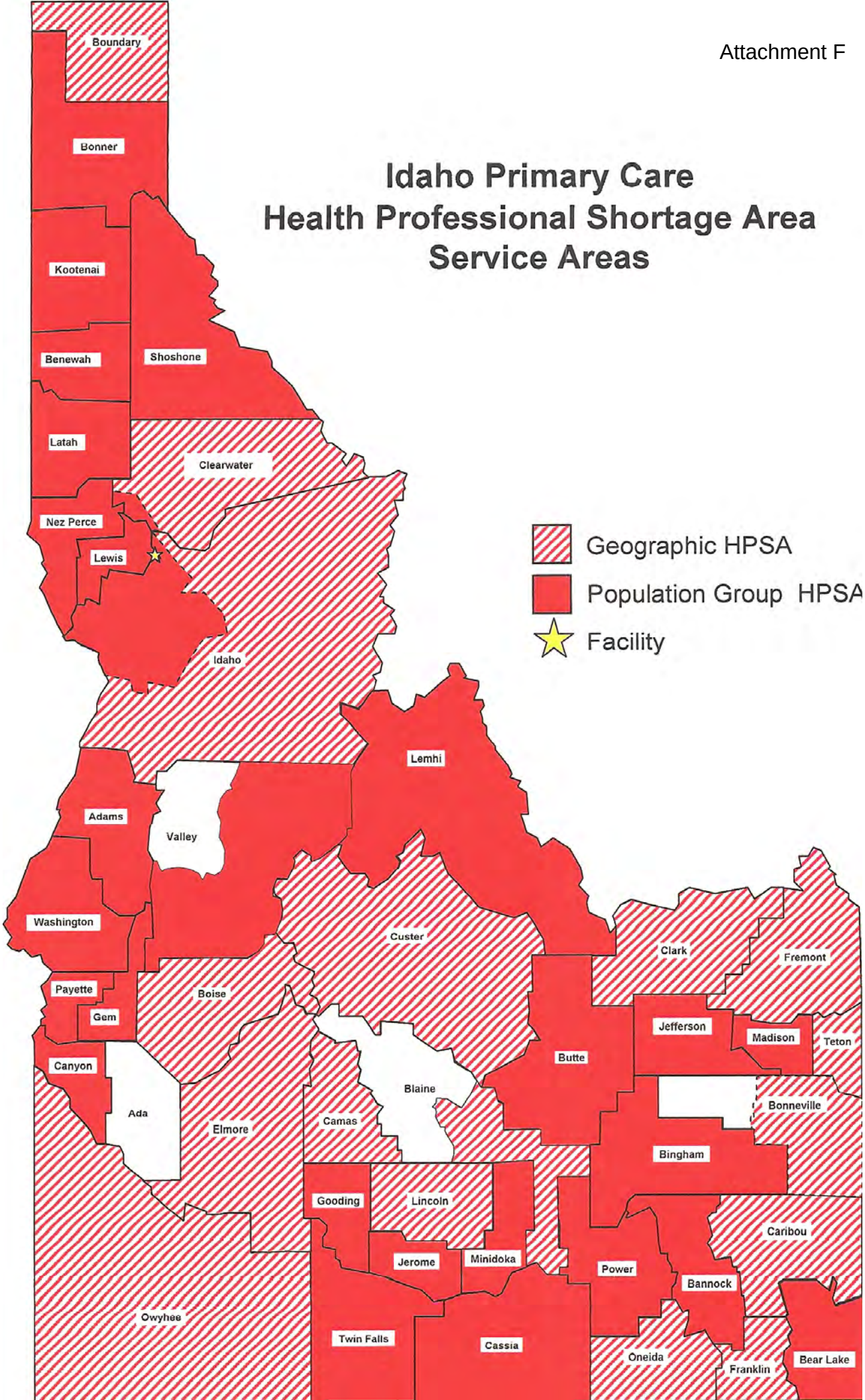
Specialties with One Physician in Idaho

Attachment F

Specialty
Allergy
Aerospace Medicine
Craniofacial Surgery
Clinical Neurophysiology
Cosmetic Surgery
Cardiothoracic Radiology
Developmental-Behavioral Pediatrics
Geriatric Medicine (Family Medicine)
Sports Medicine (Family Medicine)
Geriatric Medicine (Internal Medicine)
Legal Medicine
Medical Management
Internal Medicine/Pediatrics
Nuclear Radiology
Adult Reconstructive Orthopedics
Obstetrics
Osteopathic Manipulative Medicine
Sports Medicine (Orthpedic Surgery)
Orthopedic Surgery of the Spine
Pediatric Anesthesiology (Anesthesiology)
Cytopathology
Pediatric Cardiothoracic Surgery
Pediatric Infectious Disease
Pediatric Otolaryngology
Pediatric Radiology
Pediatric Emergency Medicine (Emergency Medicine)
Forensic Psychiatry
Pediatric Gastroenterology
Pain Management
Pain Medicine
Trauma Surgery
Undersea & Hyperbaric Medicine (Preventive Medicine)

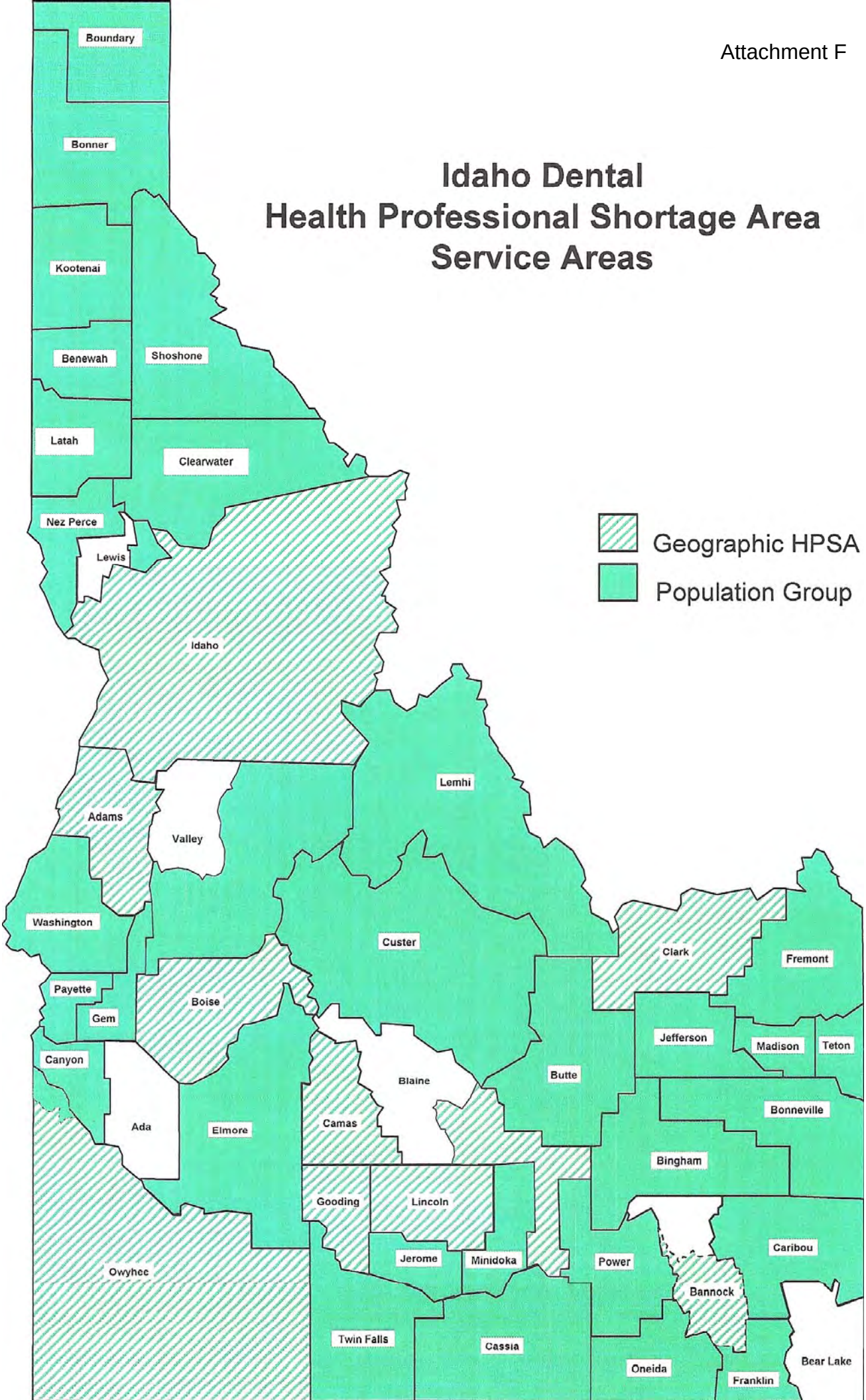
Attachment F

Idaho Primary Care Health Professional Shortage Area Service Areas



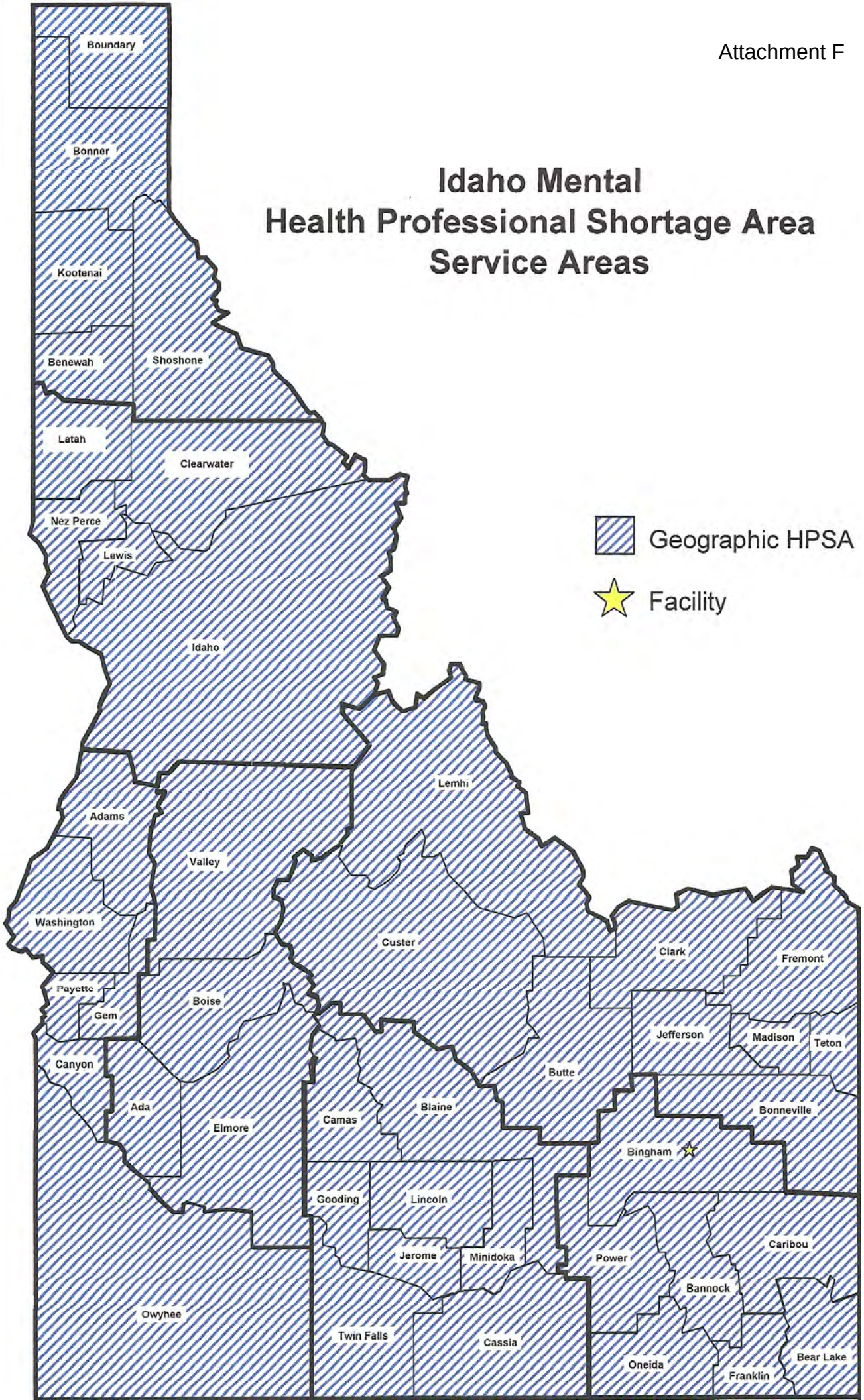
Attachment F

Idaho Dental Health Professional Shortage Area Service Areas



Attachment F

Idaho Mental Health Professional Shortage Area Service Areas



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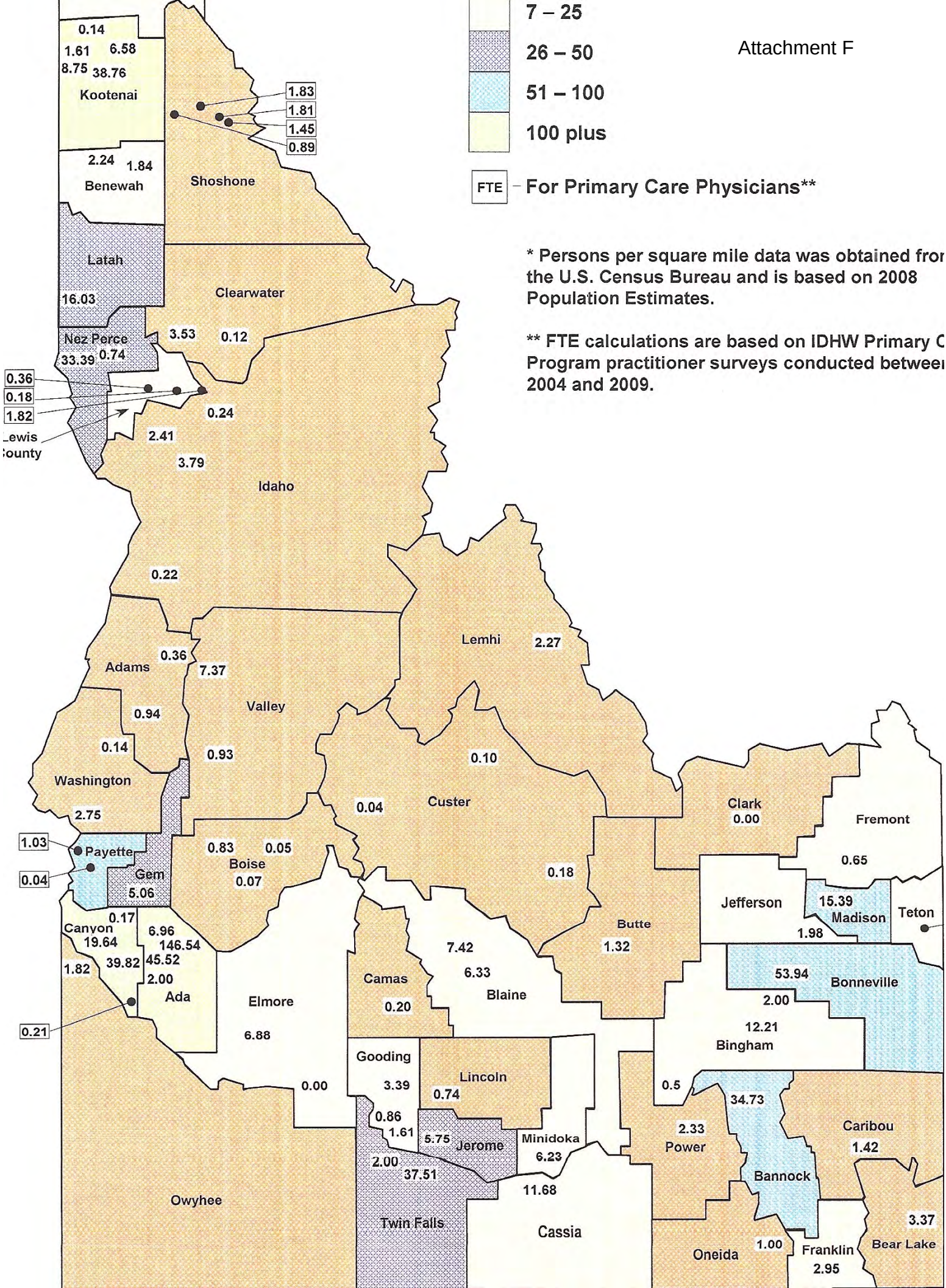

Simple Ranking Tables from 2009 MCH Needs Assessment Survey

		Response Groups					
		All	Organization				
		Idaho	District	IDHW	Not Govt	Other Agency	School
	Respondents in Group	191	23	31	99	10	28
Rank							
1	Subject	Intentional injuries	Immunization rates	Child Obesity	Intentional injuries	Access to medical specialists CSHCN	Intentional injuries
	Mean	4.73	3.83	4.45	4.40	4.20	4.61
	Std Dev	2.889	2.516	2.779	2.875	3.458	2.699
2	Subject	Child Obesity	Teen pregnancy	Intentional injuries	Access to medical specialists CSHCN	Intentional injuries	Teen pregnancy
	Mean	5.29	4.17	4.58	4.57	4.70	5.00
	Std Dev	3.150	2.657	2.953	3.387	2.627	2.404
3	Subject	Access to medical specialists CSHCN	Intendedness of pregnancies	Immunization rates	Child Obesity	Child Obesity	Preconception/ prenatal health care
	Mean	5.37	4.30	4.71	5.51	4.80	5.14
	Std Dev	3.469	3.611	3.495	3.138	3.190	2.990
4	Subject	Teen pregnancy	Premature births/ LBW	Preconception/ prenatal health care	Transitional services CSHCN	Teen pregnancy	Child Obesity
	Mean	5.56	5.26	4.90	5.53	5.60	5.14
	Std Dev	2.826	2.281	2.181	3.121	2.951	3.597
5	Subject	Immunization rates	Dental disease	Teen pregnancy	Premature births/ LBW	Premature births/ LBW	Access to medical specialists CSHCN
	Mean	5.75	5.83	5.58	5.74	5.80	5.54
	Std Dev	3.216	2.980	2.975	2.363	3.259	3.237
6	Subject	Premature births/ LBW	Child Obesity	Premature births/ LBW	Teen pregnancy	Preconception/ prenatal health care	Immunization rates
	Mean	5.81	5.87	5.71	6.03	5.90	5.79
	Std Dev	2.515	3.094	2.807	2.834	2.558	2.558
7	Subject	Preconception/ prenatal health care	Preconception/ prenatal health care	Unintentional injuries	Unintentional injuries	Immunization rates	Unintentional injuries
	Mean	5.88	5.91	6.29	6.35	6.30	5.93
	Std Dev	2.599	2.314	3.237	3.032	2.627	3.185
8	Subject	Unintentional injuries	Intentional injuries	Access to medical specialists CSHCN	Preconception/ prenatal health care	Unintentional injuries	Premature births/ LBW
	Mean	6.45	6.48	6.74	6.39	6.60	6.61
	Std Dev	3.089	2.810	3.296	2.579	3.688	2.601
9	Subject	Transitional services CSHCN	Access to medical specialists CSHCN	Dental disease	Immunization rates	Dental disease	Dental disease
	Mean	6.76	7.26	7.19	6.46	7.10	7.18
	Std Dev	3.311	3.208	2.725	3.271	2.767	3.267
10	Subject	Intendedness of pregnancies	Unintentional injuries	Intendedness of pregnancies	Intendedness of pregnancies	Transitional services CSHCN	Transitional services CSHCN
	Mean	7.18	7.65	7.71	7.45	7.10	7.32
	Std Dev	3.581	2.690	2.759	3.515	3.247	3.068
11	Subject	Dental disease	Transitional services CSHCN	Transitional services CSHCN	Dental disease	Intendedness of pregnancies	Intendedness of pregnancies
	Mean	7.21	9.43	8.13	7.57	7.90	7.75
	Std Dev	3.002	2.233	3.085	2.997	3.755	3.668

Organizations are recoded from Q1 and Q2 responses. "Not Govt" is all individuals and non-governmental response.