

Chapter IV

Idaho Health Care Infrastructure

Overview

The MCH population groups obtain information, health care, and other health-related services through a variety of organizational entities. Some, other institutions, such as university training programs, exist to support the system of care. Taken together, all these components make up the health infrastructure. In order to understand the needs of the Idaho MCH population and opportunities available to meet those needs, it is important to understand the system that is currently in place. The following is a description of the major components of the infrastructure of the Idaho system of care for the MCH populations.

A. Public Sector Health and Wellness System

The public sector health and wellness system includes State and local agencies who address health and health-related issues in Idaho. This section provides an overview of the key agencies and divisions involved.

1. *Department of Health and Welfare*

The overall mission of the IDHW is to actively promote and protect the economic, behavioral, and physical health and safety of all Idahoans. The goals of the department focus on area where the IDHW and its partners can:

- Improve health
- Strengthen individuals, families, and communities
- Integrate health and human services.

To accomplish these goals, the IDHW will assure that all employees are knowledgeable, skilled, and accountable in the Department's core competencies. An additional focus is the alignment of structures, people, and technology to meet the needs of the people of Idaho (Idaho Department of Health and Welfare, 2004a).

The Department of Health and Welfare is organized into seven divisions. Three of these divisions—the Division of Management Services, Division of Information and Technology

Services, and the Division of Human Resources—are mainly responsible for administrative functions. The other divisions are described below.

a. Division of Health

The Division of Health is organized into five bureaus:

- The Bureau of Clinical and Preventive Services (BOCAPS) is the designated Title V agency and has responsibility for services to CSHCN, health program support, immunizations, reproductive health, STD/AIDS, WIC Nutrition, Women’s Health Check, and Worker Health and Safety. The vast majority of these services are delivered through contracts with the District Health Departments.
- The Bureau of Community and Environmental Health has responsibility over adolescent pregnancy prevention, chronic diseases, environmental health, injury prevention, oral health, and tobacco prevention and control.
- The Bureau of Health Policy and Vital Statistics is responsible for health preparedness, and vital statistics.
- The Bureau of Emergency Medical Services oversees emergency medical services including certification and licensure and communications.
- The Bureau of Laboratories oversees laboratory services.

Unlike the other divisions within the Department of Health and Welfare, the Division of Health does not have regional staff to oversee service delivery. Most of the services are delivered through contracts with the District Health Departments. The District Health Departments are described after the completion of description of the DHW.

b. Division of Welfare

The Division of Welfare administers what are referred to as the Self-Reliance Programs in Idaho. The responsibilities of the division include administering TANF, which is named the TAFI Program in Idaho; the Idaho Child Care Program, which subsidizes child care costs for low-income families; Aid to the Aged, Blind, and Disabled; Food Stamps; Refugee Assistance; the Community Service Block Grant; Low-Income Energy and Weatherization Assistance; Emergency Food Assistance; Telephone Assistance, which provides cash assistance to help cover telephone installation and monthly charges; and the Child Support Program. The Division also is responsible for determining Medicaid eligibility. In-person interviews are not required for medical assistance or the child care program but are required for TAFI and Food Stamps. Regional Medicaid Services offices are responsible for administering applications and orientations for new Medicaid providers.

c. Office of Medicaid

The Office of Medicaid designs, implements and reviews State-funded medical assistance services. Medicaid is a shared Federal and State program. The Federal matching rate for Medicaid in Idaho has been declining with a 73.91 percent match reported for FY 2004, 70.62 percent for FY 2005 and 69.91 percent for FY 2006 (Kaiser Family Foundation, 2005a).

Spending per child enrolled in the program in FY 2002 was reported at \$953 and at \$12,845 for each elderly enrollee. In comparison, the spending per child enrollee for FY 2002 was \$1,227 for the U.S. overall and \$10,026 for elderly enrollees. In Idaho in FY 2002, children comprised 61 percent of Medicaid enrollees, compared to 49 percent nationally. In 2003, 74.7 percent of Idaho Medicaid enrollees were enrolled in managed care (Kaiser Family Foundation, 2005b).

The office is responsible for Medicaid policy and overseeing Medicaid providers. These responsibilities include administering reimbursement to providers, provider licensure and survey, and Medicaid utilization review and fraud control. The Medicaid program has the largest appropriation in the Department of Health and Welfare with an initial appropriation of \$1.05 billion in FY 2005. Over 96 percent of these funds are payments for providers, and 66.5 percent are Federal funds.

One of the key enabling services provided under Medicaid is case management services. These services are available for many of the populations that are covered under this needs assessment including CSHCN. Private contractors provide case management services. These contractors recruit and obtain consent from Medicaid participants. There are four types of case management services provided under Medicaid:

- ***EPSDT case management.*** Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) case management services are provided to those under age 21 who have been identified on an EPSDT case management screen as needing case management services. The case manager's responsibilities are to help the child and family secure and coordinate needed health, educational, early intervention, advocacy, and social services identified in an authorized service plan.
- ***Mental health case management.*** Mental health case management services are provided to adults with a severe and persistent mental illness and functional limitations, and a history of using high-cost medical services. The purpose of these services is to assist eligible individuals to gain access to needed medical, social, educational, mental health, and other services.
- ***Developmental disability service coordination.*** These case management services are provided to adults with developmental disabilities who have a need for service coordination and a desire to live, learn, or work in community-based settings.

- **Personal care services case management.** This service is provided to Medicaid participants who have a demonstrated need for personal care services and need assistance to obtain other Medicaid and non-Medicaid services.

The Developmental Disabilities Program within the Division of Family and Community Services oversees the service by certifying the providers who meet the qualifications for providing the service and conducting quality assurance activities.

d. Division of Family and Community Services

The Division of Family and Community Services includes the Children and Family Services Program (CFS) covering a wide range of children's services, services for persons with developmental disabilities including early intervention services, and the Mental Health and Substance Abuse Program.

i) Children and Family Services Program.

The Children and Family Services Program is responsible for administering child protective services, foster care, adoptions, substance abuse treatment and prevention, licensure of children's care facilities, and children's mental health. Currently, each region has a Children and Family Services Program Manager. The program manager reports to a Deputy Division Administrator over program operations. Each region has two chiefs of social work, or an equivalent position, with one chief specializing in child protection and the other specializing in children's mental health. The primary role of the chiefs is to assure that practice is consistent with the goals and values of Children and Family Services. These chiefs have different job duties in each region, but they all report to the regional program manager.

Child Protective Services, Foster Care, and Adoptions. Child protective services are provided through the regional offices. There are seven regional offices and 21 field offices. Each office has a different phone number for reporting abuse and neglect, but people who need to report a case are sometimes told to contact the Idaho CareLine which connects them to the appropriate office. A risk assessment is required for all referrals of child abuse or neglect that fall within the definitions in State law. CFS social workers carry out the risk assessment and, if the child is removed from the home, are responsible for managing the case and referring the child and family to appropriate services. Family preservation, family support, family reunification, and adoption recruitment and support services are contracted out.

Children's Mental Health. A child can be referred for mental health services by a parent, local school district, county probationary officer, juvenile court, or Department of Juvenile Corrections. All mental health services are voluntary and require parental consent unless the child is a threat to himself or herself or others. A child can be treated on an emergency basis if the child exhibits psychotic symptoms, risk of harm to self, or risk of harm to others. Ongoing services require that the child is assessed as having a serious emotional disturbance based on a diagnosis from the Diagnostic Statistical Manual of Mental Disorders (DSM-IV) and a functional impairment based on their score on the Child and Adolescent Functional Assessment Scale (CAFAS). The Department provides a wide range of services including assessment, case management services, day treatment, family support, residential treatment, and crisis

stabilization and response. Children may also receive Medicaid-funded mental health services under the Psychosocial Rehabilitative Services Program (PSR). These services include assessment, crisis support, psychiatric services, and planning activities. PSR services were developed for Medicaid recipients but are available with a parental copayment to children who are eligible for Department of Health and Welfare Children's Mental Health Services, but not eligible for Medicaid. CFS clinical staff or PSR contractors conduct assessments. CFS staff develop a service plan and services are provided by the agency, other agencies, or private providers. In 2002, there were a total of 75 CFS regional staff providing children's mental health services. The total ranged from 8 in Region 5 to 12 in Region 7.

While CFS continues to provide the bulk of mental health services, the State is in the process of developing a community-based system of care. The intent is that children who are accessing services from multiple agencies will begin to have their care managed through local children's mental health councils. This system is described below under the Idaho Council on Children's Mental Health.

ii) Developmental Disabilities Program

The Developmental Disabilities Program provides services to both children and adults with developmental disabilities. There are separate program managers for children and adult services. The responsibilities include overseeing early intervention services through the Infant-Toddler Program; overseeing EPSDT service coordination; and certifying, licensing, and providing oversight to the agencies that provide developmental disabilities services. Adult developmental disability services are provided by private agencies. The Developmental Disabilities Service Coordinator works with the person with the disabilities to develop a case management plan, to arrange the services necessary to implement the plan, to monitor the plan and services, and to revise the plan as needed.

The Infant and Toddler Early Intervention Program is Idaho's Part C Program. This program has the responsibility of providing services to children from ages 0 to 3 with developmental disabilities. Program staff responsibilities include overseeing the services provided and monitoring the program's progress on achieving its goals. In addition, local division staff provides interim service coordination. Interim service coordination is provided until a family selects a contracted care coordinator; the services provided on an interim basis include:

- Educating the family about the Infant-Toddler Program
- Explaining the evaluation process
- Explaining the family's role as a participant on the multidisciplinary team
- Explaining and reviewing the procedural safeguards
- Providing support and resource information on service options
- Facilitating the initial Individual Family Service Plan (IFSP)
- Assisting the family with selection of ongoing service coordinator.

iii) Adult Mental Health and Substance Abuse Programs

Adult Mental Health. Publicly funded mental health services for adults are provided primarily through a network of seven State-operated regional community mental health centers (CMHCs) and two State hospitals. The Family and Community Division Adult Mental Health Program supports systems improvement, oversees Federal grant applications, contract development, and monitoring of contractors. The seven CMHCs have the primary responsibility for the development of a community-based, consumer-guided system of care. Each CMHC has a Regional Mental Health Advisory Board consisting of interested citizens, consumers, and advocates. The Boards provide input and recommendations for changes in the mental health delivery system.

The CMHCs are the designated Regional Mental Health Authorities and have responsibility for the prior authorization of psychosocial rehabilitation services. Prior to FY 2003 the CMHCs also had primary responsibility for assessment and service planning. In response to budget constraints, private-sector case managers have been given responsibility for assessment and service planning.

Substance Abuse. IDHW provides funds to treatment providers and prevention programs throughout the State. Services are provided on a sliding-fee basis. There are seven Regional Substance Abuse Authorities which partner with IDHW to establish priority populations and priority prevention needs, ensure that treatment services are available, and work with providers on quality improvement. There is a single statewide contractor for administering prevention services. Local providers of prevention services apply for funding through the State contractor. Treatment services are provided by a diverse array of community-based providers. Business Psychology Associates, a behavioral health managed care company, authorizes care and oversees the provider network.

e. Regional Health and Welfare Offices

The Regional Health and Welfare offices are responsible for local administration of the programs that are the responsibility of the Divisions of Welfare, Family, and Community Services and Medicaid. While there is a Regional Director, program staff report directly to the respective division offices in Boise. Up until about 3 years ago, the Regional Director was responsible for managing the local programs and making decisions about local resource allocation. Under this system, there were concerns that programs were not being administered consistently across the State. Program staff in the local offices now report directly to program staff in the State offices. Regional directors have taken on a new role of serving as the agency's liaison in the community. They also are serving as Health and Welfare's representative on the Regional Substance Abuse Authority. However, decisions about allocations of resources within and across regions are made at the State program level. The new role for the Regional Directors has created opportunities by allowing a staff person to dedicate their time to representing the agency within the community and to explore ways resources can be coordinated.

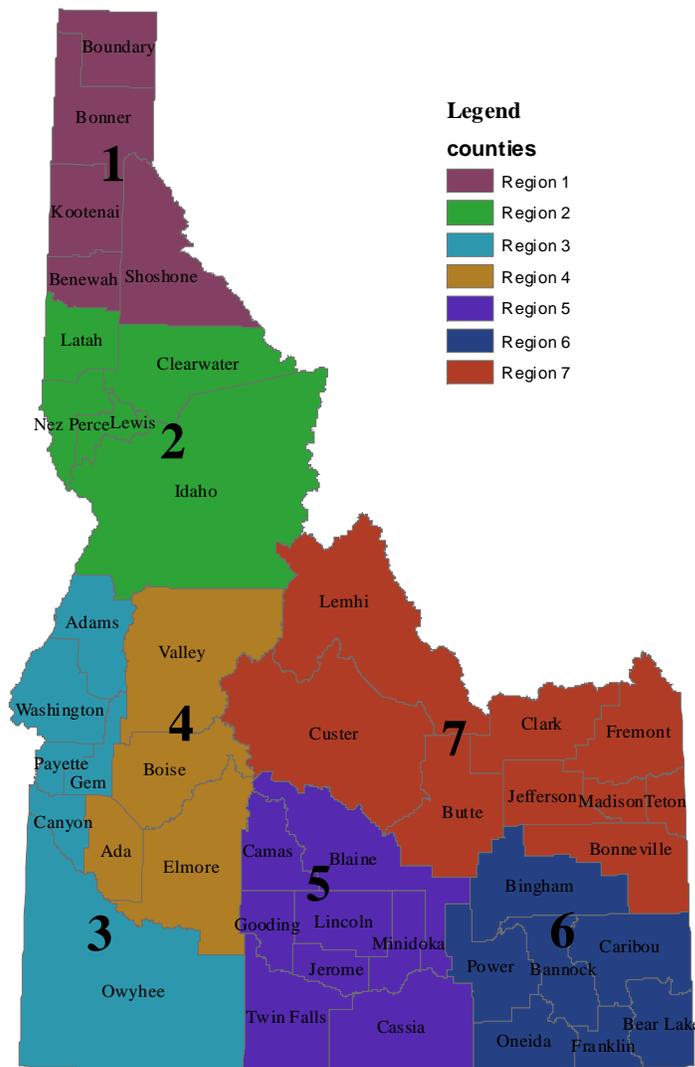


Figure IV-1: Map of Idaho’s Regional Health Districts

2. District Health Offices

The Public Health Districts were created by the Idaho Legislature in 1970 to ensure that essential public health services were available to protect the health of all citizens of the State. The Districts are autonomous: State agencies do not have direct authority over their activities. Each of the seven Districts is governed by a Board of Health composed of seven to eight members appointed by the county commissioners from that district. Each Board of Health defines the public health services to be offered in its district based on the particular needs of the local populations serviced. They also employ a director to oversee the daily operations of the districts. Each of the Districts may have several satellite offices within their region. The boundaries of the Public Health Districts are identical to the Health and Welfare Regional boundaries, with one exception: Butte County is in Health District VI and Health and Welfare Region VII.

**Table IV-1.
Idaho Public Health Districts**

| District I | District II | District III | District IV | District V | District VI | District VII |
|--|---|---|--|---|---|---|
| Population: 188,838 Sq. Miles 7,654 | Population: 100,348 Sq. Miles 13,447 | Population: 213,465 Sq. Miles 12,009 | Population: 369,002 Sq. Miles 9,677 | Population: 167,444 Sq. Miles 11,461 | Population: 158,266 Sq. Miles 11,443 | Population: 145,865 Sq. Miles 16,986 |
| Benewah | Clearwater | Adams | Ada | Blaine | Bannock | Bonneville |
| Bonner | Idaho | Canyon | Boise | Camas | Bear Lake | Clark |
| Boundary | Latah | Gem | Elmore | Cassia | Bingham | Custer |
| Kootenai | Lewis | Owyhee | Valley | Gooding | Butte | Fremont |
| Shoshone | Nez Perce | Payette | | Jerome | Caribou | Jefferson |
| | | Washington | | Lincoln | Franklin | Lemhi |
| | | | | Minidoka | Oneida | Madison |
| | | | | Twin Falls | Power | Teton |

Source: U.S. Census Bureau, 2004a

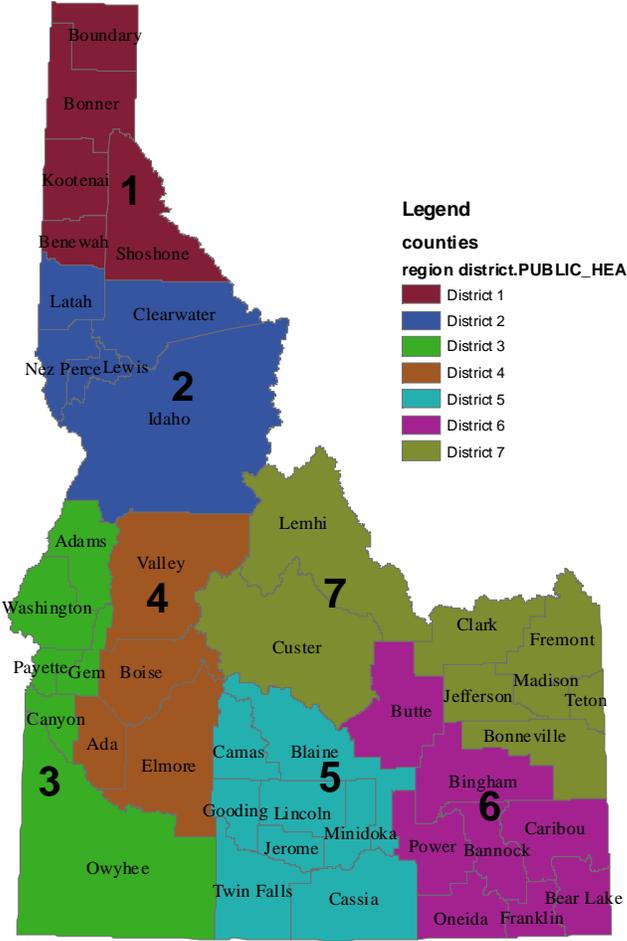


Figure IV-2: Map of Idaho’s Public Health Districts

Although services vary depending on local need, all seven districts provide the essential services that assure healthy communities. These may include:

- Monitoring health status by developing reports that call attention to emerging health problems
- Investigating health hazards
- Empowering people to make good health choices
- Linking people to needed health services or providing them directly if access is limited
- Enforcing laws to protect health.

The Public Health Districts receive income from three sources. About 36 percent of income is derived from the counties, the State General Assembly, and State Millennium Fund. The Millennium Fund is the account holding the State's share of the national tobacco settlement. An additional 25 percent is obtained through fees and another 39 percent from service contracts. The Districts have developed a 2005 Strategic Plan that identifies goals based on the national Healthy People 2010 Goals. The goals focus on physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, immunizations, access to health care, and public health infrastructure (Idaho Public Health Districts, 2004). Each of the Districts prepares a report detailing their priorities and activities.

The Department of Health and Welfare, Division of Health develops contracts with the local District Offices to carry out a number of activities. These include:

- Operating the WIC program
- Providing family planning services
- Providing immunizations
- Providing preventative oral health services
- Investigating and controlling of infectious diseases.

Until recently, the District Offices were also responsible for organizing and administering clinics for the CSHP Program and providing case management services to CSHP participants.

District Health Offices also contract with the Division of Family and Community Services to provide "child find" services for the Infant-Toddler Program. In this role, they provide developmental monitoring, conduct screening and assessments, and initial referrals to services. The Department of Health and Welfare, Division of Welfare contracts with the District Health Office to monitor health and safety standards in child care facilities.

In addition, districts have other responsibilities they carry out, including responsibility for public health preparedness and environmental health, which entails food establishment inspections and sewer and septic monitoring.

3. *Idaho's Council on Children's Mental Health*

Idaho is in the process of developing a system of care for children's mental health services. The implementation of the system is taking place in response to the "Jeff D. Lawsuit." The lawsuit was filed over 25 years ago to protect children with SED who were placed in State hospitals. The lawsuit was expanded to include the State's lack of community-based services.

As a result of a 1999 needs assessment of children with SED conducted in response to the lawsuit, the State is in the process of implementing 50 recommendations to create a system of care. The intent of the new system is to deliver integrated, community-based services that cut across agency lines. Children's mental health services are overseen by the Idaho Council on Children's Mental Health consisting of representatives from the Governor's office and the Departments of Health and Welfare, Juvenile Corrections, and Education as well as parent advocacy groups; a county commissioner; and representatives of the legislature, judicial branch, children's mental health service providers, and regional councils. There is a regional council in each of the seven regions. The regional councils are responsible for supporting data collection, recommending the release of funds to local councils, monitoring the use of funds, providing technical assistance to the local councils, and assessing the need for and approving additional local councils. The regional councils are required, at minimum, to include membership from parent or parent advocacy organizations, county probation, the Department of Health and Welfare, the Department of Juvenile Corrections, local school districts, the Regional Mental Health Advisory Board, and each local council in the region.

The first local councils were created in FY 2002 when a total of seven were established. The next fiscal year, the number of councils reached 31 and has recently risen to 34. Additional local councils can be created if it is determined that a need exists for them. The local councils report to the regional councils and are responsible for the staffing of individual cases of children brought to the local council; service coordination and collaboration; initial data collection; representation of the local perspective on the regional councils; the request of funds from the regional councils; and the monitoring of utilization of those funds. In 2002, local councils worked directly with 94 children and their families. In 2003, 110 children were served. Currently, the local councils are serving only a small proportion of the total number of children receiving publicly funded mental health services.

4. *Department of Education*

There are 112 school districts and 681 schools in Idaho. Idaho ranked 48th among the States and the District of Columbia in per pupil education spending in 2001-2002. Only Utah, Mississippi, and Arizona spent less per pupil. Expenditure per pupil was \$5,923 compared to a figure of \$7,701 for the country as a whole. Idaho schools receive a larger share of their funding from the State than is typical. Idaho ranks 11th among States in the percent of revenue coming from State-funding sources (U.S. Census Bureau, 2002).

| Table IV-2. Education Expenditures and Revenues in Idaho and the U.S., 2001-2002 School Year | | |
|---|--------------|-------------|
| | Idaho | U.S. |
| Total per Pupil Spending | \$5,923 | \$7,701 |
| Sources of Revenue for Local School Districts | | |
| Local | 30.6% | 42.8% |
| State | 60.9% | 49.4% |
| Federal | 8.6% | 7.8% |

The Idaho State Department of Education is organized into an administrative section and six bureaus: Finance and Transportation, Special Education, Technology Services, Federal Programs, Curriculum and Accountability, and Certification and Professional Standards. The two main ways that the school system contributes to the health infrastructure are through special education services and by providing health education. The Bureau of Special Education is responsible for overseeing preschool and district special education programs. The school districts are one of the key providers of services to CSHCN. In the past few years, the Bureau has worked with the Division of Medicaid to assist school districts in becoming authorized Medicaid providers. This enables the districts to receive Medicaid reimbursements for children who need special education services and are Medicaid recipients. The Bureau is also working with the Districts to encourage them to bill Medicaid when it is appropriate.

The Idaho Department of Education develops achievement standards and a list of approved curricular materials. School districts may request a waiver if they wish to use other material. For Health Education, the Department has developed five Achievement Standards for Health Education. The standards are that, through health education, students will:

- Acquire the skills to lead a healthy life
- Demonstrate the ability to practice health-enhancing behaviors that reduce health risks
- Demonstrate the ability to use communication skills to enhance health
- Organize, analyze, and apply health information practices and services appropriate for individual needs
- Understand and demonstrate the key components to positive mental and emotional health.

The decision as to whether any program in family life and sex education is to be introduced in the schools is a matter for determination at the local district level by the local school board. The legislature has adopted principles for sex education programs that stress abstinence and view sex education in the schools as a supplement to what is taught at home and church.

B. Access to Health Information

The Idaho CareLine is the central telephone information line that allows everyone in Idaho access to information about health and human services. The CareLine began as a collaboration between the Part C Early Intervention Program and the State Title V agency. The CareLine served as the Part C Central Directory and the Maternal and Child Help Line that is required as a condition of receiving MCH Block Grant funds. The CareLine has evolved over the years to become a much more expansive health and human services resource directory and information and referral service. In May 2002, the Idaho CareLine entered into a collaborative partnership with the 2-1-1 Idaho Project which allows anyone in the State to reach the CareLine by dialing 2-1-1. The effort to relaunch the information line as the “2-1-1 Idaho CareLine” took more than 5 years. The effort involved the support and collaboration of various public and private entities, including the Junior League of Boise, United Way of Treasure Valley, the Mountain States Group, Saint Alphonsus Regional Medical Center, the Idaho Department of Health and Welfare, and the Governor’s Coordinating Council for Families and Children. In November 2001, a 2-year startup grant from M.J. Murdock Charitable Trust was awarded which provided critical funds needed for the project to move forward.

The CareLine is free, statewide, and bilingual. Calls are confidential and a caller does not need to provide his or her name, address, or telephone number to receive services. The hours of operation are 8 a.m. to 6 p.m. Monday through Friday. After-hours calls are answered by voice mail with messages returned the following business day. The CareLine uses an extensive database of health and human service providers to support the information and referral activities. Callers are connected to a wide array of services including prenatal care, immunizations, Medicaid resources, adoption and foster care, child care, emergency food and housing and many other community services.

To include new resources in the database and to keep information current, the CareLine disseminates a service inventory questionnaire to be completed by participating agencies. The CareLine serves all of Idaho, and an Idaho CareLine Customer Service specialist will personally transfer the caller directly to the requested resource in his or her community.

Since converting to the 2-1-1 number, the CareLine has seen an extensive increase in volume. The 83,726 calls in FY 2004 represented a 135 percent increase from FY 2003. There have been 58,862 calls in the first 6 months of FY 2005. This means that for the second year in a row the CareLine is on track for a very large increase in call volume. If calls continue at this pace, the number will top 100,000 for the first time ever.

Participants in the Idaho Family Survey were asked about the CareLine. More than half (55 percent) had heard of the CareLine and 39 percent reporting using the CareLine. Among those who used the CareLine, most had positive impressions. At least 40 percent strongly agreed that the CareLine was helpful, provided resources in their area, and offered help that addressed the problem they called about. A little over 10 percent had problems in all those areas. Clearly, there is still room for improvement, since at least one in five respondents did not report a clearly positive experience with the line. In addition, a few respondents reported that they were unable to reach the CareLine by dialing 2-1-1. It is possible that they had tried using cell phones that do

not incorporate the 2-1-1 feature, but what is clear is that this problem caused them great frustration.

| Table IV-3. Experiences Using the Idaho CareLine | | | | |
|--|-----------------------|-----------------------|-----------------------------------|--------------------------------------|
| | Strongly Agree | Somewhat Agree | Neither Agree nor Disagree | Strongly or Somewhat Disagree |
| The CareLine has been helpful | 45.4 | 30.8 | 11.5 | 12.3 |
| The CareLine provided resources that were accessible to someone living in my area of Idaho | 46.0 | 32.3 | 10.5 | 11.3 |
| The help that was offered addressed the problem about which I called | 40.0 | 27.2 | 18.4 | 14.4 |

Source: Idaho Family Survey

Focus group participants and key informants both indicated that the CareLine is better publicized and provides more extensive information about services in Boise and surrounding Treasure Valley area than in the rest of the State, especially the Northern Panhandle. Data from the Idaho CareLine provided some support for this finding. Region IV, which includes Boise, has a considerably higher percentage of calls than the region's share of the population. Region III, which is adjacent to Boise and shares common television and radio stations, is the only other region with a higher percentage of calls than its share of the population. CareLine utilization in Region I, the northernmost region of the State, actually came close to its share of the population in FY 2003 but showed a decline compared to other Regions in FY 2004. Regions III and VI showed the greatest percentage increase in calls between FY 2002 and FY 2003, though all Regions had a substantial increase in call volume. Overall, the CareLine appears to be making progress toward its goal of being a statewide health and social service information resource.

| Table IV-4. Calls to the 2-1-1 Idaho CareLine by Region | | | | | |
|--|---|--------------------------------------|----------------|--------------------------------------|----------------|
| Region | Region's Share of State Population July 2003 | FY 2003 (July 2002-June 2003) | | FY 2004 (July 2003-June 2004) | |
| | | Number | Percent | Number | Percent |
| Region I | 13.8% | 4675 | 13.1% | 8781 | 10.5% |
| Region II | 7.3% | 1963 | 5.5% | 3662 | 4.4% |
| Region III | 15.6% | 6064 | 17.0% | 17179 | 20.6% |
| Region IV | 27.0% | 12918 | 36.2% | 29987 | 35.9% |
| Region V | 12.3% | 3009 | 8.4% | 7242 | 8.7% |
| Region VI | 11.6% | 2437 | 6.8% | 8146 | 9.8% |
| Region VII | 12.4% | 2953 | 8.3% | 6662 | 8.0% |
| Out-of-State | NA | 1682 | 4.7% | 2067 | 2.5% |

Source: Idaho CareLine, 2004

An examination of calls that looks at the language of the caller and the types of information they were seeking shows that Spanish speakers are much more likely to inquire about economic assistance or welfare programs. There has been an enormous increase in the number of calls concerning childcare among both English and Spanish-language callers though it is a still much more common topic for English-language callers. The increase in calls concerning child care (29,523) represents 61 percent of the total (48,025) increase in calls from FY 2003 to FY 2004. Calls about CHIP and Medicaid declined as a percent of all calls between FY 2003 and FY 2004, but because of the huge increase in volume the number of calls on the topic actually increased by a few hundred calls.

| Table IV-5. Idaho CareLine Calls by Topic and Language of Caller | | | | | | |
|---|--|--|--------------------------------|--|--|--------------------------------|
| Topic | FY 2003 (July 2002-June 2003) | | | FY 2004 (July 2003-June 2004) | | |
| | English-language Calls: 96.7%; 34,525 Calls | Spanish-language Calls: 3.3%; 1,176 Calls | Total Calls: 35,701 | English-language Calls: 97.0%; 81,177 Calls | Spanish-language Calls: 3.0%; 2,549 Calls | Total Calls: 83,726 |
| Childcare | 2.5% | 1.2% | 2.5% | 36.9% | 17.1% | 36.3% |
| Welfare | 18.7% | 32.4% | 19.1% | 17.2% | 41.9% | 17.9% |
| CHIP | 17.0% | 25.6% | 17.2% | 7.9% | 13.9% | 8.1% |
| Medicaid | 17.8% | 14.2% | 17.6% | 7.9% | 8.2% | 8.0% |
| Medicaid Dentist | 8.3% | 5.4% | 8.2% | 6.7% | 3.4% | 6.6% |
| Medicaid Doctor | 5.1% | 3.4% | 5.0% | 3.6% | 2.6% | 3.6% |
| Miscellaneous | 5.2% | 3.8% | 5.2% | 3.6% | 2.2% | 3.5% |
| Health, Miscellaneous | 5.0% | 2.3% | 4.9% | 3.2% | 1.8% | 3.1% |
| WIC | 3.1% | 3.5% | 3.1% | 2.1% | 2.4% | 2.1% |
| Adoption | 3.8% | 0.2% | 3.6% | 3.8% | 0.2% | 3.6% |
| Other Topics | 13.6% | 8.0% | 13.4% | 10.9% | 6.6% | 10.8% |

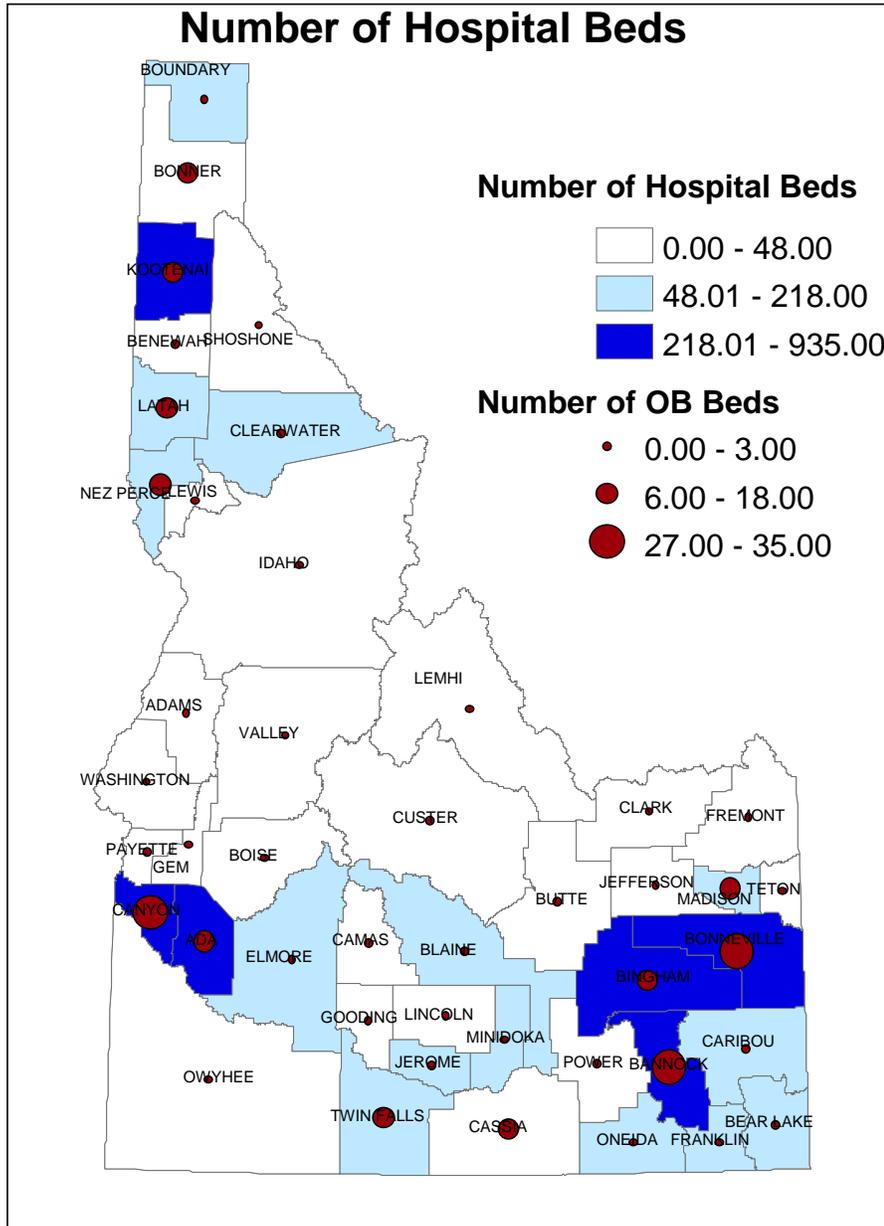
Source: Idaho CareLine, 2005

C. Other Health and Wellness Providers

1. Hospitals

Hospitals are an essential component of the health care delivery system, and the following map displays the hospitals that are 2004 members of the Idaho Hospital Association by number of acute care beds and presence of obstetrical beds.

Figure IV-2: Idaho Hospital Association Members by Number of Hospital and Number of OB Beds



Source: American Hospital Association Survey, 2000

Twenty-three of the hospitals are Critical Access Hospitals (CAH). These are rural hospitals that have met certain conditions (e.g., provide 24-hour emergency care services) and are eligible for

cost-based Medicare reimbursement. This program is designed to support the financial viability of small, rural hospitals.

A total of 22 hospitals listed are Disproportionate Share Hospitals (DSHs) (Idaho Hospital Association, 2004). DSHs serve a high percentage of low-income and uninsured individuals. In recognition of the services they provide they are given additional payments for services provided to Medicaid and Medicare recipients. Several out-of-State hospitals also receive DSH funds as they provide services to Idaho residents. The total Idaho DSH payments for FY 2003 totaled \$10,263,964 (Kaiser Family Foundation, 2005c).

The number of all hospitals declined somewhat from 42 in 1999 to 39 in 2002 (Kaiser Family Foundation, 2005d). The number of hospital admissions and emergency room visits per 1,000 people in 2003 was lower in Idaho than for the Nation in 2003.

| Table IV-6. Hospital Admissions, Outpatient and Emergency Room Visits, Idaho and U.S., 2003 | | |
|--|--------------|-------------|
| | Idaho | U.S. |
| Hospital Admissions (per 1,000 People) | 99 | 120 |
| Hospital Outpatient Visits (per 1,000 People) | 2,026 | 1,937 |
| Emergency Unit Visits (per 1,000 People) | 343 | 382 |

Source: Kaiser Family Foundation, 2005e

Other Categories of Health Care Provider Organizations

2. *Community Health Centers*

Community and migrant health centers (C/MHC) are community-sponsored and -governed not-for-profit practices that provide access to primary and preventive health care designed to be affordable for all Idaho families. There are 7 C/MHC grantees in Idaho with 39 health delivery sites. Collectively these sites provided care to 64,714 patients in 2002 (National Association of Community Health Centers, 2003). The following are the names and locations of the Centers in Idaho along with examples of services provided (Table IV-7).

| Table IV-7. Summary: Idaho C/MHC | | | |
|---|--------------------|---|---|
| Name of Center | Location(s) | Examples of Services | Examples of Special Services |
| Benewah Medical Center | Plumer, ID | Primary care, all ages Health screenings Laboratory Physical therapy Prenatal Care Pharmacy | Substance abuse counseling Preventive and restorative dental Health and safety education programs Onsite Medicaid enrollment |

**Table IV-7.
Summary: Idaho C/MHC**

| Name of Center | Location(s) | Examples of Services | Examples of Special Services |
|--|---|--|---|
| Boundary Regional Community Health Center | Bonner's Ferry, ID | Primary care, all ages Health screenings Laboratory Physical therapy Pharmacy | North Idaho Partner in Care Rural Mobile Clinic Preventive and restorative dental Onsite Medicaid enrollment |
| Dirne Community Health Center | Coeur d'Alene | Primary care | Onsite Medicaid enrollment |
| Family Health Services: - Buhl Center - Burley Center - Jerome Center - Behavioral Health Services - Family Health | - Buhl - Burley - Jerome - Twin Falls - Twin Falls | Primary care, all ages Health screenings Obstetrics Laboratory Physical therapy Prenatal care | Onsite Medicaid enrollment Mental health counseling |
| Glens Ferry Health Center - Valley Center - Desert Sage Center | - Glens Ferry - Grandview - Mountain Home | Primary care, all ages Obstetrics Laboratory | Health and safety educational programs Dental Health Onsite Medicaid enrollment |
| Health West, Inc. - Aberdeen Clinic - American Falls Clinic - Lava Medical Center - Downey Clinic - Old Town Clinic | - Aberdeen - American Falls - Lava Hot Springs - Downey - Pocatello | Primary care, all ages Obstetrics Health screenings Laboratory Physical therapy Prenatal care | Onsite Medicaid enrollment |
| Terry Reilly Health Services - Canyon Dental - Teen Clinic - SANE Solutions (3 sites) - Homedale Clinic and Dental - Marsing Clinic - Melba Clinic and Dental - Boise Clinic and Dental - Nampa Clinic - Behavioral Health Center | - Nampa - Homedale - Marsing - Melba - Boise | Primary care Obstetrics Family Planning Urgent care | Behavioral health Onsite Medicaid enrollment |

Source: Idaho Primary Care Association, 2005

These Centers are located in 22 medically underserved Idaho communities. The Centers play a major role in providing health services to the MCH population with each Center offering prenatal care and reporting that slightly over 37 percent of the total number of patients are under age 19 years. Each Center also has the ability to provide translation and interpretation services, which is

important in that 37.5 percent of Community Health Center (CHC) patients are Hispanic and may be in need of these services. In 2002, almost 65 percent of CHC patients reported incomes at or below 100 percent of the FPL, with another 18.3 percent with incomes between 101-150 percent FPL and 6.1 percent with incomes between 151 and 200 percent of the FPL. In addition, 10.8 percent of Health Center patients reported incomes over 200 percent of the poverty level. Of the total number of Health Center patients in 2002, 46.6 percent had no health insurance, 22.1 percent had Medicaid or the State Children’s Health Insurance Program (SCHIP), and 21.8 percent had private insurance. As a result of increased Federal funding and expanding need, CHCs are growing in importance as a key component of the Idaho health care system (National Association of Community Health Centers, 2003).

Idaho’s CHCs received far less of their funding from State and local grants and Medicaid compared to CHCs in other States. This may be an indication that the important and growing role of CHCs has yet to be recognized by the public sector in Idaho. This possibility is supported by findings from key informant interviews that indicated partnerships between CHCs, District Health Departments, and State Health agencies have been limited to date. The relatively high percentage of private insurance and patient self-pay revenue suggests that Idaho CHCs are providing useful services for people who might be able to afford other types of care but find the location or the services offered by their local CHC to be a better choice.

| Table IV-8. Distribution of Revenue by Source for Federally Qualified Health Centers | | |
|---|--------------|----------------------|
| Revenue Source | Idaho | United States |
| Federal Grants | 37.5% | 25.5% |
| State & Local Grants/ Contracts | 1.7% | 9.4% |
| Foundation/Private Grants/Contracts | 1.1% | 3.2% |
| Medicaid | 23.1% | 35.5% |
| Medicare | 4.4% | 5.5% |
| Other Public Insurance | 0.5% | 2.5% |
| Private Insurance | 10.7% | 6.2% |
| Patient Self-Pay | 10.9% | 5.9% |
| Other Revenue | 10.0% | 6.4% |

Source: Kaiser Family Foundation, 2005f

3. Rural Health Centers

Rural Health Clinics were established by the Rural Health Clinic Services Act enacted in 1977 to help meet the primary and emergency health needs of the rural communities. There are over 3,000 RHCs through out the Nation certified by CMS. Rural health services provided by independent RHCs owned and operated by a physician, nurse practitioner, physician’s assistant, and/or certified nurse-midwife. In addition, the RHC may be owned and operated by a Medicare participating provider (hospital, skilled nursing facility, and home health agency).

RHCs are paid on the basis of a face-to-face encounter using cost-based reimbursement. To be eligible for participation in the RHC program, a facility must apply for and become certified as a RHC. To qualify, a facility must be located in an area defined as rural and as having a shortage of personal health care services or primary care medical services. Nationally, Medicaid, uninsured, self-pay, and free or reduced-cost care patients account for 45 percent of their overall volume. There were 44 RHCs in Idaho in 2004 (Kaiser Family Foundation, 2005g). They received \$7.0 million in Medicaid funding in FY 2004 (Idaho Legislative Services Office, 2004), up from \$3.1 million in FY 2001 (Idaho Legislative Services Office, 2001).

4. Tribal Health Services

Federally recognized American Indian tribes and Alaskan Native corporations enjoy a government-to-government relationship with the United States of America. This unique relationship has been given substance through numerous Supreme Court decisions, treaties, legislative acts, and Executive Orders. The provision of health services grew out of this government-to-government relationship. Congress passed the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended) to provide tribes the option of either assuming from the IHS the administration and operation of health services and programs in their communities, or to remain within the IHS administered direct health system.

| Table IV-9. Tribal Health Centers in Idaho | | | | |
|---|--|-----------------|--|------------------------------|
| Tribe | Health Center | Location | Services | Active users 2002 |
| Coeur d'Alene | Benewah Medical Center | Plummer | Programs include: Comprehensive primary care, dental, MH, drug and alcohol, youth shelter. | 3,611 |
| Kootenai* | Kootenai Tribal Clinic | Bonnors | Primary care, MCH | 169 |
| Nez Perce* | Nimiipuu Health Center | Lapwai-Kamiah | Programs include: community and MCH health, WIC, drug and alcohol, child protective IHS services include dental, health education, lab, pharmacy, MH | 3,433 |
| NW Band of Shoshoni | Does not operate a health center – use Fort Hall IHS | | | 112 |
| Shoshone Bannock* | Not-So-Gah-Nee Health Clinic | Fort Hall | Programs include: MCH, preventive health, counseling and family services, chemical dependency, dental, and WIC | 5,824 |

*Supported fully or partially under a PL 93-638 self-governance contract
Source: Northwest Portland Area Indian Health Board, 2005

5. Professional Schools

There are no medical or dental schools in Idaho. There have been some discussions about developing a medical school at Idaho State University, but there are no firm plans to carry this out at this time. There is, however, a College of Pharmacy at Idaho State University that offers a range of programs in pharmacy including a doctor of pharmacy. While there is no nurse-midwife program in the State, the Frontier Midwife Training, although located in Kentucky, has developed a program using State-based preceptors to prepare nurse-midwives. Programs are also available in Seattle, Washington, and Portland, Oregon. At least some of the lay midwives delivering babies in Idaho have received training from these programs. The following table displays the names and locations of nursing programs in Idaho.

| Table IV-10. Nursing Programs in Idaho | | | |
|---|-----------------|---------------------------|--|
| School | Location | School | Location |
| Boise State University | Boise | Lewis-Clark State College | Lewiston |
| Brigham Young University | Rexburg | North Idaho College – * | Coeur d’Alene |
| College of Southern Idaho * | Twin Falls | NW Nazarene University | Nampa |
| Idaho State University | Pocatello | University of Phoenix | Boise and Other Locations Throughout State |

* Limited to Associate Degrees and Practical Nursing Program

Source: All Star Directories, 2005

The Idaho State University – College of Health Professions in Pocatello offers programs leading to the following degrees or specialties:

- Audiology
- Dental Hygienist
- Health Care Administration
- Nutrition/Dietetics
- Physical Therapy
- Physician Assistant
- Radiographer
- Speech-Language Pathology

The University also offers a master of public health program, the only such program in Idaho.

Boise State University – College of Health Sciences, located in Boise, offers the following programs:

- Health Information Technology and Management
- Radiological Technology
- Respiratory Therapy
- Sonography

There are a variety of other public and private programs offering training in health care and health support services.

6. Professional Organizations and Associations

Idaho Medical Association. The Idaho Medical Association (IMA) has over 1,800 members. Predominant membership is comprised of nearly 1,600 actively practicing physicians, including residents, with the balance of members comprised of retired physicians, physician assistants, nurse practitioners, and medical students. The IMA’s physician members represent 62 medical and surgical specialties. A high percentage of IMA members are board certified by their specialty accreditation organizations. Many IMA members have multiple specialties and board certifications. The IMA is comprised of seven Trustee Districts and 14 component medical societies. Representatives of each component society comprise the IMA House of Delegates, which meets once a year at the IMA Annual Meeting.

Idaho Primary Care Association. Idaho Primary Care Association (IPCA) founded in 1983 is a not-for-profit membership organization serving CHCs and similar organizations that provide primary health care to underserved populations in Idaho and bordering communities. IPCA coordinates and facilitates shared activities among CHCs and advocates for the expansion of preventive and primary care among underserved populations. IPCA works with organizations interested in developing new CHCs or expanding CHCs to new sites including helping them with the Federal application process.

Idaho Chapter of the American Academy of Pediatrics. The Idaho AAP works with pediatricians and others around the State to address a range of health care issues involving children. These issues have included the creation of a volunteer immunization registry, SCHIP enrollment, asthma, and parent education. The Executive Director of AAP is a nurse at St. Luke’s Hospitals and the Coordinator for the Idaho Perinatal Project.

Idaho Perinatal Project. While not an association in and of itself, the Perinatal Project is an umbrella organization for a number of key MCH Associations. The Idaho AAP, Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN), and American College of Obstetrics and Gynecologists hold business meetings during the Perinatal Project Conferences. The conference provides an opportunity for networking among different provider types and offers continuing education credits for a variety of fields.

Idaho Rural Health Association. The Idaho Rural Health Association is a project of the Institute of Rural Health at Idaho State University. The purpose of IRHA is “to improve the

health of rural Idahoans and populations through establishing access to appropriate and equitable health care services and to assist its members in providing leadership on rural issues through advocacy, communications, education, evidence-based research, and community health education.” The organization has held four biennial conferences; the last in 2004 included joint sessions with the Idaho Psychological Association.

Other professional organizations include the Idaho Chapter of the American College of Nurse-Midwives, the Academy of Family Physicians, and the Idaho Nurses Association.

7. *Advocacy Groups*

Idaho Parents Unlimited (IPUL). IPUL is a statewide organization founded to provide support, information, and technical assistance to parents of children and youth with disabilities. Since 1989, IPUL has been designated as Idaho’s Parent Training and Information Center (PTI) by the U.S. Department of Education, which provides funding for its programs. IPUL conducts regional workshops to inform families about a variety of topics including special education policies, written material, individual consultations, and a toll-free information number for families.

Idaho Covering Kids and Families is a 5-year initiative funded by the Robert Wood Johnson Foundation that works at the State and Community-level to promote the identification and enrollment of children in health insurance. There are both a statewide coalition and 3 community partnership sites covering 11 counties.

The Idaho Association for the Education of Young Children (IAEYC) is both a professional organization for early childhood educators and an advocacy organization focused on early education issues. IAEYC has been the holder of the Healthy Child Care America grant that promotes stronger links between health and child care and conducts Medicaid and SCHIP outreach in child care settings. IAEYC provide scholarships for child care providers to increase their training and education and advocates for improved child care regulations.

D. The Provider Picture

1. *Health Professional Shortage Designations for Rural Areas*

The Federal Government has established two main health care shortage area designation systems, Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Medically Underserved Populations (MUAs/MUPs), to help recruit, retain, and support RHPs and the provision of services to rural areas. These shortage area designations are used by multiple Federal agencies to determine eligibility and funding preference. Currently, only 9.6 percent of nonmetropolitan counties have no designation as full- or partial-county HPSAs or MUA/MUPs (Hartley and Gale, 2003).

a. HPSA Designations

Areas designated as HPSAs have inadequate access to one or more of the following categories of care: 1) primary care, 2) mental health care, and 3) dental care. Areas must exceed a specified ratio of population to full-time-equivalent providers and lack adequate access to health services in adjacent areas. Lastly, shortage areas can be designated at the county and subcounty levels. Within each of these levels, shortages can apply to the entire population, a geographic HPSA, or a particular population group, a population HPSA. Population subgroups may include federally recognized tribes, migrant and seasonal workers, and the low-income among others (Hartley and Gale, 2003).

The majority of counties in Idaho have areas with at least one of the three categories of HPSA designations (IDHW Office of Rural Health and Primary Care, 2004). Eighty-four (84) percent of counties had current or pending primary care HPSA designations in 2004. The proportion has not significantly changed since the late 1990s. In addition, about 68 percent of counties have a dental care HPSA designation. This represents a decrease since 1998, when 78 percent of counties in Idaho had dental care HPSA designations (Idaho Department of Health and Welfare, 1999). However, the number of counties with geographic dental HPSAs has increased from 7 in 1998 to 14 in 2004. This may indicate that the health professional shortage has worsened in these counties and now affects the entire population rather than just a subgroup. Lastly, all 44 counties have mental health care HPSA designations. This represents a significant recent increase. In 1998, no counties in health districts 1 and 4 had a mental health care HPSA designation. Moreover, all of these designations are geographic HPSAs and therefore represent mental health professional shortages for the entire population in those areas (Idaho Department of Health and Welfare, 2004b).

b. MUA/MUP Designations

The MUA/MUP system was initially established as a means to identify ideal areas to locate Community and MHCs. Areas designated as MUAs/MUPs are similar to primary health care HPSAs, but have less rigorous requirements. Communities that fail to qualify for a HPSA designation often obtain MUA designation to ensure they will qualify for some Federal funding. Communities applying for MUA designation are assigned a score using the Index of Medical Underservice (IMU). The IMU is based on four variables: 1) ratio of primary care physicians per 1,000 people, 2) IMR in the area or among the population group, 3) percentage of the population living below the FPL, and 4) percentage of population age 65 and older. The lower the score, the more underserved a community is. Areas with an IMU score of 62.0 or lower are designated as MUAs and MUPs (Hartley and Gale, 2003).

Just over half, 53 percent, of Idaho's counties had at least one area with a MUA/MUP designation in 1998 (Idaho Department of Health and Welfare, 1999). This proportion has since grown to 68 percent of counties in 2004 (Idaho Department of Health and Welfare, 2004c). Also, in 1998, there were only two counties with MUP designations, but this number increased to seven in 2004. Most designated counties scored just below the 62.0 IMU cutoff. However, several counties had relatively lower scores and thus a more severe health care shortage. Clark,

Elmore, Owyhee, and Boise Counties all scored less than 51.0 on the IMU in 2004 (Bureau of Primary Health Care, 2005).

c. Physician Availability

As reported in the Statistical Abstract of the United States: 2004-2005, 2,158 non-Federal physicians were in active practice in Idaho in 2002 (U.S. Census Bureau, 2004b). The physician rate per 100,000 residents was reported as 161, the lowest rate of all States and Puerto Rico. A survey conducted by the Dartmouth University, Center for Evaluative Clinical Sciences using 2000 physician supply data and 2000 Census data indicates that 87 general pediatricians, 13 pediatric subspecialists, and 530 family practitioners are practicing in Idaho.

Using data from the American Medical Association, the Kaiser Foundation has developed information detailing the race and ethnicity of non-Federal physicians by State. In 2003, the number of white physicians in Idaho was reported as 1,711 (71.0 percent of the total number), 10 Black physicians, 35 Hispanic physicians (1.45 percent), 37 Asian or Pacific Islander physicians (1.54 percent), and 2 American Indian or Alaskan Native physicians. Data were not available for 598 physicians (25 percent) (Kaiser Family Foundation, 2005h).

E. The Financing Picture

1. State and Federal Appropriations

a. FY 2005 State Appropriations

Over \$3 billion a year are spent on health care in Idaho (National Health Statistics Group, 2004). Twenty (20) percent of all State dollars are expended for health and social service programs in Idaho, but this category accounts for 32 percent of government spending when Federal funds are included.

Seventy-three (73) percent of all moneys appropriated to the Department of Health and Welfare are expended by the Medicaid Program (Idaho Legislative Services Office, 2004). Since 1995, growth in the Department of Health and Welfare (less Medicaid) has remained relatively flat, while Medicaid has grown significantly. From 1990 through 2005, Medicaid has grown 935 percent, compared to the rest of the Department budget, which increased by 112 percent. Medicaid made up 5 percent of the State General Fund budget in 1990 but has grown to about 14 percent in 2005. The single biggest category of expenditures under Medicaid in FY 2004 was prescription drugs, which accounted for \$146.3 million or 15 percent of all expenditures. Inpatient hospital costs were a close second at \$145.3 million followed by nursing facilities, which mostly serve the elderly, at \$124.8 million (Idaho Legislative Services Office, 2004).

When comparing Medicaid enrollment and expenditures, most Western States rank in the lower half nationally. From 1998 through 2002, expenditures grew significantly, while the cost per enrollee went down in Idaho, Nevada, Utah, and Wyoming (Idaho Legislative Services Office,

2004). This suggests that most of the increased cost was due to increasing enrollment in these States.

Approximately \$38 million dollars were appropriated to public health in FY 1995 and \$68.8 million in FY 2005, reflecting an annual change of 6 percent and a total change of 78.9 percent (Idaho Legislative Services Office, 2004). This includes funding to District Health Departments, but excludes Medicaid expenditures.

During the key informant interviews, one of the major areas of concern involved the planned sunset of the half-cent temporary sales tax increase that the legislature enacted in 2003 because of the economic downturn. This decrease will take place June 30, 2005. The temporary increase is expected to contribute \$178.9 million dollars to the State revenues in FY 2005, which is 8.1 percent of total revenue. There is a great deal of concern among the health and social service community about that loss of revenue, especially at a time when Federal funding for health and social services may also face reductions.

b. Federal Appropriations

According to the Consolidated Federal Funds Report for Fiscal Year 2003, the Federal Government per capital expenditure by Idaho was slightly in excess of \$6,000 (U.S. Census Bureau, 2004c). This compares to an U.S. average of \$7,000 and the highest average in Alaska of over \$12,000 and the lowest in Nevada of \$5,200. Total Federal Government expenditures by Idaho in 2003 were \$8.6 million compared to \$5.3 million in 1995.

There are a variety of sources of Federal funding for health and human services that flow into Idaho. The table below lists a few of those sources and the total amount of spending. There are many other programs that provide services to the MCH populations in Idaho. For example, the Department of Housing and Urban Development provided \$77.3 million in funds to Idaho in 2003. A portion of these funds is directed to a segment of the MCH population to address one of their most basic needs: housing. The wide range of Federal funding services and the extensive amount of total spending illustrates the need to consider a wide range of services and funding sources when considering how to address the needs identified in this assessment.

**Table IV-11.
Federal Funding for Selected Health and Human Service Programs in Idaho
2003**

| Source of Funds | Total Amount FY 2003 (in Millions of Dollars) |
|--|--|
| Medicaid | \$644.9 |
| Food Stamps | \$76.6 |
| TANF | \$37.5 ¹ |
| Head Start | \$30.2 |
| WIC | \$17.9 |
| Child Care and Development Block Grant (Mandatory and Matching Funds) | \$10.8 |
| Social Services Block Grant | \$7.8 |
| Maternal and Child Health Block Grant | \$2.7 |
| Early Intervention Program | \$2.2 |
| Preschool Special Education | \$2.1 |
| Family Planning Services | \$1.5 |
| Comprehensive Community Mental Health Services for Children and Families | \$1.4 |

Source: U.S. Census Bureau, 2004c

F. Data

The Health Districts and the Regional Health and Welfare offices reported limited use of data for program planning. Most of the key informants we spoke with said they had little data available for these purposes. Most of the data they saw on a regular basis were process measures such as how many clients were served. The major exception was the Infant-Toddler Program and the Special Education Program who made extensive use of program data to set priorities and establish program goals. The Part B and Part C annual performance reports required by the Department of Education have some useful features that are worth emulating in other performance reports (Idaho Department of Education, 2004).

States are required to report trends over time on indicators and to account for both progress and slippage. Future activities designed to improve the results on the indicator are also listed. If data are not available, efforts to develop that data are noted. Performance measures that require qualitative assessments are also treated the same with a need to talk about trends and reasons for progress or slippage. These features make the data useful for understanding the current status of the program and for focusing program staff on improving both performance and data. It should be noted that one of the flaws of the reporting system is that States are required to report on an enormous number of indicators, which is burdensome and can detract from the focus on key

¹ Idaho's total TANF allocation in FY 2003 was 53.4 million. The State transferred 8.7 million to the Child Care Development Fund Block Grant and 1.4 million to the Social Services Block Grant. An additional \$12.2 million was unspent at the end of the year. These unspent funds were available for carryover (Office of Family Assistance, 2004).

indicators of program performance. Performance improvement efforts that borrow the overall approach without incorporating the flaws could be very useful.

G. Title V

A major component of the health care infrastructure in each State is the Title V Program. As described earlier, every 5 years, States are required under the Title V Maternal and Child Health Grant to conduct a comprehensive MCH assessment. This section describes Title V and the Block Grant and addresses the issue of how Title V is and can be used to meet the needs of the MCH population.

What is Title V?

The Title V Maternal Child Health Block Grant statute is authorized to improve the health of all mothers, infants, children, youth, and CSHCN consistent with national health objectives. Like public health programs, Title V always has focused on entire populations, unrestricted by categorical eligibility requirements. The program's statutory mission remains *to improve the health of all mothers and children*. With roots in child labor protections, child welfare, and health, Title V provides for comprehensive, family-centered policies and programs.

Title V is intended to enable each State to provide and assess quality MCH services, reduce infant mortality, prevent diseases and disabilities, promote health, provide services to children and youth with disabilities, and promote community-based, coordinated care. The program is referred to as “Title V” because the Social Security Act of 1935 included a section (Title V) authorizing grants to States to promote maternal child health. While Title V has evolved over the years to strengthen accountability while maintaining State flexibility, its mission has remained the same: improve the health of mothers, infants, children, youth, and CSHCN in each of the States and Territories.

Each state has a Title V Agency generally housed within the State’s public health agency’s organizational entity focused on maternal, child, and family health issues.

How Do States Obtain Title V Funds?

Each State receives Title V funds earmarked for the improvement of MCH. The amount each State is allocated from the overall Federal allocation is calculated on a formula basis factoring in child poverty rates and the level of funding the State received prior to the development of a Block Grant approach. States are required to match \$3 for every \$4 that is allocated. The match can include local expenditures on MCH. A Block Grant means that States receive a block of dollars that are not tied to specific categorical services. As a block grant, States have extensive flexibility as to how their funds are used as long as activities are focused on the improvement of MCH. However, some guidelines are in place to assure that attention is paid to specific MCH population groups. States must document that 30 percent of their MCH Block Grant funds are used for prevention and primary care activities for children, with another 30 percent directed to activities to service CSHCN and their families.

The Idaho Title V Agency is the Department of Health's BOCAPS. The Idaho 2004 Title V Block Grant Award was \$3,387,761. Thirty (30) percent of the block grant was used to support primary and preventive care for children, and 45 percent was used to support programs and initiatives for CSHCN. The State and local matching funds amounted to \$2.54 million, \$1.54 of which consisted of local health district funds invested immunization and reproductive health programs.

Among other things, Idaho used Title V funds to support:

- Activities to improve access to and quality of care for CSHCN
- Comprehensive reproductive health services for low-income residents
- Improvements in access to dental services including dental sealant programs for low-income children
- Access to genetic and metabolic specialists and genetics counseling
- Health surveillance activities in the District Health Offices
- The Idaho Perinatal Risk Assessment Tracking Survey.

Each year the state Title V agency must prepare a Title V application that describes how the MCH funds will be used to meet the identified needs of mothers, infants, children, youth, and CSHCN in their State. This application must be accompanied by an annual report that describes the outcomes from the previous year achieved through the auspices of the Title V program. Every 5 years, each State is required to conduct a comprehensive assessment of the needs of their MCH population groups and of the capacity of systems in the State to address those needs.

Title V in other Program Statutes

To promote collaboration among programs designed to serve the MCH population groups, other programs have statutory requirements to work with the State Title V agencies:

- The *Medicaid* statute was amended in 1967 to require that States provide for agreements with Title V agencies to deliver Medicaid services. This language has been interpreted to place Title V in the position of payer of last resort, after Medicaid. The language also assures that Title V services can be billed to Medicaid for Medicaid-eligible children and offered free of charge to others. This provision, which is contrary to general Medicaid policy requiring payment for all services, has been used in Title V-supported, school-based health programs. Finally, some have used the language to argue that Title V programs should receive cost-based Medicaid reimbursement. Federal Medicaid regulations provide additional requirements for Medicaid agreements with Title V.
- *Amendments to Medicaid* to address managed care made special provisions for CSHCN, citing Title V as one category in defining special needs children exempt from mandatory enrollment.

- The Federal *State Children's Health Insurance Program* legislation requires States to coordinate with MCH programs. Although Title V is not specifically cited, this was the intent behind the language.
- In the *Supplemental Security Income (SSI)* for Disabled Children Program, reference to Title V has provided the basis for State CSHCN programs to receive lists of all children enrolled in SSI. These lists have facilitated Title V outreach and follow-up to assure these children are linked with needed services. This policy also helped support a Title V role in outreach and recertification efforts following changes in Federal eligibility rules in the 1990s.
- The authorization for the federal *Healthy Start* program requires grantees to coordinate their services and activities with state Title V agencies.

As the only Federal program with a focus on all mothers, children, and families, Title V is mandated to work with the entire range of public and private sector organizations, agencies and initiatives that address issues related to improving the health of women, infants, children, youth, and CSHCN. The State Title V agency therefore has a unique perspective on the State's MCH system and can and should focus on understanding the system's overall strengths and challenges so that plans can be developed to address the challenges.

Moving from Paying for Services to Building Systems of Care

MCH and CSHCN programs historically have played a strong role in "filling the gaps" or serving as part of a "safety net" for low-income, underserved, and special needs populations. Many State programs historically filled this role by directly providing services through state and local clinics. As the Nation took action, beginning in the late 1980s, to improve health care coverage for children and pregnant women, and as Medicaid recipients moved to managed care delivery systems, public health programs re-examined their roles. There was less of a role for these systems in providing direct health care. The trend in moving away has continued especially with the advent of the SCHIP and more recently with the expansion in the number of CHCs.

Building a System for Children with Asthma

Traditionally, public health (using epidemiological methods) works to eliminate or reduce environmental contributors affecting asthma rates. Health care providers medically managed children with asthma. Child care centers and schools sought help preventing and managing asthma in efforts to reduce absenteeism. The Title V systems-building role is to bring together all the stakeholders and assure that all of the components and strategies are carried out in a coordinated and integrated way and monitored, evaluated, and adjusted as necessary. The Title V Program leads only some of these components, but it works with the others to ensure that the entire picture is addressed and that the system is linked and responsive to families.

As a result, in a desire to use Title V funds as effectively as possible, MCH Title V programs are decreasing their role in "direct service" while focusing more on systems building. Systems building means that instead of using all the Title V funds to pay for specific services for a few, the focus is on building and sustaining a *system* of services

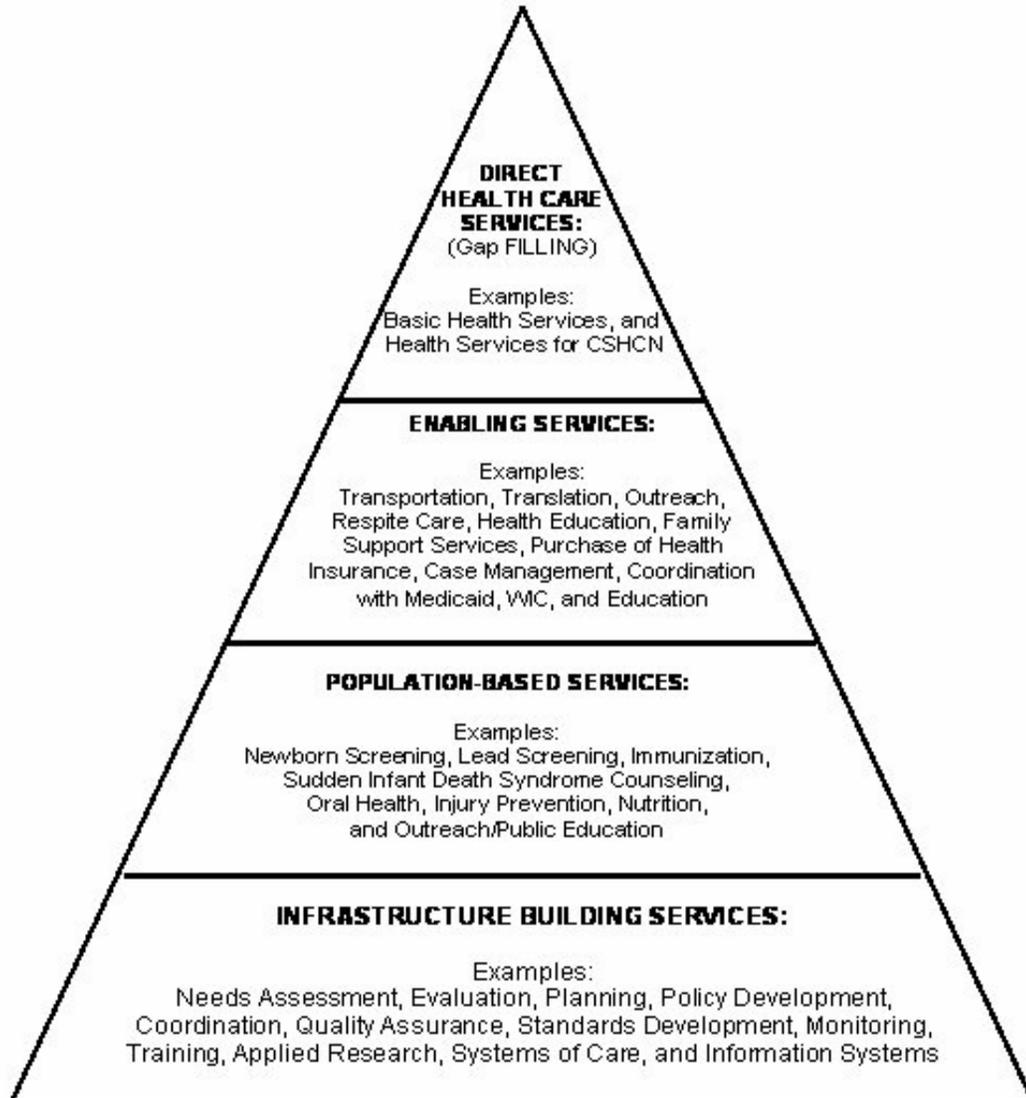
that will care for the many. Title V programs build systems of care by working collaboratively with the public and private health sectors, health care insurers, and the full array of child and family service organizations and agencies. Title V funds are used to conduct assessments and provide leadership to mobilize and convene providers and consumers to plan, implement, monitor, and evaluate strategies to promote systems of care for mothers, children, and families. Title V funds can be blended with other State and Federal resources to provide seamless care to the MCH populations.

Over the last several decades, the Federal Maternal and Children's Health Bureau (MCHB) has placed strong emphasis on systems development. Congress first added language focusing on this Title V role in 1987 and later in the 1989 amendments. State systems development for children and youth with special health care needs is now incorporated into national health objectives as well as Title V performance measures. Title V agencies and their partners strive to develop systems of care that are family centered, comprehensive, coordinated, culturally competent, and community based.

The Core MCH Services Pyramid

In the 1990s, the Federal MCHB developed a framework for Title V that graphically represents the role of the program as the foundation for the family health system and helps to visualize the shift in emphasis from direct services to systems building.

Now known as the MCH pyramid, the framework is consistent with the essential public health services described below and distills core MCH services into four main categories within an overall system of care.



- ***Infrastructure Building Services*** are services and activities that are important to the entire MCH system.
 - ***Example:*** Services for data collection and data analysis used for policy and program development and evaluation

- ***Population Based Services*** in this framework are largely primary prevention programs, universally reaching everyone that might be affected or in need.
 - ***Example:*** Services for the organization, promotion, provision and monitoring of immunizations for all children in the State

- ***Enabling Services*** help families access and use health services and are usually targeted to families that have special needs or face specific barriers.

- **Example:** Services that provide families with information about available resources and assistance in using them
- **Direct Health Care Services** are directly provided to individuals by grantees, contractors, or State or local agency staff. Title V programs commonly support prenatal care, well-child and school-based health services, and specialty services for children and youth with special health care needs.
 - **Example:** Prenatal care, well-child care, or specialty services for a particular MCH population groups

Federal Title V requirements, including applications, annual reports, and performance measures, are tied to this framework.

Title V's role has always been to "assure" services, a role for public health also emphasized in the Institute of Medicine's core public health roles. State leaders can assure services through multiple mechanisms, including needs assessment, planning, and recommendations to State policymakers and other agencies to fill gaps. But when no other recourse is available, State leaders use Title V resources to provide access. As the need for Title V to fund direct services has diminished, States have begun to shift resources down through the pyramid to support enabling, population-based, and infrastructure-building services.

Because of the flexibility inherent in Title V, it is a resource that States can use to diminish the fragmentation and duplication that so often accompanies categorical funding and develop ways to develop systems of care rather than categories of services.

Essential Public Health Functions

To fulfill the Title V mission and promote collaborative systems building, State Title V programs engage in certain essential public health functions.

The Institute of Medicine in a 1989 report, *Toward the Future of Public Health*, recommended that public health agencies focus on three core functions. These include:

- Assessment
- Policy Development
- Assurance

The IOM suggested that public health agencies should envision as their responsibility the assessment of health status and the factors that influence health status, the formation of policy to promote and protect the health of the public, and activities to assure access to and the quality of public health services. This was meant to imply not that public health agencies are solely

responsible for the conduct of these activities but that they should take a leadership role and convening responsibilities to see the health of the public is protected and promoted.

Simultaneous to this work by the IOM, the AMCHP, in collaboration with the Federal MCHB and The Johns Hopkins University Child and Adolescent Health Policy Center, formulated *The Public Maternal Child Health Program Functions Framework: Essential Public Health Services to Promote Maternal, and Child Health in America*. This document helped provide a common framework for MCH programs across the country. The content is consistent with broader public health frameworks but is tailored to promoting MCH and serving CSHCN. Strong emphasis is placed on assuring availability, access, and quality of health services as well as on linkages with other systems serving women, children, youth, and families. Because the MCH essential services are adapted from the 10 essential public health services framework, they offer an important common language and bridge to broader public health efforts.

Ten Essential Public Health Services to Promote Maternal and Child Health and Existing and Potential Strategies for Providing These Services

This section discusses the ten essential public health services and describes some of the ways that Title V is fulfilling these roles in Idaho. In addition, there is a discussion of some ways that Title V and its partners can continue to fulfill these essential functions in the future. To determine the state MCH Title V program's capacity to carry out the essential public health functions, AMCHP in collaboration with the MCHB and The Johns Hopkins University developed CAST-5. CAST-5 is a process used to identify the organizational capacity needs of the State Title V program and to specify ways to address these needs. CAST-5 was conducted during this needs assessment and is a natural and important complement to the findings described throughout this document.

1. *Assess and monitor maternal and child health status to identify and address problems.*

The Title V agency is responsible for assessing and monitoring MCH to identify and address problems. BOCAPS in Idaho has accomplished this through a variety of means including supporting an increase in the number of women surveyed through the PRATS survey. One need that was identified in this area was that local health districts are interested in being able to better assess and monitor MCH in their region. They do not feel that they have adequate data on health status at the regional level or their staff has the skills to conduct assessment activities. Enhancing existing data and providing more extensive training in assessment at the district level are additional ways that this essential service could be provided.

2. *Diagnose and investigate health problems and health hazards affecting women, children, and youth.*

One of the health problems BOCAPS is currently helping investigate relates to concerns over health complications that may be occurring when lay midwives deliver babies. There are many health problems that are surfacing in Idaho that need investigation including youth suicide, diabetes, and obesity. Efforts are occurring in a variety of these areas, and it will be important

that they result in recommendations that public health providers and their partners will be willing and able to implement.

3. *Inform and educate the public and families about MCH issues.*

Some of the best examples of what has been done in this area are the activities around breastfeeding promotion. State and local councils helped develop program activities that served to educate the public about breastfeeding. These efforts have paid off in increased percentages of mothers who breastfeed their babies. There are lots of other areas where opportunities exist. For example, postpartum depression appears to be a serious problem in Idaho, and BOCAPS and its partners can play a role in educating the public and provider about this topic and what can be done to help relieve the problem.

4. *Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve MCH problems.*

BOCAPS has participated in a wide variety of efforts to identify and solve maternal and child health problems. As noted, in years past the agency played a major role in developing Breast Feeding Coalitions around the State. In more recent years the agency has played more of a supportive role than a mobilizing role. While participation is important, there are some areas where BOCAPS may be needed to play more of a mobilization role. District Health Departments have expressed an interest in having a State staff person focused on MCH issues. BOCAPS may have a role in creating and enhancing partnerships among District Health Departments, CHCs, and Regional Health and Welfare offices.

5. *Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth, and their families.*

Part of the reason that MCHB requires this 5-year needs assessment is to provide a tool that can be used in planning and policy development. However, there is a real need to ensure that such information is used for planning and policy development. As discussed in the system collaboration chapter, Idaho has created many planning bodies and task forces to address particular problems. At this point, there may be a need to step back and figure out how all the pieces fit together and where responsibilities lie for setting priorities in particular areas and among various populations.

6. *Promote and enforce legal requirements that protect the health and safety of women, children, and youth and ensure public accountability for their well-being.*

The Title V agency and its partners have played a role in promoting legal requirements related to the use of seatbelts and child safety seats. Idaho's legislature is very reluctant to impose legal requirements that restrict individual behavior. However, there may be other ways to promote and enforce standards of behavior that protect health and safety. BOCAPS and its partners can develop recommended screening tools that providers can utilize to identify high-risk pregnant women or young children who may need assessment by the Infant-Toddler Program. By working with Medicaid, providers, and insurance companies, it is possible that such tools would win widespread adoption without being required by law.

7. *Link women, children, and youth to health and other community and family services and assure access to comprehensive, quality systems of care.*

The use of Title V funds to support the Idaho CareLine is one of the ways in which families are linked to care in Idaho. Part of the responsibility for this function has shifted to the private sector Medicaid care coordinators. However, it is unrealistic to expect these coordinators to be effective without training and strong linkages to public sector health and welfare providers. Certification and training of these providers, especially in providing services to special populations, is needed in order for them to effectively link their clients to comprehensive services. Public health and its partners must fulfill this function for the new system to fulfill its function.

8. *Assure the capacity and competency of the public health and personal health work force to address MCH needs effectively.*

BOCAPS helps sponsor a number of meetings that are designed to provide continuing education of health care providers. Despite this, District Health staff indicate that there is a need for opportunities for educating and training both new and continuing staff in providing public health services. Tools such as the Bright Futures publications may be useful in providing practical information that can strengthen the services offered by public health agencies.

9. *Evaluate the effectiveness, accessibility, and quality of personal health and population-based MCH services.*

One way to improve the ability to evaluate the effectiveness, accessibility, and quality of services is to begin to include performance measures within contracts. It is important that such measures are carefully selected and can be used for program planning. Other programs, such as the Infant-Toddler Program, that have successfully used performance measures may be able to provide useful information on how to succeed.

10. *Support research and demonstrations to gain new insights and innovative solutions to MCH-related problems.*

BOCAPS and its partners support such efforts through the collection of data that can be used to obtain funding for research and demonstrations and in the analysis phase of research and demonstrations. Other opportunities exist including having State and local staff serve as advisors to research and demonstration efforts. Program staff are often experts on services and know a great deal about what is happening in communities. They can serve as an excellent resource for researchers as they try and figure out how to address health and welfare challenges.