Maternal and Child Health Services
Title V Block Grant

State Narrative for Idaho

Application for 2014
Annual Report for 2012

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I. General Requirements

A. Letter of Transmittal

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

B. Face Sheet

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

C. Assurances and Certifications

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

D. Table of Contents

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

E. Public Input

During the public comment period, the semi-final version of Idaho's Maternal and Child Health Block Grant Application and Annual Report is posted to the external website of the Idaho Department of Health and Welfare (IDHW), along with a request for input. The IDHW website is "crawlable" by Google and other search engines, and the grant application is therefore exposed to the world. However, in recognition that there is a plethora of information out on the web, staff also notify interested groups and individuals that the grant application is available for review and comment. This year the notified groups will include, among others:

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

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

* Idaho Families of Adults with Disabilities (IFAD).

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

- Panhandle Autism Society

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

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

II. Needs Assessment

In application year 2014, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Reduce premature births and low birth weight

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

Reduce the incidence of teen pregnancy

Idaho reported some of the highest declines in teen birth rates from 2007 to 2011. Overall, the teen birth rate declined 33.0 percent, from 41.4 births per 1,000 to 27.7 births per 1,000 women aged 15-19. The decrease in birth rates among non-Hispanic white teens and among Hispanic teens, especially in some of the most populated counties, is driving down the overall teen birth rates for Idaho.

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

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

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

Reduce intentional injuries in children and youth

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

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

Improve access to medical specialists for CSHCNs

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

III. State Overview

A. Overview

Geographical Information

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

Population Information

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

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

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

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

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

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

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

Ethnic Groups

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

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

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

Economic Information

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

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

Educational Information

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

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

Health Delivery System in Idaho

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

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

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

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

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

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

D. Idaho has 12 Community Health Centers and one Federally Qualified Health Center "Look-Alike" that provide high quality health care to about 130,000 people each year. They are located in 37 communities throughout the state and in three communities across the border in eastern

Oregon. Dental, mental health and behavioral services are also offered at many of these locations. Annually, Idaho's Community Health Centers serve just over 100,000 patients.

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

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

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

E. As of the end of 2008, there were 3,063 licensed and practicing physicians within the state. The physician to patient ratio of care in Idaho was 201 physicians providing patient care per 100,000 population, as compared to the national average of 309. There were 1,020 primary care practitioners licensed and practicing in Idaho. There were a total of 511 physician assistants in Idaho. There were 1,480 pharmacists, 840 physical therapists, 80 psychiatrists and 863 general dentists licensed in Idahoans. These numbers represent whole counts made available through State Licensure Boards and do not reflect the actual time (or fractions of time) that these practitioners avail themselves in health care services.
As of January 15, 2010 16.7% of Idahoans lacked access to primary care, as compared to the national average of 11.5%.

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

Access to Health Care Needs of the Population in General

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

Utilization of Medicaid in Idaho is average compared to the rest of the nation. In 2009 35%

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

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

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

/2013/ Between 2000 and 2009, the percent of children in Idaho without health insurance decreased from 16% to 9%. During this period, children receiving health insurance thr0ugh a parent's employer decreased from 54% to 46T. children with private insurance not associated with an employer increased from 7% to 12%. Children with public insurance increased from 15T to 24%. This trend has resulted in a decline of uninsured Idaho children from 16% in 2000 to 9% in 2009. During this same time period, the combined enrollment of children in SHIP and Medicaid increased from 74,040 in 2000 to 164,999 in 2009, an increase of 122%.

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

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

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

Oral Health

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

A 2006 Idaho Oral Health Needs Assessment identified the following oral health facts about the state. 67% of the population visited the dentist or dental clinic within the past year. 65% of the population had their teeth cleaned by a dentist or dental hygienist within the past year. 23% of the population age 65+ have lost all of their teeth. 44% of the population age 65+ have lost 6 or more teeth. 48% of the population on public water systems is receiving fluoridated water. 52% of 3rd

grade students have one or more sealants on their permanent first molar teeth. 65% of 3rd grade students had caries experience (treated or untreated tooth decay). 26% of 3rd grade students had untreated tooth decay.

The Idaho Oral Health Needs Assessment also identified the following barriers to oral heath. The cost of dental treatment and services is one of the most common barriers. It does not matter if the patients are insured; it is still a major factor for not getting dental care. There are many rural areas in Idaho and dental patients often have a difficult time traveling to a dental care provider. If a patient is in need of specialty care they often have to travel to the more metropolitan areas, adding costs to patients' treatment. Patients need to be educated about the importance of oral health in relationship to overall health. They also need to be educated about the new advancements in dentistry to help reduce their dental fear. There is a growing Hispanic population in Idaho and the language barrier continues to grow.

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

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

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

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

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

Impact on Health Outcomes

Although our linking of these factors to health outcomes may not be empirical, a number of them as described above including: the state's rural nature, long travel distances, shortage of health care providers, economics, and conservative philosophy, may contribute to health care outcomes characterized by a low percentage of immunization in the two year old population, low prenatal care utilization, a high percentage of uninsured children, and a low accessibility to pediatric specialists. Moreover, the conservative outlook has kept government involvement to a minimum.

This limits the impact that government driven programs can have on many health outcomes. An example is the limitation on covered conditions in the Children's Special Health Program. Additionally, the rural and agricultural nature of the state has a strong association with high death rates due to motor vehicle accidents as well as other injuries and may also contribute to the high suicide rate, which is also seen in other western states.

Current MCH Initiatives

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

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

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

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

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

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

/2013/ As of May 2012, the Idaho State immunization registry, IRIS, has ¬¬approximately 2,100

facilities which include Vaccine for Children (VFC) providers, private providers, health departments, schools, daycares and out-of-state clinics. The majority of these are child care providers of which 325 were actively using IRIS in May of 2012. Providers are primarily becoming active users as they receive their inspections and realize the value of the system to their child care business. 991,350 patients have enrolled in the system, with a total of 10.2224.454 vaccinations delivered to them. Of those patients, 724,053 have received two or more immunizations. Several factors contributed to this increase including the change from an opt-in to an opt-out system, a strengthening of the laws governing immunizations required for school, increased capabilities for child care providers and the fact that Vital Records' birth records are exported into IRIS on a weekly basis. Additionally, IRIS moved to a new more agile and user friendly information system. The new information system was deployed on March 1, 2012, and was based on the Wisconsin Immunization Registry (the WIR System). The WIR System is currently deployed in nearly 20 states, and in Idaho it has been very well received by end users. //2013//

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

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

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

Current MCH Priorities

A 5-year Needs Assessment was conducted during 2009 and 2010, with significant public input, to establish Idaho's MCH priorities for the coming five-year period. The survey garnered 189 completed responses within the following self-identified groups:

* Individual (parent, guardian, self) - 36.4%
* Representative of a government agency -- 34.5%
* Representative of a non-profit group -- 14.3%
* Representative of a for-profit company -- 2.3%
* Other -- 12.4%

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

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

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

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

B. Agency Capacity

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

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

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

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

/2011/ During State fiscal year 2011, the Women's Health Check program received $150,000 in Millennium funding from the state legislature to provide diagnostic services for breast and cervical cancer to young women aged 18 through 29. This is an age group for whom there are very few resources in Idaho. This funding will not be available in state fiscal year 2012. As of June 10, 2011 this program had enrolled 107 young women for symptoms/tests suspicious for cancer. Of these, 16 have received breast cancer work-ups, and 91 have received cervical cancer work-ups. Of these, 35 have been diagnosed with cancer or dysplasia and referred to Breast / Cervical

Cancer (BCC) Medicaid for treatment of pre-cervical cancer. Thirty four of these were cervical related, and one was for breast cancer. //2011//

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

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

Bureau of Clinical and Preventive Services (BOCAPS)

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

Newborn Screening Program

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

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

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

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

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

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

Bureau of Clinical and Preventive Services

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

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

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

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

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

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

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

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

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

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

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

Kris Spain, MS, RD, LD, is the manager of the WIC program having accepted the position in March of 2010. Prior to accepting the manager position, Ms. Spain served with the Idaho state WIC office for 6 years, and 3 years in a local WIC clinic.

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

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

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

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

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

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

Office of Epidemiology, Food Protection and Immunization

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

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

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

Bureau of Community and Environmental Health

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

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

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

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

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

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

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

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

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

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

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

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

Bureau of Health Planning and Resource Development

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

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

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

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

/2014/ Laura Rowen resigned in March, 2013. Andrew Noble was hired in April, 2013 to

manage the Primary Care program. //2014//

Bureau of Vital Records and Health Statistics

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

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

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

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

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

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

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

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

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

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

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

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

Public Health Districts

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

C. Organizational Structure

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

Pregnant Women, Mothers and Infants

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

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

The Newborn Screening program provides newborn metabolic screening through a contract with the Oregon Public Health Laboratory. As of July 2007, the Idaho NBS program screens for all 29 conditions recommended by the March of Dimes, and for several others. Medical information relative to conditions screened for is provided through contractors at the Oregon Health and Science University to Idaho physicians and other health care professionals involved with the follow-up of abnormal newborn screens. /2011/ Current screening in Idaho can detect more than 40 serious conditions. //2011//

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

services in Boise, St. Luke's hospital has contracted additional services from the geneticist, resulting in improved genetic services infrastructure in Idaho.

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

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

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

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

Children

The Bureau of Community and Environmental Health (BCEH) administers the Title V programs of Oral Health, Adolescent Pregnancy Prevention, and Injury Prevention. The other programs include several preventive health education programs such as diabetes and tobacco use prevention. This bureau provides consultation to assist local district health departments, industries, schools, hospitals and nonprofit organizations in providing preventive health education.

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

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

prevention coalitions.

Children with Special Health Care Needs

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

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

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

All MCH Populations

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

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

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

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

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

associations, universities and other key players in the Idaho health system.

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

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

D. Other MCH Capacity

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

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

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

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

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

/2011/ MCH Block Grant funds are no longer supporting a Principal Research Analyst in the Bureau of Vital Records and Health Statistics, though an analyst remains dedicated to MCH programming. //2011//

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

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

information. //2014//

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

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

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

/2014/ In May, 2013, the Idaho MCH Program collaborated with Medicaid Children's Healthcare Improvement Collaboration (CHIC) to introduce the patient-centered medical home model to providers of pediatric and family care to families with children with special health care needs (CSHCN) in rural parts of Idaho, utilizing the Public Health Districts. The demonstration project will pilot in Southeastern and Eastern Idaho. This area of the state has the highest birth rate and identified children with special healthcare needs. MCH will fund a Medical Home Coordinator (MHC) in each health district who will serve as a member of the provider practice team. The MHC will assist the practice in identifying patient populations (CSHCN) who could benefit from care coordination, along with helping the practice learn to track evidence-based care through formal quality improvement techniques. Medicaid is providing some funding for the project, in addition to in-kind contributions for MHC training and on-going coaching, web-based quality improvement team site for data entry, an evaluation component and assistance with overall project oversight.

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

E. State Agency Coordination

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

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

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

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

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

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

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

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

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

a) The Pediatric Pulmonary Center Advisory Committee at Children's Hospital in Seattle provides advice concerning funding issues, program planning and data.
b) The MCH Director serves on the Early Childhood Coordinating Council (supported by the State Early childhood Comprehensive Systems -- SECCS grant.)
c) The Idaho Perinatal Project.
d) Emergency Medical Services for Children Taskforce.
e) Perinatal Substance Abuse Prevention Project, funded by the Division of Family and Community Services, Bureau of Substance Abuse. This project is to develop statewide guidance

for health care and other human service providers in identifying substance use among potentially pregnant women with the intent of intervening early for the prevention of substance affected newborns.
f) Disability Determinations Services (DDS) addresses the needs of children with special needs and their families.
g) Idaho's Rural Health Program (RHP), established to create a focal point for health care issues that affect the state's rural communities.
h) Idaho Sound Beginnings -- the state's Early Hearing Detection and Intervention (EHDI) program -- provides public awareness, and collects statewide data.
i) Sexual Assault Prevention Advisory Committee.
j) The Idaho Oral Health Alliance, a group dedicated to improving the general health of Idahoans by promoting oral health and increasing access to preventive and restorative dental services.
k) Idaho Kids Count Editorial Board, a group whose expertise helps guide development of the Idaho KIDS COUNT book and related efforts to track and promote the well-being of children in Idaho through research, education, and mobilization strategies.
l) Association of State and Territorial Dental Directors Data Surveillance Committee.
m) The CSHCN Director serves on the Developmental Disabilities Council.
n) Idaho Immunization Coalition.
o) Comprehensive Cancer Alliance for Idaho (CCAI) -- a partnership between many individuals and organizations to address issues relating to the impact of cancer in Idaho. The CCAI is working to reduce the number of preventable cancers and decrease late stage diagnosis of treatable and survivable forms of cancer by improving screening rates in Idaho and to improve the quality of life of Idahoans impacted by cancer.
p) Operation Pink B.A.G. (Bridging the Access Gap) -- a coalition of agencies and hospitals in Southwestern Idaho funded through the Boise Affiliate of Susan G. Komen Race for the Cure.
q) Breast and Cervical Cancer Medicaid Team -- brings together three divisions of IDHW to address unique issues relating to Women's Health Check clients who are diagnosed with breast or cervical cancer and transferred into the Medicaid system for the duration of cancer treatment.
r) Coordinated School Health Committee, an effort through the Division of Public Health and the Department of Education.
s) The Covering Idaho's Kids Coalition -- insurance coverage for children.
t) The CSHCN Director serves on the advisory board for Idaho Parents Unlimited (IPUL), which is Idaho's Family Voices State Affiliate organization.
u) Canyon County Area Immunization Coalition.
v) Idaho Safe Routes to School Advisory Committee - enable and encourage children to walk and bicycle to school; improve the safety of children walking and bicycling to school; and facilitate projects and activities that will reduce traffic, fuel consumption, and air pollution near schools.
w) Idaho Highway Safety Coalition - reduce traffic deaths, injuries, and economic losses through outreach programs and activities that promote safe travel on Idaho's transportation systems.
x) Idaho Partnership for Hispanic Health - the main objective is to decrease health disparities experienced by Hispanics in Idaho.
y) The Tobacco Free Idaho Alliance (TFIA) - meets quarterly and is a statewide coalition.
z) Idaho Voices for children.
aa) Idaho Chapter of American Academy of Pediatrics.
bb) Northwest Bulletin editorial board.
cc) Healthy Eating, Active Living (HEAL) Idaho.
dd) Idaho Families of Adults with Disabilities (IFAD).
ee) BYU-Idaho EC/EC Special Education Program.
ff) Idaho State Department of Education.
gg) Coeur d'Alene Tribe Early Childhood Learning Center.
hh) Idaho Head Start Association.
ii) Idaho State child Welfare Programs.
jj) St. Luke's children's Specialty Center.
kk) Idaho Infant Toddler Program (IDEA, Part C).
ll) Head Start Collaboration Office.
mm) Idaho Department of Insurance.

nn) Idaho Services for the Deaf and Blind.
oo) Local Public Health Districts.
pp) Coordinator for the Homeless, State Department of Education.
qq) Child Care Administration, Idaho Department of Health and Welfare.
rr) University of Idaho Center on Disabilities and Human Development.
ss) Idaho Primary Care Association.
tt) Medicaid, Idaho Department of Health and Welfare.
uu) Substance Abuse Program, Idaho Department of Health and Welfare.
vv) Child Protection Services, Idaho Department of Health and Welfare.
ww) Idaho Hunger Task Force.
xx) Idaho Chapter of American Academy of Family Practice Physicians.

Local Health Departments

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

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

Federally Qualified Health Centers/Community Health Centers

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

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

Universities

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

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

relationship. //2011//

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

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

The MIECHV program partners with BSU to conduct a formal evaluation of program activities and technical assistance to both the State and local contractors.

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

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

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

F. Health Systems Capacity Indicators

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

INDICATOR #05 *Comparison of health*	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-**	**ALL**

system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State				**MEDICAID**	
Percent of low birth weight (< 2,500 grams)	2011	payment source from birth certificate	7.2	5.3	6.1

Narrative:
/2014/ HSCI 05a: Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State. Title V in Idaho uses data from vital statistics which publishes prenatal care based on the 2003 U.S. Standard Certificate. Percent of low birth weight (<2500 grams) births in Idaho has declined slightly; 6.6% of total births in 2007 compared to 6.1% in 2011. Specific to Medicaid populations, this same decline was observed; 7.3% in 2007 to 7.2% in 2011. A slightly greater decline was observed in the Non-Medicaid population; 5.9% in 2007 to 5.3% in 2011. //2014//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2011	payment source from birth certificate	72.6	80.2	77.2

Narrative:
/2014/ HSCI 05d: The comparison of health status indicators for Medicaid, non-Medicaid, and all populations in the State - Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index]).

From 2007, Idaho has experienced overall improvement in the number of pregnant women with adequate prenatal care; from 72.7% in 2007 to 77.2% in 2011. Medicaid populations have also improved from 65.9% in 2007 to 72.6% in 2011. One contributing factor to this trend may be the Adequacy of Prenatal Care Utilization (APNCU) Index which classifies care as intensive, adequate, intermediate, inadequate, or no care by comparing the number of actual prenatal care visits to the number of visits that a woman was expected to receive, given the onset of prenatal care and the length of gestation. Since 2007, Idaho has experienced a 25% increase (31.4% in 2007; 39.3% in 2011) in Medicaid as source of payment for deliveries. This too, is likely a contributing factor in overall prenatal care

improvement. [Source: ID Vital Statistics Report, Boise, Idaho] //2014//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2012	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2012	185

Narrative:
HSCI 06: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. In 2007, Idaho reported 223,518 persons enrolled in Medicaid and in 2009, this rose to 251,494 enrolled. Of the latter, 86.9% received their health care services through a managed care program. Managed care services are typically delivered by an organization under state contract. [Source: Medicaid.gov-Idaho Medicaid Statistics] This rise in Medicaid utilization aligns with the Healthy People 2020 Objective; to increase the proportion of persons with health insurance.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 16) (Age range 17 to 18)	2012	 133 133 133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 5) (Age range 6 to 16) (Age range 17 to 18)	2012	 185 185 185

Narrative:
/2014/ Health System Capacity Indicator 06B The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs - Medicaid Children. Since 2007, enrollment in the SCHIP program has increased by 28.9% from 33,060 to 42,604 in 2011. //2014//

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

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

Notes - 2014

Narrative:

/2014/ HSCI 09A: The state either provides or assures the creation of these databases, assures the MCH programs access to these databases, and assures the MCH programs ability to obtain timely analysis from these data for programmatic and policy issues. Idaho is able to obtain data from annual linkage of infant birth records and death certificates, as well as linkage of birth certificates and WIC eligibility. For SFY14, DHW is undertaking a system upgrade to allow medical providers to submit electronic birth records to vital statistics. Currently, this is a manual paper entry of information. MCH funds will be utilized to support this important infrastructure system upgrade. With this project, there is an opportunity to expand on the collection of data elements. Specifically, Idaho will be creating two sub-categories of data under pregnancy related to infertility treatment to collect "assisted reproductive technology" and "infertility medications utilized". Additionally, eclampsia will be a sub-category of gestational diabetes. //2014//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No

Notes - 2014

Narrative:

/2014/ HSCI 09B: The ability of states to monitor tobacco use by children and youth. Idaho collects this data directly from the Idaho Youth Risk Behavior Survey (YRBS) which measures smoking experimentation, current smoking patterns, age at initiation, attempts to quit smoking, etc. In the number of youth who have ever tried smoking decreased slightly from 48.3% in 2007 to 39.0% in 2011. Smoking prevalence among Idaho teens has decreased from 20% in 2007 to 14% in 2011. The proportion of high school students who smoked on 20 of the previous 30 days did increase slightly; 4% in 2009 to 6% in 2011. Despite this slight increase, frequent smoking among Idaho students has declined significantly over the past ten years. [Source: 2011 Idaho YRBS Report; sde.idaho.gov/site/csh]. //2014//

IV. Priorities, Performance and Program Activities

A. Background and Overview

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

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

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

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

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

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

B. State Priorities

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

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

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

PREGNANT WOMEN AND INFANTS

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

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

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

CHILDREN AND ADOLESCENTS

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

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

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

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

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

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

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	30	19	29	18	19
Denominator	30	19	29	18	19
Data Source	Idaho Newborn Screening Program	Idaho Newborn Screening Program	Idaho Newborn Screening Program	Idaho Newborn Screening Program	Idaho Newborn Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments
The Idaho Newborn Screening (NBS) program revised the exemption section of the NBS Practitioner's Manual in order to accurately clarify that religious reasons are the only legally accepted exemption from NBS as identified in Idaho code. The Idaho Department of Health and Welfare's legal section approved the changes made to the exemption form, the updated version of the NBS Practitioner's Manual was placed on the Idaho NBS website, and was printed in hard copy for hospitals, birth facilities, and other practitioners.

For 2012, the number of NBS specimens submitted without error was not below 90% all year and achieved the highest compliance rate in the past five years. The NBS coordinator's consistent communication with providers and face-to-face provider educational and compliance visits supported this effort.

As the state's lead Text4Baby partner, the Maternal and Child Health Program's (MCHP) and Newborn Screening (NBS) program's care coordinator promoted information about Text4Baby and Newborn Screening at meetings and conferences around the state. Other activities included coordinating efforts with other state partners to promote Text4Baby, marketing Text4Baby via mailings and social media, and tracking enrollment for the state. Idaho's Text4Baby marketing efforts were recognized nationally at the AMCHP Conference and the National Healthy Mothers Healthy Babies Coalition's newsletter.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities
The NBS coordinator is planning a number of in-service visits to hospitals and birthing facilities in northern and eastern Idaho this summer to discuss any issues and answer questions related to NBS collection and submission performance.

As of May 2013, enrollment in Text4Baby has reached nearly 3,000 pregnant women and new

mothers which are more than double the enrollment numbers from the same time last year. The MCHP and NBS coordinator has done an excellent job of promoting public service announcements for television and radio (produced by the National Text4Baby Office) and partnering with Medicaid to send letters to Medicaid-enrolled pregnant women or new mothers about Text4Baby benefits. This mailing is conducted every 6 months.

c. Plan for the Coming Year
Idaho will continue to collaborate with state partners to promote the Text4Baby campaign.

The Idaho Newborn Screening Program has discussed plans with the Oregon State Public Health Lab educator to develop a self-paced educational newborn screening curriculum which can be accessed via the Idaho NBS website.

Some consideration is being given to adding SCID to the NBS panel.

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

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

Total Births by Occurrence:	**22487**					
Reporting Year:	**2012**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	22185	98.7	3	0	0	
Congenital Hypothyroidism (Classical)	22185	98.7	254	7	7	100.0
Galactosemia (Classical)	22185	98.7	6	0	0	
Sickle Cell Disease	22185	98.7	0	0	0	

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	53	53	53	53	73

Annual Indicator	52.7	52.7	52.7	72.4	72.4
Numerator					
Denominator					
Data Source	National Survey of CSHCNs 2005-2006	National Survey of CSHCNs 2005-2006	National Survey of CSHCNs 2005-2006	National Survey of CSHCNs 2010	National Survey of CSHCNs 2010
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	75	75	75	75	75

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

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

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

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

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

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

Table 4a, National Performance Measures Summary Sheet

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

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

In order to remain eligible for the CSHP, families must return an updated application form and tax return information to the program by July 1 (beginning of state fiscal year). As of May 2013, after sending a letter asking for updated information, the program received information from 40 of approximately 130 families with children enrolled in the program. A second letter will be sent to families in July requesting updated information, and it is expected that the majority of families will provide the information at that time. The CSHP typically receives updated application information from approximately 90 percent of families.

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

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

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

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	52	52	52	52	43
Annual Indicator	47.7	47.7	47.7	42.9	42.9
Numerator					
Denominator					
Data Source	National Survey of CSHCNs 2005-2006	National Survey of CSHCNs 2005-2006	National Survey of CSHCNs 2005-2006	National Survey of CSHCNs 2010	National Survey of CSHCNs 2010
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	45	45	50	50	50

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

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

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

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

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
When new families apply for the CSHP, staff assist the family with completing an application for Medicaid to check for eligibility. Care through Medicaid is more likely to resemble a Medical Home than the limited financial support through CSHP.

Last year, the CSHP explored the possibility of establishing a contract with Idaho Parents Unlimited or a similar type of agency to deliver training to pediatric providers and relevant stakeholders throughout Idaho about the medical home model of care for CSHCNs. It was determined that the timing did not work for the training as other pediatric medical home demonstrations were in the early stages of implementation.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHP staff continue to work with uninsured CSHCNs to apply for Medicaid if they are eligible.		X		
2. CSHP's Transition-to-Adulthood materials include a section on how to find a medical home.		X		
3. MCH staff serve on the IPUL advisory board which provides input into the Children's Healthcare Improvement Collaboration (CHIC) project's three newly implemented pediatric practice demonstrations of patient-centered medical homes.		X		X
4.				
5.				
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10.				

b. Current Activities

The Maternal and Child Health (MCH) Program has collaborated with the Idaho Children's Healthcare Improvement Collaboration (CHIC) project to implement a patient-centered medical home demonstration for children with special health care needs in rural areas of the state. The CHIC project is part of a federal grant that Idaho and Utah received to look for ways to improve healthcare for kids. A focus of the CHIC project is transforming pediatric practices to a medical home in order to increase access to care for patients, support a Medical Home Coordinator to lead and facilitate the transformation to a patient-centered medical home, and provide support to parents and feedback to clinics to improve patient and family involvement and satisfaction. The MCH Medical Home Demonstration will be implemented in Public Health Districts in the eastern and southeastern portions of the state. An innovative approach to support the transformation of rural pediatric practices is being used by providing funding and establishing contracts with the Public Health Districts to hire and support a Medical Home Coordinator in each district who will partner with 2-3 pediatric and family practices in the rural areas to facilitate the medical home model of care for children with special health care needs.

c. Plan for the Coming Year

In the coming year, the MCH Program will work closely with the CHIC Project and the Southeastern Idaho Public Health and Eastern Idaho Public Health Districts to support the pediatric patient-centered medical home demonstration in the rural areas, provide training to the districts and Medical Home Coordinators, and document successes and challenges. The demonstration will be for two years and will include an evaluation component. The goal of the collaboration between CHIC, Title V MCH Program, and Public Health is to introduce the patient-centered medical home model in rural settings where it may not be feasible for a single practice to support a MHC. This collaboration will present a complete patient care model goal that includes health education, prevention and quality improvement. At the end of the demonstration period a local infrastructure (personnel, best processes, best procedures, and materials) will be accomplished. Benefits of this partnership and infrastructure building may include:

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

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	60	60	60	60	60
Annual Indicator	56.9	56.9	56.9	55.2	55.2
Numerator					

Denominator					
Data Source	National Survey of CSHCNs 2005-2006	National Survey of CSHCNs 2005-2006	National Survey of CSHCNs 2005-2006	National Survey of CSHCNs 2010	National Survey of CSHCNs 2010
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	60	60	60	60	60

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

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

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

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

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

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

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

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

c. Plan for the Coming Year

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

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	86	86	86	86	65
Annual Indicator	86	86	86	64.6	64.6
Numerator					
Denominator					
Data Source	National Survey of	National Survey of	National Survey of	National Survey of	National Survey of

	CSHCNs 2005-2006	CSHCNs 2005-2006	CSHCNs 2005-2006	CSHCNs 2010	CSHCNs 2010
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	65	67	67	70	70

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

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

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

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

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
The Children's Special Health Program (CSHP) continued to fund the only cystic fibrosis, genetics, and metabolic medical services available in Idaho. These clinics continue to be held at St. Luke's Children's Hospital in Boise, and the relationship between CSHP and St. Luke's

continues to be strong (metabolic clinics are held in other parts of the state as well). With all of CSHP's specialty clinics housed within medical facilities at St. Luke's, CSHP has been conducting "maintenance of effort".

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHP funds and staffs metabolic clinics around Idaho using MCH Block Grant funds. Since Idaho has no metabolic physicians, CSHP imports one from Oregon to provide services to Idaho's children who would otherwise have to travel out-of-state for care.	X			
2. CSHP funds and staffs monthly genetics clinics in Boise using MCH Block Grant funds. Since Idaho has no genetic physicians, CSHP imports one from Oregon to provide services to Idaho's children who would otherwise have to travel out-of-state for care.	X			
3. CSHP partially funds Idaho's Cystic Fibrosis center, providing no-cost clinical services to Idahoans under the age of 18 with cystic fibrosis.	X			
4. CSHP funds ongoing PKU services around the state by supplying dieticians to advise PKU clients and by providing medical foods and formula to manage their PHE levels.	X			
5. CSHP funds a quarterly cleft lip and palate (CLP) clinic in northern Idaho were CLP services are otherwise unavailable. This clinic serves uninsured children at no cost to their families.	X			
6. CSHP funds several specialty clinics in eastern Idaho that provide no-cost care for uninsured children with cardiac and orthopedic conditions.	X			
7.				
8.				
9.				
10.				

b. Current Activities

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

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

c. Plan for the Coming Year

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

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

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	46	46	46	46	47
Annual Indicator	45.8	45.8	45.8	46.6	46.6
Numerator					
Denominator					
Data Source	National Survey of CSHCNs 2005-2006	National Survey of CSHCNs 2005-2006	National Survey of CSHCNs 2005-2006	National Survey of CSHCNs 2010	National Survey of CSHCNs 2010
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	47	49	49	51	51

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

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

Notes - 2011

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

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

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
CSHP printed and distributed the Transition-to-Adulthood kits for CSHCN. There are three different kits, each targeted at a specific age group: junior high or middle school-aged youth, high school-aged youth, and young adults transitioning to college and/or the workforce. All kits are available electronically on the CSHP website, as well as in hard-copy. The second round of kits were printed, hole-punched, and bound in plastic in order to be binder-ready rather than printed and assembled in a binder. The elimination of the binder resulted in a large cost savings for the program which allowed for more kits to be printed.

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

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

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

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

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Idaho's Transition-to-Adulthood materials for CSHCN were redesigned and mass-produced in order to be available to all CSHCNs in Idaho.		X	X	

2. Transition-to-Adulthood training sessions are being offered to families of CSHCNs and to providers by CSHP staff in coordination with staff from IPUL. These sessions are offered at meetings and conferences around the state.		X		
3. CSHP is working to build a partnership with the Idaho Department of Education's Special Education Programs to provide Transition-to-Adulthood training directly to special education teachers.		X	X	
4. CSHP's care coordinator has been promoting the use of the Transition-to-Adulthood kits to various community partners and agencies including colleges and universities, Head Start, and physician's offices.		X	X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

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

The CSHP is in the process of redesigning the Transition-to-Adulthood website in order to make the Transition Kits interactive online. The redesign is expected to be done by December 2013.

c. Plan for the Coming Year

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

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	83	83	75	75	75
Annual Indicator	65.9	65.8	65.1	68.8	68.8
Numerator					
Denominator					
Data Source	NIS	NIS	NIS	NIS	NIS

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	75	75	75	75	75

Notes - 2012
NIS data for CY2012 is not available until August, 2013. 2011 value used as estimate for 2012, The value entered is 4:3:1 plus >2or >3 doses of Hib vaccine depending on brand type (primary series only), 3 or more doses of HepB, and 1 or more doses of varicella vaccine.

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

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

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

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

Notes - 2010
NIS data for CY2010 is not available until August, 2011. 2009 value used as estimate for 2010, Prior to this year the rate reflected four or more doses of DTaP, three or more doses of poliovirus vaccine, one or more doses of any MCV, three or more doses of Hib, and three or more doses of HepB. That series is no longer reported in the NIS summary. The value entered is 4:3:1 plus >2 or >3 doses of Hib vaccine depending on brand type (primary series only), 3 or more doses of HepB, and 1 or more doses of varicella vaccine.

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

a. Last Year's Accomplishments
In 2012 the immunization program successfully deployed a new immunization registry based on the open-source Wisconsin Immunization Registry. Data was migrated from the previous system, and the replacement system went "live" on March 1st.

Quality Assurance Site Visits
In 2012, the IIP continued to conduct quality assurance reviews (QAR's) with Idaho's VFC providers. The program is still exceeding the CDC requirement to conduct visits with 50% of providers each year, with 66% of providers receiving a full VFC/AFIX visit in 2012. It is worth noting that other types of visits are done by the IIP staff and the staff of the local health departments, so that every provider in Idaho receives at least one, and usually more than one, visit each year.

Legislative
The 2012 legislative session was relatively quiet for the IIP. The only bill of interest was carried

by the Idaho Department of Insurance, and it made some modifications to the system that keeps vaccines free for insured children in Idaho. The changes included allowing for administrative costs to be charged to the program, and brought the list of vaccines required to be covered through the program into line with national recommendations.

Education and Promotion
In 2012 the CDC used Idaho as the kick-off location for National Infant Immunization Week, and the first International Infant Immunization Week. The IIP hosted the Deputy Director of the National Center on Immunization and Respiratory Diseases, Dr. Melinda Wharton, that week. Media, vaccine, and education events were held around the state during the week.

WIC and Immunization strengthened the ongoing collaboration for vaccine assessment and referral. IIP provided WIC staff with online training and abbreviated notes to allow for easy navigation through IRIS.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities
The 2013 legislative session is a bit more exciting than last year's. There are (were) three pieces of legislation of interest to the IIP. The first two were proposed to change the statute governing Idaho's immunization registry to allow for bi-directional data exchange (between the registry and Electronic Medical/Health Records), to allow for a connection to the state Health Data Exchange, to change the requirements for people opting-out of participation in the registry, and to clarify that the registry also includes adults. Due to strong opposition from anti-vaccine activists, these bills wer held in committee and will not be heard during the 2013 session.

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

c. Plan for the Coming Year

It is expected that the IIP will once again try to make the changes to the immunization registry statutes described in the "Current Year" section, during the 2014 legislative session.

Currently the IIP is trying to realign its systems and processes to adjust for the impact of the Affordable Care Act, Sequestration, the continuing resolution, and of a report issued by the HHS Office of the Inspector General which found a series of faults (nationally, not in Idaho) within the Vaccines for Children program. As a result of all of these factors, the CDC is issuing many policy changes which are significantly impacting state vaccine programs and 2013 is expected to be a period of significant change.

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

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	17.8	17.7	16	16	15
Annual Indicator	19.9	16.8	15.1	11.5	11.5
Numerator	651	548	505	385	385
Denominator	32772	32573	33362	33425	33425
Data Source	Estimate from prior year	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	15	15	14.5	14.5	14

Notes - 2012
Due to out-of-state birth certificates not received as of date of entry 2011 values are used as estimate.

Notes - 2011
Due to out-of-state birth certificates not received as of date of entry 2010 values are used as estimate.

a. Last Year's Accomplishments
During CY2012, family planning clinics around the state served a total of 2,165 (unduplicated) teens aged 15-17 years of age compared with 2,272 teens aged 15-17 years of age who received services in CY2011 -- a decrease of 4.7%, or 107 clients, who were served in CY2012 (Ahlers table AL-12). Idaho's 2011 teen pregnancy rate for 15-17 year olds is 15.1% (provisional data).

The 2010 teen pregnancy rate was 15.1 percent (final). The data shows a slight decrease in teen pregnancy rates for 2008 and 2009 and a slight decrease in the rates for 2010.

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

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

Funding was received for the Title X Family Planning Program for year 3 of a three-year special project, "Family Planning HIV Integration Project." Title X clinics offered and performed HIV Rapid Test screening from January 3, 2011 -- December 31, 2012. January 2011 noted one reactive (+) HIV Rapid test screening, which the client was referred for medical management following the positive confirmatory test. All other HIV Rapid Test screenings performed were non-reactive (negative).

During CY2012, the Ada County (Boise) Juvenile Detention Center project provided access to reproductive health care services for 111 high-risk adolescents. Residents were provided with the opportunity to receive services through weekly preventive reproductive health clinics. Pre- and post-test evaluations were given to measure the level of intention to change risky sexual behaviors.

During CY2012, the Adolescent Pregnancy Prevention (APP) Manager, the Family Planning Coordinator, the STD Prevention Coordinator, and the HIV Prevention Coordinator met to discuss collaboration and coordination efforts between their programs.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

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

based members and teen representatives. These relationships have allowed the boards to develop more trusting relationships with local groups.

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

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

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

c. Plan for the Coming Year

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

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

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

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

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

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	60.5	60.6	60.6	60.6	60.7
Annual Indicator	55.7	57.1	57.1	57.1	57.1
Numerator					
Denominator					
Data Source	Smile Survey	Smile Survey	Smile Survey	Smile Survey	Smile Survey

	2005	2009	2009	2009	2009
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	60	60	60	60	60

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

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

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

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

Notes - 2010
The Idaho Smile Survey is conducted every four years conducted through out the school year. Data was collected during the 2008/2009 school year.

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

a. Last Year's Accomplishments
Four of seven district health departments provided sealants to elementary school children. This was supplemented by a sealant program from Delta Dental. Delta Dental shares data with the Idaho Oral Health Program. It is estimated that between 25-49% of Idaho children have received sealants with the percentage being closer to 49%. School-based sealant clinics are provided by dental hygienists with extended access certification. In Idaho this means RDHs may provide sealants without the direct supervision of a dentist in a public health setting. During sealant clinics, the children receive oral health education. This comprehensive approach, which includes Delta Dental, has contributed to Idaho receiving a "B" in the 2012 Pew Report on Children's Oral Health. The Health Departments also conducted the fluoride mouth rinse programs in 140 schools with >50% free and reduced school lunch and in communities with no water fluoridation. The also provided fluoride varnish in WIC, Head Start and in school settings where they provide sealants. In all settings where oral health preventive services are provided, the Health Departments provide oral health education. In WIC settings oral health education is provided to women.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Title V support for oral health programs will be maintained at current levels.			X	
2. Oral health preventive services for children (fluoride, sealants, education).			X	
3. Idaho Oral Health Action Plan 2010-2015: Plan and implement goals and objectives.				X
4. Develop Burden document.				X
5. Conduct the Smile Survey.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Idaho Oral Health Program supports Idaho Medicaid's state oral health plan to increase the number of Medicaid children with sealants by 10%. The Idaho Oral Health Program is working with the Health Departments to stop the fluoride mouth rinse program and increase the number of children who receive sealants in a school setting. All Health Departments will be providing sealants starting with school year 2013-2014. Preparations are underway to equip all the Health Departments with sealant equipment, establish procedures for working with schools, billing, working with Delta Dental to coordinate schools, and negotiating contracts. During the school year 2012-2013, the Health Departments have been conducting the Smile Survey, which is statewide and conducted on third grade students. The Smile Survey is completed and awaiting analysis as of this report. The sample size is approximately 4,100 children. The Health Departments continue to provide fluoride varnish in community settings. The fluoride mouth rinse program will be completed as of June 2013. The Idaho Oral Health Program also receives funding from the DentaQuest Foundation to provide oral health services to children.

c. Plan for the Coming Year

The Idaho Oral Health Program will work with the Health Departments to implement the sealant program and report data. The Smile Survey data will be analyzed and reported. The Idaho Oral Health Program will continue to advocate to improve the oral health status of children. The Idaho Oral Health Program will continue to work with oral health organizations and community partners to establish programs and identify oral health policies to improve the oral health status of children.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	5.5	5.5	5.5	4.3	4
Annual Indicator	2.6	4.8	3.9	2.2	1.7
Numerator	9	17	14	8	6
Denominator	344821	351924	359922	359046	359046
Data Source	Death Certificates	Death Certificates	Death Certificates	Death Certificate	Dept of Transportation

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	3.9	3.9	3.8	3.8	3.8

Notes - 2012
Death count preliminary total from Idaho Dept of Transportatio for 2012. IDT records usually reflect deaths at the scene of an accident and therefore will be lower than subsequent death certificate data.

2012 population data by age not available at time of entry, 2011 used as best estimate.

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

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

The Idaho public may now access a variety of internal and external information resources on injury prevention and control to better protect their families and communities. Special emphasis is provided on the unintentional causes of injury including: Motor Vehicle Crashes, Poisoning, Drowning, Pedestrian & Cyclist Safety, and Fall Prevention for seniors. During 2012, there were 7,860 visits to our webpage to gain information about injury prevention.

Poisoning prevention public education continues to be a primary injury prevention intervention of the program. During 2012, the Department transitioned from the Rocky Mountain Poison & Drug Center to the Nebraska Regional Poison Center (NRPC) as the provider of poisoning prevention consultation services to Idaho residents, healthcare professionals, emergency management services and law enforcement. Evaluation and analysis of the call volume to NRPC continues to serve as a valuable source poisoning exposure information to the program. Lesson plans were developed and distributed throughout Idaho in 2012 to assist teachers and caregivers of pre-school age children in educating children and their parents about poison prevention and recognition in the home.

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

The Injury Prevention & Surveillance Program, in cooperation with the Idaho Department of Parks

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

Through December 31, 2012 Idaho has obligated over $5.4 million for Safe Routes to School (SR2S) projects. Funds are awarded through a competitive application process and all infrastructure and non-infrastructure project proposals are reviewed annually by the SR2S Advisory Committee. (The Injury Prevention & Surveillance program manager continues to serve as a member of the Advisory Committee.)

In 2010, the Injury Prevention & Surveillance Program helped develop the Idaho Highway Safety Coalition and continues its important work in developing Idaho Strategic Highway Safety Plan.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

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

i. Facilitate communications between NRPC and the Department to enhance rapid exchange of poison control and emergency health information.

ii. Maintain the Idaho Poison Control information database to collect, analyze and retrieve poison exposure data received from NRPC on a quarterly basis.

iii. Assist the Division of Health Administration in evaluating alternative funding sources for the continued support of Idaho Poison Control Services.

iv. Coordinate activities associated with the National Poison Prevention Week during March 2013.

Serve as Vice-Chair of the Idaho Safe Routes to School (SR2S) Advisory Committee.

i. Serve as State Advisory Committee Vice-Chair for the review and evaluation of annual community infrastructure and non-infrastructure improvement grants.

ii. Provide State Advisory Committee with technical assistance on pedestrian and bicycle prevention and control interventions from a public health perspective.

Serve as Department liaison to the Idaho Highway Safety Coalition.

Maintain and advance the Department's Injury Prevention and Control website.

c. Plan for the Coming Year
Injury Prevention & Surveillance Program emphasis areas for 2013 will continue to focus on reducing traffic crash fatalities, especially among vulnerable drivers (including teens); poison prevention activities directed toward parents of children 5 and younger and the reduction of prescription drug poisonings; drowning prevention; and a general expansion of public awareness associated with the burden of injury and its prevention.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	51.5	52	52.1	52.2	53
Annual Indicator	50.5	55.2	55.4	53	53
Numerator					
Denominator					
Data Source	PRATS	PRATS	PRATS	PRATS	PRATS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	53	53.1	53.1	53.1	53.1

Notes - 2012
Data source is the 2010 Idaho PRATS survey. Data for 2012 births is not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision.

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

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

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

Notes - 2010
Data source is 2009 Idaho PRATS survey. Data for 2010 not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision.

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

a. Last Year's Accomplishments
The State Breastfeeding Coordinator received training at the National WIC Association's 2012 Biennial Nutrition Education and Breastfeeding Conference.

The State WIC Program provided Local WIC Agencies with technical assistance to achieve higher standards in breastfeeding education and support.

State and Local Agency WIC staff collaborated with other breastfeeding professionals in Idaho in the beginning stages of establishing an Idaho Breastfeeding Coalition.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities
The State WIC Program provides Local WIC Agencies with technical assistance to achieve higher standards in breastfeeding education and support including implementing a new MIS.

The State WIC Program is hosting a training meeting for all Local WIC Agency staff. Breastfeeding training will be provided for all staff and a special session is scheduled for Breastfeeding Peer Counselors.

The State WIC Program is developing and enhancing MIS tools for improved breastfeeding communication and documentation.

Under the direction of the United States Breastfeeding Committee, the State WIC Program and Local WIC Agency staff are participating in the establishment of an Idaho Breastfeeding Coalition.

c. Plan for the Coming Year

The State WIC Office will continue to work with the State Breastfeeding Workgroup to provide technical assistance in enhancing Peer Counseling Programs and breastfeeding training for all WIC staff.

The State WIC Office will work with Maternal and Child Health to revise the Department of Health and Welfare breastfeeding website.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	98.8	98.8	98.8	98.8	99.6
Annual Indicator	97.9	99.3	99.5	99.4	99.3
Numerator		22179	21632	20273	20500
Denominator		22341	21751	20397	20650
Data Source	PRATS	HiTrack	HiTrack	HiTrack	HiTrack
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	99.6	99.6	99.6	99.6	99.6

Notes - 2011
Data Source is State NHS program tracking and surveillance program –HiTrack

a. Last Year's Accomplishments
Twenty percent of out-of hospital births were reported to the NHS program in 2012 due to the implementation of screening programs in 5 large midwife birth centers. Regional training and support for screening programs was divided among 3 pediatric audiologists. Specialized national training in pediatric audiology diagnostics was provided for all audiologists providing services to infants. The number of infants early diagnosed with hearing loss in 2012 increased to 63 from a previous high of 45.

Table 4a, National Performance Measures Summary Sheet

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

and the provision of a medical home.				
6. Assess needs of EHDI providers with regards to increased data integration, including upgrading to a web based data tracking system.				X
7.				
8.				
9.				
10.				

b. Current Activities
Regional audiologists have increased training efforts for the currently screening midwife centers with the goals of increasing the midwives reporting of birth numbers and their number of completed hearing screenings. Quarterly audiology phone chats are being hosted to encourage full participation by audiologists, including reporting to the state program, and increasing the quality of diagnostic services. Quality assurance and improvement training and site visits continue.

c. Plan for the Coming Year
Federal MCH- EHDI (Early Hearing Detection and Intervention) grant funding was decreased by 30 percent over the previous year's funding. The Program is focusing on increasing program efficiency and ensuring sustainability both in state procedures and operations and in individual site operations. A detailed Business Process Flow diagram will be developed and reviewed in order to identify and target areas of improvement both in program operations and in data reporting. The program will investigate possible data sources of missing birth and screening information, as well as opportunities for increasing program efficiency while decreasing the time required for data collection and system maintenance. A plan for integration with other electronic data systems will be developed.

Performance Measure 13: *Percent of children without health insurance.*

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	12.5	12.4	8.8	10	9
Annual Indicator	11.0	8.9	10.2	9.0	11.3
Numerator	45621	37161	42845	37721	48315
Denominator	414662	418764	421894	417962	427360
Data Source	Current Population Survey	Current Population Survey	Current Population	Current Population Survey	Current Population Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	9	9	8.9	8.9	8.9

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

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

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

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

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

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

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

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

Notes - 2010
Source: U.S. Census Bureau
Current Population Survey, Annual Social and Economic Supplement,

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

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

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

a. Last Year's Accomplishments
Idaho Medicaid saw an increase in enrollment of approximately 3% in the number of children enrolled in Idaho Medicaid in FFY 2012 over FFY 2011.

Idaho Medicaid received an incentive payment for FFY2011 and FFY2012 for increasing CHIP enrollment and streamlining eligibility processes.

Idaho Medicaid reported on nine clinical quality measures of participant care in our Annual CHIPRA Report.

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

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to implement, expand and monitor CHIP coverage through the child-only health coverage applications.				X
2. Monitor the impact of the Children's Redesign and work with Medicaid as appropriate.				X
3. MCH staff serve on the Covering Kids Coalition which is managed by Idaho Voices for Children to address health coverage for Idaho children.				X
4. Work with the Department of Insurance to address child specific issues as insurance exchanges and health care reform are implemented.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Idaho Medicaid currently partners with a CHIP outreach grantee whose goal is to target minority populations in specific under enrolled rural areas.

Currently in the process of contracting with a vendor to administer our first CAHPS survey to CHIP beneficiaries. The survey will establish a baseline for quality measurement based on care, as part of our ongoing effort to increase the number of quality measures we report to CMS.

Preparing for the full implementation of the Affordable Care Act, which will shift approximately 10,000 CHIP participants with income at or below 133% of FPG to traditional Medicaid coverage.

c. Plan for the Coming Year
Complete the transition of 10,000 CHIP participants to traditional Medicaid coverage.
Report on all claims based CHIPRA quality measures and the CAHPS survey.

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

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

Annual Objective and Performance	**2008**	**2009**	**2010**	**2011**	**2012**

Data					
Annual Performance Objective	31	30.9	30.8	29.5	29.4
Annual Indicator	31.3	30.1	29.5	29.4	28.9
Numerator	6762	7314	7259	7012	6555
Denominator	21581	24316	24629	23828	22716
Data Source	State WIC Data	State WIC Data	State WIC Data	State WIC Data	State WIC Data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	28.9	28.9	28.4	28.4	28.4

Notes - 2012
As of last certification visit per child.

Notes - 2010
Based on PedNSS data avail as of March 2011

a. Last Year's Accomplishments
WIC participated in the Idaho Hunger Relief Taskforce and the ID Hunger Summit. The mission of the Task Force is "To put public and private resources into action statewide in order to eliminate hunger and provide food security for all Idahoans."

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

WIC developed and implemented training materials to strengthen staff skills related to Participant Centered Services/Education (PCS/PCE), OARS counseling techniques and the Value Enhanced Nutrition Assessment (VENA) process. This is part of an ongoing national effort to Revitalize Quality Nutrition Services (RQNS) in WIC to enhance and strengthen the effectiveness of WIC nutrition services especially assessment and education towards achieving desired health outcome.

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

WIC utilized USDA/FNS and state developed materials to reinforce tailored nutrition education messages designed to promote healthy eating, breastfeeding and an active lifestyle.

WIC expanded methods of delivering nutrition/breastfeeding/activity education from individual counseling and group classes to also include Quick WIC (WIC interactive education fairs including things like cooking demonstrations, etc.).

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

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC participated in the Idaho Hunger Taskforce, ID Hunger Summit.				X
2. WIC participated in HEAL ID.				X
3. WIC developed/implemented staff training to strengthen nutrition services towards achieving a desired health outcome.				X
4. WIC provided tailored nutrition services/education aligned with DGA, promotion of WIC foods and breastfeeding, and an active lifestyle.			X	
5. WIC promoted/referred participants to other Title V funded programs.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

WIC continues to participate in the Idaho Hunger Relief Taskforce.

WIC continues to participate in HEAL ID including collaborating with IPAN.

WIC continues to develop and implement training materials to strengthen staff skills related to PCS/PCE, OARS counseling techniques and the VENA process.

WIC continues to promote WIC food packages which align with the DGA and offers breastfeeding resources/support.

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

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

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

c. Plan for the Coming Year

WIC will participate in the Idaho Hunger Relief Taskforce and the ID Hunger Summit. The mission of the Task Force is "To put public and private resources into action statewide in order to eliminate hunger and provide food security for all Idahoans."

WIC will participate in Healthy Eating Active Living (HEAL) Idaho. The primary focus of HEAL ID is to develop and maintain an active engaged network of partners working together; investing

resources and expertise to create/support an active living, healthy eating Idaho. Networking includes collaborating/planning with Idaho Physical Activity and Nutrition Program (IPAN).

WIC will implement regional Learning Management System (LMS) training modules to strengthen staff skills related to Participant Centered Services/Education (PCS/PCE), OARS counseling techniques and the Value Enhanced Nutrition Assessment (VENA) process. This is part of an ongoing national effort to Revitalize Quality Nutrition Services (RQNS) in WIC to enhance and strengthen the effectiveness of WIC nutrition services especially assessment and education towards achieving a desired health outcome.

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

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

WIC will offer participants a variety of nutrition/breastfeeding/activity education opportunities including individual counseling, group classes, Quick WIC (WIC interactive education fairs including things like cooking demonstrations, etc.) and any other feasible method.

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

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	8.5	8.5	8.4	8.4	8.3
Annual Indicator	8.8	9.1	8.8	8.1	8.1
Numerator	2198	2158	2033	1804	1804
Denominator	25101	23713	23173	22277	22277
Data Source	Birth certificate	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	8.3	8.3	8	8	8

Notes - 2012
Due to out-of-state birth certificates not received as of date of entry 2011 values are used as estimate.

Notes - 2010
Due to out-of-state birth certificates not received as of date of entry 2009 values are used as estimate.

a. Last Year's Accomplishments
Approximately 2% women calling the Idaho QuitLine and registering on the Idaho QuitNet report being pregnant (2012).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide Family Planning services to educate pregnant women on the risk of tobacco use.			X	
2. Provide WIC services to pregnant women.			X	
3. Provide Idaho QuitLine services.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Project Filter has a new vendor for telephone and online cessation services. This contract began in February 2013. The 1-800 Quit Now number remains the same; however, there is a new website (www.quitnow.net/Idaho). All of the quit coaches for the Idaho QuitLine and online cessation program, as well as the instructors for the local cessation services, are trained to work with pregnant women. Project Filter is not currently target pregnant women in our media efforts, but the local public health districts have been targeting pregnant women for their local group classes.

c. Plan for the Coming Year
Project Filter received $2,000,000 for FY13 to provide telephone and online cessation services, including 4-weeks of free Nicotine Replacement Therapy. This funding is also used to provide media and counter-marketing throughout the state. Project Filter will also receive $2,000,000 for FY14 to provide the same services.

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

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	11	10.9	9.8	9.8	9.8
Annual Indicator	15.3	8.7	16.5	23.3	23.3

Numerator	17	10	19	27	27
Denominator	110959	114944	115359	116117	116117
Data Source	Death Certificates	Death Certificates	Death Certificates	Death Certificates	Death Certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	16.5	16.5	16	16	16

Notes - 2012
2012 death records have not been finalized, 2011 deaths have been used as best estimate.

2012 population data by age not available at time of entry, 2011 used as best estimate.

a. Last Year's Accomplishments
We trained approximately 1,200 individuals last year in our Better Todays / Better Tomorrows For Children's Mental Health program, which was described in our previous reports.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities
Volunteers were trained on the new Idaho Suicide Prevention Hotline and on The Link Between Mental Illness and Stigma. A training was held for 33 clinicians on the implications of stigma in treatment. These trainings were held in October 2012. Our grant from SAMHSA under the Garrett Lee Smith Memorial Act closed on Sept. 30, and we are conducting data analysis now on a no cost extension. All other activities under the Awareness to Action Idaho Youth Suicide Prevention Project have ceased. We distribute a Mental Health ENews each month to 4,600

individuals on children's mental health research and practice under our Outreach Partner Grant with the National Institute of Mental Health, which continues through 2014. Under that grant, we conducted an ethics webinar in October 2012 for Idaho clinicians on considerations in referring clients to clinical trials. It was taught by patient advocates at the National Institutes of Health research laboratories in Bethesda.

c. Plan for the Coming Year
Continue to expand and conduct trainings related to suicide prevention.

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

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	75	75	99	99	99
Annual Indicator	99	99	99	99	99
Numerator					
Denominator					
Data Source	No reliable data	No reliable data source	No reliable data source	No reliable data source	No reliable data source
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	99	99	99	99	99

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

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

Notes - 2010
Prior to data year 2003, Idaho hospitals with a NICU were used as a proxy measure. However, Idaho has since found errors in that proxy measure and currently does not have a replacement measure. 99 entered to save form.

a. Last Year's Accomplishments

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

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

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. PRATS survey will monitor utilization of neonatal intensive care services.				X
2. Contractors with family planning, Title X services, will provide pregnancy testing and make referrals as appropriate.	X			
3. MCH staff will serve on the board of the Idaho Perinatal Project.				X
4. MCH staff will continue to promote the Text4baby program through partnerships with Idaho birth centers, hospitals, and providers.			X	
5. MCH staff will partner with March of Dimes and Association of State and Territorial Health Officers to meet the 8% challenge to reduce prematurity in Idaho.			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

As part of the ASTHO challenge to reduce preterm births and ensure more healthy births in the state, the Idaho MCH program and the local March of Dimes chapter will distribute PSAs to television stations throughout the state to encourage public awareness of the importance of waiting until labor occurs naturally or until 39 completed weeks of gestation before elective delivery. Awareness-building efforts will also be targeted to rural areas of the state as these areas have higher rates of non-medically indicated elective inductions prior to 39 weeks.

c. Plan for the Coming Year

The MCH Program will continue to work with the March of Dimes on the ASTHO challenge. The MCH Program will also explore methods of capturing data on very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	73	73.2	73.2	73.2	73.6
Annual Indicator	69.4	71.5	73.6	74.4	74.4
Numerator	17177	16880	17016	16529	16529
Denominator	24737	23611	23104	22206	22206
Data Source	Birth certificate	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	75	75	75.5	75.5	75.5

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

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

Due to out-of-state birth certificates not received as of date of entry 2011 values are used as estimate.

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

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

Notes - 2010
2004, the Idaho birth certificate was revised. Beginning in 2004, Idaho prenatal care data are based on date of first prenatal care visit as reported in the mother's medical record. Data are not comparable with Idaho or national data based on month prenatal care began. Prior to the revision, month prenatal care began may have been estimated from mother's recollection or based on information in mother's medical record

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

a. Last Year's Accomplishments
During CY 2012, 21,252 (unduplicated) women received counseling from the Title X Family Planning Program. There were a total of 2,604 pregnancy tests, of which 46% (766) were planned and 54% (874) were unplanned. All women were screened for high-risk behaviors and referral made as indicated. All women having positive pregnancy tests were provided with options counseling and referred appropriately to obstetricians to begin early prenatal care.

Table 4a, National Performance Measures Summary Sheet

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

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

Funding was received from the Title X Family Planning Program for year 3 of a three-year special project, "Family Planning HIV Integration Project." Title X clinics implemented HIV Rapid Test screenings in all Title X clinic sites on January 3, 2011. All Title X clients were offered, and continue to be offered, a HIV Rapid screening test through CY 2013.

c. Plan for the Coming Year
Women will receive program services including counseling from the Title X Family Planning Program. Women with positive pregnant tests are screened for high-risk behaviors and appropriately referred. Pregnant women will be appropriately referred to obstetricians to begin early prenatal care.

HIV Rapid Test screenings will continue per activities specified in year 3 of the three-year special

project, "Family Planning HIV Integration Project," funded by the Title X Family Planning Program. Clients with reactive screening test will be offered confirmatory testing. Clients with a positive confirmatory test are referred for medical management of the diagnosis.

D. State Performance Measures

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

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective			35.5	39	39
Annual Indicator	42	39	39	40	40
Numerator					
Denominator					
Data Source	YRBS	YRBS	YRBS	YRBS	YRBS
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	39	39	38.9	38.9	38.9

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

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

Notes - 2010
Results from: RESULTS OF THE 2009 IDAHO YOUTH RISK BEHAVIOR SURVEY , Numerator and denominator not available. Latest data available.

a. Last Year's Accomplishments
During CY 2012, family clinics around the state served a total of 2,165 teens 15-17 years of age compared with 2,272 teens aged 15-17 years of age who received services in CY2011 -- a decrease of 4.7%, or 107 clients, who were served in CY2012 (Ahlers table AL-12). Idaho's 2011 teen pregnancy rate for 15-17 year olds is 15.1% (provisional data). The 2010 teen pregnancy rate was 15.1 percent (final.) The data shows a slight decrease in teen pregnancy rates for 2008 and 2009 and a slight decrease in the rates for 2010.

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

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

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

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

During CY2012, the Ada County (Boise) Juvenile Detention Center project provided access to reproductive health care services for 111 high-risk adolescents. Residents were provided with the opportunity to receive services through weekly preventive reproductive health clinics. Pre- and post-test evaluations were given to measure the level of intention to change risky sexual behaviors.

During CY2012, the Adolescent Pregnancy Prevention Manager, the Family Planning Coordinator, the STD Prevention Coordinator, and the HIV Prevention Coordinator met to discuss collaboration and coordination efforts between their programs.

b. Current Activities

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

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

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

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

c. Plan for the Coming Year

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

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

The Ada County Juvenile Detention Center project will continue during CY2013. The project provides access to reproductive health care services for high-risk adolescents. Residents will be given the opportunity to receive services through weekly preventive reproductive health clinics.

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

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

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective			55	55	55
Annual Indicator	45.3	53.9	53.9	51.1	51.1
Numerator					
Denominator					
Data Source	PRATS	PRATS	PRATS	PRATS	PRATS
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	55	55	55	55	55

Notes - 2012
Data source is the 2010 Idaho PRATS survey. Data for 2012 births is not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision.

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

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

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

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

Notes - 2010
Data source is 2009 Idaho PRATS survey. 2010 data not available at entry date. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numerator and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision.

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

a. Last Year's Accomplishments
Six of seven Health Departments provide education to pregnant women in WIC clinics. The Idaho Oral Health Program does not have a systematic approach to ensure pregnant women receive dental care during pregnancy. However, funding from the Dental Quest Foundation is

allowing two community health centers to establish systems to refer pregnant women to the dentist and provide oral health education.

b. Current Activities
The Idaho Oral Health Program in partnership with the Health Departments continues to provide oral health education to pregnant women in WIC clinics and other settings as appropriate. The Idaho Oral Health Program is working with the two community health centers to develop strategies for educating pregnant women. Information is also provided to some OB-GYN clinics to inform patients about oral health during pregnancy

c. Plan for the Coming Year
The plan for 2014 at this time remains the same.

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

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective			18	18	18
Annual Indicator	11	20.8	20.8	22.6	22.6
Numerator					
Denominator					
Data Source	YRBS	YRBS	YRBS	YRBS	YRBS
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	18	18	18	18	18

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

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

Notes - 2010
Source is 2009 YRBS. Numerator and denominator not available as the source is weighted survey data and would imply artificial precision.

a. Last Year's Accomplishments
The Idaho Physical Activity and Nutrition Program (IPAN) contracted with the seven local public health districts to complete the Community Health Assessment and Group Evaluation (CHANGE Tool) in one community within their respective district. The CHANGE Tool walks community team members through an assessment process and helps define and prioritize possible areas of improvement. The five community sectors that are assessed are the following: schools, healthcare, community institutions and organizations, worksites and community at large. Each health district completed the CHANGE tool assessment phase and developed both long term and short term community action plans based on the needs of their community that were determined by the assessment.

The community action plans that were developed were the following:

1) Health District 1:
- Create a community resource guide that contains information on community healthy living opportunities. These guides will be distributed at health care settings, online and other community sites.
- Install way-finding signage on trail ways, and increase trail usage.

2) Health District 2:
- Implement wellness toolkits at health care settings to inform patients on physical activity, healthy nutrition and mental health benefits and community resources.
- Expand the Lunch for Life program to more schools in the area.
- Incorporate wellness guidelines and initiatives in worksites.
- Establish a community garden in downtown Lewiston.

3) Health District 3:
- Provide tobacco cessation education for youth, adults and school staff.
- Construct a walking path at Emmett City Park.

4) Health District 4:
- Work with community faith based organizations and schools to host healthy food drives to ensure food collected and given to local food pantries meets healthy nutrition standards.
- Implement healthy portion sizes in at least 2 food retail venues.
- Increase the number of transportation alternatives such as transit, walking and biking.
- Implement healthy worksite policies and initiatives addressing healthy eating and physical activity in Meridian worksites.

5) Health District 5:
- Work with city officials to permit distribution of health information along with city mailings.
- Implement healthy food vending options at community 4th of July celebration.
- Increase usage of city walking path
- Assist employers in implementing heart healthy policies at their worksite

6) Health District 6
- Establish health checkout lines in local grocers
- Increase physical activity for elementary school students at recess
- Increase usage of the local walking path, the Portneuf Greenway

7) Health District 7
- Increase awareness and use of community resources, including biking/walking paths

Each health district conducted a BMI screening of a sample of 3rd grade students within their district. The data collected was compiled and reported out by BCEH on statewide, district and individual school levels. The public health districts then disseminated the reports to each participating school.

IPAN also continued to support the HEAL Idaho Network, consisting of over 150 individuals and organizations statewide. The HEAL Network created an Advisory Committee of approximately 10 members representing the entire network geographically and by sector. The IPAN staff lead the Advisory Committee and continue to move the group forward. Two HEAL network meetings were held in 2012 that provided opportunities for networking and education, as well as presentations on the community CHANGE Tool work throughout the state.

b. Current Activities

IPAN continues to work with local public health districts on implementation of community action plans listed above. The health districts have sought out additional sources of funding for implementation activities, including funds from other Bureau of Community and Environmental Health Programs (Heart Disease and Stroke Prevention Program, Diabetes Prevention and Control Program). IPAN will also contract with the districts to work in large early child care centers and worksites on promoting healthy nutrition/food service guidelines and physical activity. They will conduct an assessment of large child care facilities and hold meetings with Head Start centers to determine the current nutrition and physical activity practices. Districts will promote a recognized worksite wellness program in a select number of worksites in their districts as well.

IPAN has an MOU with the State Department of Education to continue the YRBS and School Health Profile surveys. IPAN and SDE will also work to promote healthy nutrition and physical activity practices in all schools statewide through Coordinated School Health connections, the wellness plans created through the USDA School Meals program, and other means.
IPAN will continue to lead the HEAL Idaho Advisory Committee and network. Regional HEAL meetings were held during Spring 2013, hosted by CHANGE Communities. An annual HEAL summit will be held in October 2013 bringing in partners across the state to address community initiatives.

c. Plan for the Coming Year
In 2014, IPAN will further the work in early child care centers and worksites through contracts with the local public health districts. The early child care assessment will be completed and an educational training planned based on the results of the assessment. The training will cover best practices on physical activity and nutrition standards for early child care centers based on the needs and gaps identified in the assessment. Worksite wellness programs will be expanded to more worksites throughout the district.
IPAN will keep the MOU with SDE to continue work in the schools around promoting healthy nutrition and comprehensive school physical activity programs.
The HEAL network will continue to be led by IPAN staff. An annual summit will be the only network face to face meeting, but will be highlighted with national keynote speakers, excellent educational workshops and networking opportunities statewide. The HEAL Facebook site will be launched to promote networking and dissemination of information on a constant basis. The HEAL Idaho Framework will be updated with current data, success stories and best practice recommendations.

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

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective			59	59	59
Annual Indicator	51.2	49.8	48.2	49.7	49.7
Numerator	12431	11475	10943	10890	10890
Denominator	24289	23036	22684	21909	21909
Data Source	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	59	59	59	59	59

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

Due to out-of-state birth certificates not received as of date of entry, 2011 values are used as estimate.

Notes - 2011

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

Notes - 2010
Based on records where valid pre-pregnancy height and weight were recorded on birth certificates.

a. Last Year's Accomplishments
In 2010, the Idaho Physical Activity and Nutrition Program launched the Healthy Eating, Active Living (HEAL) Idaho Network to develop a comprehensive statewide strategic operations framework to address nutrition and physical activity for Idahoans of all ages. HEAL Idaho is a voluntary network of organizations, agencies, businesses, and individuals committed to creating an environment where all Idahoans have access to healthy food options and opportunities to be physically active to improve their health and well-being. The goals or benchmarks of success for the HEAL Idaho Framework for 2001-2013 are:

- Idaho children and adults report an increase in physical activity and healthy eating that promotes health and well-being.
- Recommended dietary and physical activity guidelines are followed by Idaho's children and adults to achieve healthy weight and prevention of chronic disease.
- The infrastructure is in place that supports all Idahoans' ability to eat healthy foods and be physically active.
- Healthy eating and active living efforts in Idaho are sustainable and utilize coordinated approaches.

b. Current Activities
HEAL Idaho continues to build membership, exchange information and access resources via the statewide website, and hold regular regional and statewide meetings. Agencies and organizations work together to make recommendations for the framework and identify best practices for addressing nutrition and physical activity. Idaho WIC program is a member of the HEAL Idaho Network. The HEAL Idaho Network is hosting five regional meetings throughout Idaho during the spring of 2013. The meetings feature speakers from local communities and highlight successes in addressing obesity in the community through nutrition and physical activity initiatives.

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

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

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

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012

Annual Performance Objective			43	43	43
Annual Indicator	38.6	40.3	40.3	41.3	41.3
Numerator					
Denominator					
Data Source	PRATS	PRATS	PRATS	PRATS	PRATS
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	43	43	43	43	43

Notes - 2012
Data source is the 2010 Idaho PRATS survey. Data for 2012 births is not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision.

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

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

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

Notes - 2010
Data source is 2009 Idaho PRATS survey. 2010 data not available as of entry date. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numerator and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision.

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

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

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

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

Another avenue to promote preconception health behaviors such as multivitamin use is through the Healthy Eating, Active Living (HEAL) Idaho Network which published a framework and made

recommendations for best practices to impact nutrition and health behaviors in 2011. As HEAL Idaho continues to grow, impact to MCH populations will be monitored.

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

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

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

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective			35	50	50
Annual Indicator	77	79.2	79.2	78.7	78.7
Numerator					
Denominator					
Data Source	PRATS	PRATS	PRATS	PRATS	PRATS
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	50	50	50	50	50

Notes - 2012
Data source is the 2010 Idaho PRATS survey. Data for 2012 births is not available at time of submission. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numeration and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision.

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

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

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

Notes - 2010
Data source is 2009 Idaho PRATS survey. 2010 data not available at entry date. PRATS is a representative sample of resident women aged 18+ who gave birth in Idaho. Numerator and denominator not provided as they would be the results of weighted survey sample data and imply artificial precision.

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

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

Through the Idaho Maternal, Infant, and Early Childhood (MIECHV) program's steering committee, the MCH program strengthened its relationship with the Idaho Substance Abuse program's Pregnant Women and Women with Dependent Children (PWWC) program. The PWWC program has identified a network of providers to serve the specific needs of pregnant women and women with children who are facing substance use issues. This network will be used as a referral source for women enrolled in the MIECHV program. We will monitor referral and alcohol use data since the MIECHV program service delivery began in June 2012.

b. Current Activities
MIECHV local implementing agencies are currently providing home visiting services to families in north and south central Idaho. Currently, home visitors discuss and gather information from pregnant and non-pregnant women about alcohol, tobacco, and illicit drug use prior to and during pregnancy.

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

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

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

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective			90	90	90
Annual Indicator	85.2	85.0	85.8	86.4	91.1
Numerator	18966	19240	19654	19675	21761
Denominator	22257	22624	22913	22762	23888
Data Source	Summary SIR	SIR 2009	SIR 2010	SIR 2011	SIR 2012
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	91	91	91	91	91.1

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

The numerator includes a record category of "Conditional Admittance" which counts students with

partial immunization series where parents/guardians indicated they would bring the child up to date within three weeks.

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

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

Notes - 2010
SIR = State Immunization Report

a. Last Year's Accomplishments
In 2011, the administrative rules that govern immunization requirements for children attending Idaho schools were updated. Students born after September 1, 2005 are now required to receive two doses of varicella and two doses of hepatitis A vaccines to enter school. During the 2010-11 school year, 70.8% of kindergarteners had received varicella and 72.2% of had received hepatitis A vaccine. During the 2011-12 school year, after the implementation of the new school entry immunization requirements, 85.8% of kindergarteners had received varicella and 86.6% of had received hepatitis A vaccine.

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

c. Plan for the Coming Year
One of the issues facing the Immunization Program is how to handle those schools who have a large percentage of children who are neither up-to-date with their vaccines nor have exemption forms on file. The non-compliant children are in breach of state law, but enforcement mechanisms are unclear. Discussions with the Idaho Department of Education have begun, and some may be taken to increase enforcement.

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

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective			95	95	95
Annual Indicator	94.4	93.8	93.5	78.3	81.3
Numerator	20327	19997	20293	17736	18396
Denominator	21539	21317	21714	22659	22636
Data Source	No data available	SIR 2009	SIR 2010	SIR 2011	SIR 2012

Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	95	95	95	95	95

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

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

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

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

Notes - 2010
SIR = State Immunization Report

a. Last Year's Accomplishments
In 2011, the administrative rules that govern immunization requirements for children attending Idaho schools were updated. Students are now required to receive Tdap and meningococcal vaccines to enter the seventh grade. During the 2010-11 school year, 14.2% of seventh grade students had received Tdap and 5.6% of had received meningococcal vaccine. During the 2011-12 school year, after the implementation of the new seventh grade immunization requirements, 80.6% of seventh grade students had received Tdap and 79.8% of had received meningococcal vaccine.

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

c. Plan for the Coming Year
One of the issues facing the Immunization Program is how to handle those schools who have a large percentage of children who are neither up-to-date with their vaccines nor have exemption forms on file. The non-compliant children are in breach of state law, but enforcement

mechanisms are unclear. Discussions with the Idaho Department of Education have begun, and some may be taken to increase enforcement.

E. Health Status Indicators

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01B - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	5.0	5.2	5.2	4.5	4.5
Numerator	1216	1189	1175	976	976
Denominator	24387	23021	22463	21623	21623
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Denominator is the total number of singleton births to Idaho women minus the number of births in which birth weight was unknown.

Due to out-of-state birth certificates not received as of date of entry 2011 values are used as estimate.

Notes - 2011
Denominator is the total number of singleton births to Idaho women minus the number of births in which birth weight was unknown.

Notes - 2010
Denominator is the total number of singleton births to Idaho women minus the number of births in which birth weight was unknown.

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

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

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	112	100	2	5	1	0	1	3
Children 1 through 4	30	26	1	0	1	0	0	2
Children 5 through 9	14	13	0	0	0	0	0	1
Children 10 through 14	14	14	0	0	0	0	0	0
Children 15 through 19	86	77	1	4	0	0	1	3
Children 20 through 24	89	81	1	4	0	0	1	2
Children 0 through 24	345	311	5	13	2	0	3	11

Notes - 2014

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

F. Other Program Activities

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

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

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

G. Technical Assistance

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

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

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

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

V. Budget Narrative

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

Form 3, State MCH Funding Profile

	FY 2012		FY 2013		FY 2014	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	3203380	2785566	3203380		3203380	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	2402535	2089174	2402535		2402535	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	5605915	4874740	5605915		5605915	
8. Other Federal Funds *(Line10, Form 2)*	36440601	38400114	40530062		38058901	
9. Total *(Line11, Form 2)*	42046516	43274854	46135977		43664816	

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

	FY 2012		FY 2013		FY 2014	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	242818	276728	314376		369616	
b. Infants < 1 year old	1373275	1137144	1377507		1381248	
c. Children 1 to 22 years old	2218445	2019208	2190196		2176867	
d. Children with	1280507	1001749	1255566		1164248	

Special Healthcare Needs						
e. Others	265870	299432	265870		248620	
f. Administration	225000	140479	202400		265316	
g. SUBTOTAL	5605915	4874740	5605915		5605915	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	0		0		0	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	29369567		32684119		30320679	
h. AIDS	2133507		2550540		2679762	
i. CDC	2319421		2049784		2182100	
j. Education	0		0		0	
k. Home Visiting	0		1317564		1000000	
k. Other						
Title X					1876360	
Title X			1928055			
MIECHV	1000000					
Ttile X	1618106					

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

	FY 2012		FY 2013		FY 2014	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	1809050	1631284	1773050		1471550	
II. Enabling Services	46750	48318	46750		45000	
III. Population-Based Services	2964335	2687841	2937268		2921667	
IV. Infrastructure Building Services	785780	507297	848847		1167698	
V. Federal-State Title V Block Grant Partnership Total	5605915	4874740	5605915		5605915	

A. Expenditures

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

Funds used for state match during federal fiscal year 2011 (FFY 11) are from local funds ($2,123,182), contributed by the local health districts to help support the childhood Immunization Program. No state general funds are used to support MCH programming.

The expenditures in FFY 11 that were directed to Pregnant Women included 25% of the MCH administrative budget ($29,087), 40% of the MCH STD budget ($7,242), 25% of the Office of Epidemiology, Immunization and Food Protection MCH budget ($56,458), 20% of the

Reproductive Health MCH budget ($131,493), and 25% of the Idaho CareLine MCH budget ($11,175).

Funds used in FFY 11 for infants < 1 Year Old included 25% of the MCH administrative budget ($29,087), 25% of the Office of Epidemiology, Immunization and Food Protection MCH budget ($56,458), 25% of the Idaho CareLine MCH budget ($11,175), and 50% of the local match ($1,061,591).

Expenditures for Children 1 to 22 Years Old included 25% of the MCH administrative budget ($29,087), 30% of the MCH STD budget ($5,431), 25% of the Office of Epidemiology, Immunization and Food Protection MCH budget ($56,458), 25% of the Idaho CareLine MCH budget ($11,175), 50% of the Immunization Program local funds used for block grant match ($1,061,591), 100% of the Oral Health Program ($386,079), 100% of the injury funds ($312,965) and 40% of the MCH budget for Reproductive Health ($262,987).

Expenditures for Children with Special Health Care Needs included 25% of the MCH administrative budget ($29,087), 25% of the Idaho CareLine MCH budget ($11,175), 25% of the Office of Epidemiology, Immunization and Food Protection MCH budget ($56,458), 100% of the Genetics Program ($125,014) and the Children's Special Health Program ($816,546).

Forty percent (40%) or $262,987 of the MCH funds directed to the Reproductive Health Program were spent in the Other category, which primarily includes women of reproductive age who are older than 22 years of age as well as males. Thirty percent (30%), or $5,431, of the MCH STD funds were spent in the Other category. Indirect costs charged against the MCH Block Grant in FFY 11 totaled $127,855 in the Administrative category.

FFY 11 expenditures by service category are as follows: Direct Health Care Services accounted for 90% of the genetics Program budget ($112,513), 100% of the Reproductive Health Program budget ($657,467) and 100% of the Children's Special Health Program budget ($816,546). The two programs included under enabling services were the Idaho CareLine ($44,700) and 10% ($1,810) of the MCH money supporting the STD program. Programs included in the Population-Based Services category were 100% of the Oral Health Program ($386,079), 100% of the Injury Prevention Program ($312,965), childhood Immunizations ($2,123,182 -- local match), and 90% of the MCH STD funds ($16,294).

Programs included under infrastructure Building Services included: 100% of MCH Administration ($116,348), 100% of Office of Epidemiology, Immunization and Food Protection ($225,832), 10% of the Genetics Program ($12,501), and the indirect budget ($127,855).

Total reported MCH expenditures for Idaho during FFY 11 are $4,954,092.

B. Budget

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

The priority areas for Idaho are children with special health care needs, reproductive health for young women, oral health of children, injury prevention, epidemiology services and genetics. These programs account for the majority of spending. Funding for the State Children's Special Health Program and Genetics account for the majority of funds used to meet 30% minimum required for CSHCN. In fact, those two programs alone account for 35.4% of the block grant funds. The programs under Preventive and Primary Care for Children that receive the largest amount of funds include Oral Health, Reproductive Health, and Injury Prevention.

MCH funds will again be used to fund a full-time research analyst dedicated to MCH programs.

The position, while housed in the Bureau of Vital Records and Health Statistics, is dedicated to MCH programming. For the past three years (2009 -- 2011) this position has been funded through receipts, which is no longer feasible due to declining birth rates. With the decline in receipts, MCH funds will also be used to support a portion of the costs associated with the Pregnancy Risk Assessment and Tracking System (PRATS) survey.

With diminishing federal funds and no state general funds supporting MCH programming "special projects" have been eliminated and funds have been moved from the administrative budget to programming.

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

Idaho's Children's Special Health Program has improved efficiencies and service delivery through its relationship with St. Luke's Children's Hospital. In order to more effectively manage eligibility issues, in 2010 all care coordination was moved back into the program, leaving the Children's Hospital responsible for the service delivery for the Children's Special Health Program and Genetics Clinics. This has proven to be a very successful change and has resulted in improved customer service to our families. While the majority of the genetics and metabolics clinics are conducted at the Children's Hospital in Boise, the two physicians that support these clinics do travel hold clinics throughout the state. The Children's Special Health Program and Genetics Clinic together account for 35.4% of the MCH Block Grant expenditures. This decrease in percentage from 39.5% in 2010 is because the Children's Hospital has taken on the billing function where appropriate and is much more successful in collecting than the program had been.

During the 2010 state legislative session a vaccine assessment fund was created to provide funding to maintain Idaho's status as a universal vaccine provision state. In state fiscal year 2011 the Division of Public Health used approximately $6,400,000 from the fund to provide childhood vaccines at no cost to all Idaho children. While this assessment fund helps ensure the health of Idaho children, the money cannot be used for any purpose other than the purchase of childhood vaccines. In state fiscal year 2012 the expenditure from the fund will be $13,618,979. During 2011 some costs were offset by federal ARRA funds and providers are giving more childhood immunizations in an effort to improve Idaho's rates. Additionally, in 2011, the program was not providing all ACIP recommended vaccines; specifically flu and HPV. Another jump is anticipated in the coming year, bringing expenditures to approximately $17 million. This increase will be primarily due to inflation and adding coverage of HPV vaccine for boys.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.