



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

**State Narrative for
Louisiana**

**Application for 2013
Annual Report for 2011**



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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.

An attachment is included in this section. IA - Letter of Transmittal

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 will be maintained on file in the MCH program's central office. Requests for copies of these documents may be obtained by sending a written request by fax to (504) 568-3503 or by mail to the following address:

MCH Block Grant Coordinator
Office of Public Health
Maternal and Child Health Section
1010 Common Street
Suite 2710
New Orleans, LA 70112

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MCH Block Grant Coordinator
Office of Public Health
Maternal and Child Health Section
P.O. Box 60630
New Orleans, LA 70160 //2012//

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***MCH Block Grant Coordinator
Office of Public Health
Maternal and Child Health Section
P.O. Box 60630
New Orleans, LA 70160//2013//***

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

Public input for the 2010 needs assessment placed significant emphasis on consumer feedback and stakeholder engagement. MCH conducted a consumer survey which assessed the importance of MCH issues including women's health, infant health, child health, adolescent health, oral health and access to services. Clients of the state's 82 parish health units were asked to participate in the survey over a two month period. Over 2,500 clients provided valuable feedback on the MCH issues most important to them.

Stakeholder engagement for the 2010 needs assessment was conducted at the community, regional and state levels. MCH staff presented epidemiological data along with consumer survey feedback to community groups, regional stakeholders and state level stakeholders in an effort to assess priority MCH needs and discuss practical strategies for implementation. Stakeholders totaling 576 participants across the state, included Regional Fetal and Infant Mortality Review Community Action Team and Case Review Team members, Office of Public Health regional staff, and regional representatives from the Office of Addictive Disorders, HIV/AIDS Program, Family Planning Program, Healthy Start Programs, Nurse Family Partnership Program, Tobacco Control Program, Tobacco Free Living Program, Children's Cabinet Advisory Board, Early Childhood Comprehensive Systems interagency committee, School Based Health Centers, American Academy of Pediatrics-Louisiana Chapter, child death review panels, EMSC Advisory Council, safety and injury advocates, first responders, law enforcement, Oral Health Coalition members, dental health professionals, dental associations, families of children with special health care needs (CSHCN), CSHCN affiliated agencies, local hospital leadership, MCH advocacy organizations, and academic institutions.

Results of the needs assessment will be disseminated to the public using a variety of methods. MCH's Partners for Healthy Babies site will include a list of the leading MCH priority needs as well as provide links on the DHH website for public access and review. MCH will also share the results of the needs assessment with all stakeholders via the existing Fetal and Infant Mortality Review and Screening Brief Intervention Referral and Treatment regional networks, MCH Coalition members, and other partners.

The Title V Application is accessible to all Louisiana's citizens via Internet access. A summarized version of the application was posted to the MCH website on 5/10/10 (see attachment) and a notice of the posting of the grant was published in the Louisiana Register in June 2010. The summary document was reviewed by 30 Children with Special Healthcare Needs (CHCN) Stakeholders from all 9 administrative regions of the state.

/2012/ MCH shared the an executive summary of the results of the needs assessment with all stakeholders via the existing Fetal and Infant Mortality Review and Screening Brief Intervention Referral and Treatment regional networks, MCH Coalition members, OPH Regional Administrators and other partners. The 2010 Needs Assessment Executive Summary was posted to the OPH website and linked to the MCH Partners for Healthy Babies website. An online stakeholder satisfaction survey was developed and recipients of the executive summary were asked to provide input on the Needs Assessment process. There were 80 participants in the online feedback survey. The results were as follows: 60% of stakeholders agreed and 26.3% strongly agreed that the priority needs identified in the Needs Assessment accurately reflected what they believed were the top priority needs of the state; 62.5% of stakeholders agreed and 22.5% strongly agreed that the priority needs identified accurately reflected the priority needs of their public health region; 58.8% of stakeholders agreed and 20% strongly agreed that their voice was heard during the needs assessment process; 58.8% of stakeholders agreed and 26.3% strongly agreed that the Needs Assessment process was useful; 61.3% of stakeholders agreed and 30% strongly agreed that based upon their experience in the needs assessment process, they would participate in future needs assessments. The Needs Assessment Executive Summary was also distributed to state libraries for placement on the library kiosk for public review.

The Title V Application is accessible to all Louisiana's citizens via internet access. A summarized version of the application was posted to the MCH website on 6/10/11 (see attachment) and a

notice of the posting of the grant was published in the Louisiana Register in June 2011. The summary document was reviewed by 30 Children with Special Healthcare Needs (CHCN) Stakeholders from all 9 administrative regions of the state.//2012//

/2013/The Title V Application is accessible to all Louisiana citizens via internet. A summarized version (see attachment) of the application was posted to the MCH and the Partners for Healthy Babies websites in June 2012. A notice of the posting of was also published in the Louisiana Register in June 2012. A link to the summary document was also sent to over 240 email subscribers of the MCH newsletter and to partners of the MCH Coalition. The summary document was reviewed by 10 Children with Special Healthcare Needs (CHCN) Stakeholders from all 9 administrative regions of the state.//2013//

An attachment is included in this section. IE - Public Input

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The MCH staff in collaboration with MCH stakeholders identified the following priority needs in the 2010 Needs Assessment: 1) Decrease infant mortality through the reduction of preterm births in the African American population; 2) Decrease intentional and unintentional injuries in the maternal, child, adolescent, and CSHCN populations; 3) Improve preconception and interconception health among Louisiana women; 4) Reduce unintended pregnancies and reduce births spaced at less than 24 months apart; 5) Increase care coordination for CSHCN and their families; 6) Improve the nutritional health of the maternal and child population with a focus on obesity prevention and breastfeeding; 7) Assure that strategies and methods in MCH and CSHCN programs are culturally competent to reduce racial disparities; 8) Improve oral health of MCH and CSHCN population by increasing access to preventive measures and access to oral health care; 9) Improve the behavioral health of the MCH and CSHCN populations through prevention, early intervention, screening, referral, and treatment, where appropriate; 10) Increase preventive services for adolescents and transition services for youth with special health care needs (YSHCN).

Similar to the 2005 Needs Assessment, the MCH program formed a steering committee that planned and organized the 2010 Needs Assessment. Based on the successful planning and implementation of the needs assessment in 2005, the steering committee again decided to organize the 2010 Needs Assessment into five subgroups: Adolescent Health, Child Health, Maternal Health, Oral Health, and Children with Special Health Care Needs.

Many of the priority needs identified in the 2010 Needs Assessment mirrored those priority needs identified in 2005. However, there were several noteworthy changes in priority needs identified and shifts in program focus that are reflected in the 2010 priority needs selected. Priority needs in 2005 that were absent from the 2010 priority needs list remain important. The absence of specific priority needs indicates the success of the MCH program in addressing these particular priority areas. Despite their absence the MCH program continues to be vigilant in monitoring these priority areas.

Decreasing intentional and unintentional injuries among maternal, child, adolescent, and children with special health care needs (CYSHCN) populations, increasing care coordination for CSHCN and their families, improving the nutritional health of maternal and child populations with a focus on obesity prevention and breastfeeding, improving oral health of MCH and CSHCN populations, and improving the mental health of MCH and CSHCN populations were each identified as priority needs in 2005 and remain top priorities in 2010.

As alluded to previously, the 2010 needs assessment includes several new priorities. These priority needs were decreasing infant mortality by reducing preterm births among African Americans (Priority Need #1) improving preconception and interconception health (Priority Need #3), Reducing unintended pregnancies and births spaced at less than 24 months (Priority Need #4), assuring that strategies and methods in programs are culturally competent (Priority Need #7) and increasing preventive services for adolescents and transition services for (YSHCN) (Priority Need #10).

In 2005, decreasing infant mortality and morbidity by partnering with regional stakeholders was a top priority. Specifically, the priority need in 2005 was to "decrease infant mortality and morbidity in collaboration with regional coalitions comprised of public and private health and social service providers". In 2010 this priority need was modified in an effort to gain better precision in targeting

those factors that influence infant mortality (IMR) and morbidity. By focusing on the African American population, who has disproportionately higher IMR's than whites, reflects the MCH program's commitment to reducing the primary driver of the state's overall high IMR and also reflects the programs commitment to reducing race based health disparities. The reduction of race disparities remains an important objective of the MCH program. This resulted in the inclusion of priority need #7. Programs such as Partners for Health Babies and the Nurse Family Partnership continue to develop marketing materials and other programming that are culturally competent. In addition, the epidemiology staff, monitor data on race and ethnicity in an effort to support and inform program decisions. New activities also include partnering with the state's Tobacco Control Program and Tobacco Free Living Program to develop cessation programs for pregnant women. The MCH program will provide resources to staff a full time position that will work with Tobacco Control staff to develop and evaluate approaches that ensure tobacco referrals and interventions are culturally competent. In 2009, The Stork Reality, a social marketing campaign with a focus on preconception health, was launched. In addition, more resources to address preconception and interconception health are expected with a new initiative from the Department of Health and Hospitals that will focus on improving birth outcomes. The Stork Reality campaign also provides information to the public on the high rate of unintended pregnancy. The CSHS subgroup formed a new stakeholder advisory group with representatives from all public health programs within the DHH and the Department of Social Services. This group is charged with providing services for YSHCN and their families and improving care coordination.

Priority needs continue to be reviewed to assess program progress, strengths and to identify changes in health status. By utilizing current data and working with community partners and other stakeholders, the MCH program continues to strive to improve the health of the state's MCH populations.

/2012/There are no changes to report in priority needs this year. The MCH and CSHS programs continue to develop and implement specific strategies to address the 2010 identified needs. Routine monitoring of activities related to the priority needs is also ongoing.

Plans are under way to improve the Child Death surveillance by implementing the National Center for Child Death Review's standardized web-based case reporting system for Louisiana case review data. The MCH Program is working closely with the program is working closely with the DHH Birth Outcomes Initiative to implement a pilot interconception care program in the New Orleans area that will address not only interconception care but also pregnancy intention, pregnancy spacing, and behavioral health. The NAP SACC nutrition program has been implemented in four child care centers to evaluate the appropriateness of the program for Louisiana children. Although no longer an independent priority need, a web-based assessment of MCH-related data needs of staff and partners was conducted this year. Results will be used for website redesign and training development for data translation. Updates to priorities will continue as data and feedback circle out to and come back from MCH partners statewide.

Plans are also underway to restructure the Oral Health school-based dental sealant program to address the challenges resulting from changes in the dental practice act that added new restrictions to mobile dentistry. These changes necessitated re-designing the program delivery model. In response, the program will utilize local community-based organizations, school-based health centers, and Louisiana's schools of dentistry and dental hygiene to schedule and conduct clinic days and to secure the services of volunteer dentists. Plans, Memorandum of Understanding and contracts are in place for reinstating the school-based dental sealant program in the 2010-2012 school year.//2012//

/2013/Priority needs remain unchanged. With declining resources, Louisiana is focusing on ensuring the quality and efficiency of essential public health services and activities to promote health. Expanded partnerships with external public health programs and local universities leverage capacity to further the MCH and CSHS mission. The programs have aggressively pursued partnerships and grant opportunities that will support synergistic alignment of efforts

around common goals including: the DHH Birth Outcomes Initiative; public and private efforts around obesity prevention and breastfeeding; statewide implementation of new Medicaid managed care systems for health and behavioral health services; statewide reforms across early care and learning to support school readiness; business planning and sustainability of OPH regional services; and the development of national collaboration and innovation networks (COINS) to prevent prematurity and infant mortality.

NS-CYSHCN data showed an increase in YSHCN from 16.5% in 2005 to 17.7% in 2010 for children age 12-17 years, while YSCHN with coordinated care (CC) in a medical home fell from 49.6% to 40.4%. YSHCN receiving transition services (TS) decreased from 40.9% to 32% from 2006 to 2010, due in part to the influx of YSHCN with increased health condition severity following Hurricane Katrina. Expanded CC/TS was initiated in 4 additional regional CSHS clinics, leaving 2 regions to be trained. CSHS clinics closed in Region 1 in December 2010 and were replaced with a Family Resource Center. CC in private practices, focusing on resident pediatricians and family practice physicians, has expanded to 12 practices. In FY 2012, 27 Resource Information Workshops were held for staff in public health agencies serving families of CYSHCN. CC/TS remain top priorities, as despite efforts to improve CC/TS, need for services has increased and families require more assistance to navigate the newly implemented Bayou Health Medicaid system. Families of CYSHCN reporting easy access to community services remains above the US average at 65.5% (vs. 65.1%US).//2013/

An attachment is included in this section. IIC - Needs Assessment Summary

III. State Overview

A. Overview

Overall Health Status

A 2009 report by the United Health Foundation ranks LA 47th out of 50th in overall health, representing the 3rd least healthy state in the nation. This ranking reflects a marked improvement over recent years, with the change from 2008 to 2009 identified as the state with the 2nd greatest improvement in overall health during that time. The report is based on 22 core measures, including infant mortality, adequacy of prenatal care, immunization coverage, infectious diseases, obesity, cigarette smoking, binge drinking, children in poverty, health insurance, and several other measures. LA's poor ranking stems from its high infant mortality rate, high rate of cancer and cardiovascular deaths, high rate of premature death, high rate of infectious diseases, high rate of uninsured population, high rate of preventable hospitalizations, and low high school graduation rate. Over the past year, 2008-2009, the average health dollars targeted toward public health programs and initiatives in LA has decreased from \$94 to \$90 per person.

LA has among the lowest life expectancy rates in the United States. These rates result partly from the high burden of chronic disease in LA as well as racial disparities in these diseases. The rates of death from heart disease, cancer, and stroke are high in LA. In 2006 age adjusted rates, LA ranks 9th highest for heart disease and stroke mortality and 5th highest for cancer mortality in the United States. According to 2005 data from the BRFSS survey based on self-reported height and weight, the highest prevalence rates of obesity in the United States were seen in Louisiana, Mississippi and West Virginia. According to the 2009 Trust for America's Health Report, LA has the 8th highest rate of adult obesity and the 7th highest rate of overweight youths (ages 10-17) in the nation. The most recent BRFSS data on hypertension show that in 2007, reproductive aged White women were 15% likely to have hypertension while almost a quarter of Black women had hypertension (23.2%). On self-ranking in 2008 13.7% of reproductive aged women (15-44) in LA ranked their health as Fair/Poor (9.5% White women, 18.8% Black women).

According to the 2009 National Kids Count Data Book, LA ranked 49th out of the 50 states in "Indicators of Child Well-being." Specifically, LA ranked 49th for both infant mortality and percent of low birth weight infants; 42nd in child deaths; 43rd in teen deaths; 39th for the teen birth rate; 47th for the percent of teens who are high school dropouts; and 45th for percent of teens not attending school and not working. The state ranked 48th, 49th and 49th in the percent of children in poverty; the percent of children in families where no parent has a full-time, year around employment; and the percent of families with children headed by a single parent each of these measures, respectively.

//2012//According to the 2010 United Health Foundation Report, LA ranked 49th in overall health. LA remained at 49th in the 2010 National Kids Count "Indicators of Child Well-Being." The state consistently ranks poorly in health indicators.//2012//**2013/Louisiana improved to 47th, in the latest 2010 data from Kids Count. LA improved in 11 of 16 measures.//2013//**

Overall Economic Well-Being

Geographically, LA is a southern state that is predominantly rural. It is divided into 64 parishes, with 29 designated as urban, or being part of a Metropolitan Statistical Area (MSA). Although LA is a rural state, approximately 74% of the state's population live in an urban designated parish (MSA), and 6 of those parishes are located in the greater New Orleans metropolitan area. The U.S. Office of Management and Budget defines a MSA as having a core urban area of 50,000 or more population.

According to the US Census from 2000 to 2008, the total population of LA fell by 1.3% from 4,468,976 to an estimated 4,410,796 people. In terms of racial makeup, LA has two main racial groups, White 64.8% and Black 32.0%, with 3.2% as other. This is vastly different from the racial makeup of the US, where in 2008, an estimated 79.8% of the population is White, 12.8% of the

population is Black, and 7.4% is other. LA has a relatively small Hispanic population compared to the US as a whole, although the proportion of Hispanic individuals has increased since the 2005 hurricanes. A comparison of LA and the Nation's racial and Hispanic origin distributions is available in Figure 1 and Figure 2 of Appendix A respectively. In 2008, the total number of LA women of childbearing age has decreased from 1,005,468 (22.5% of total population) in 2000 to 920,873 (20.9% of total population). In 2008, teenagers 15-19 years comprised approximately 7.5% of LA's population and 20.7% of the population were children 0-14 years. The state population estimates from 2000 and 2008 can be found in Appendix B, Table 1.

Personal income and education levels in LA directly impact the well-being status of mothers, children, and families. In 2008, the US Bureau of Economic Analysis reported LA as having a per capita personal income of \$36,371 compared to the national average \$40,208. This shows an increase of 2.8% from 2005. In 2008 LA median household income was \$43,635 a 2% increase since 2003. The unemployment rate, reported by the LA Department of Labor, in December of 2009 was 7.5%, as compared to a national unemployment rate of 10%. Both rates have risen since 2008 when LA had an unemployment rate of 5.5% and the national unemployment rate was 7.4%. According to the 2008 U.S. Census Bureau's American Community Survey, only 35% of the State's population 25 years of age and over, graduated with a 12th grade education, and 7.1% had less than a 9th grade education.

According to the US Census Bureau American Community Survey, LA had an overall poverty rate of 17.3% in 2008, accounting for approximately 730,000 people. Mississippi was the only state to exceed this rate, with a rate of 21.2%. The US Census Bureau reported a 2008 national rate of 13.2%, up from 12.5% in 2007. From 2006-2008, the U.S. Census also showed that approximately 25% of African Americans and Native Americans live less than 100% of the federal poverty level compared to about 10% of Caucasians. The National Center for Children in Poverty reported that 252,603(23%) LA children under the age of 18 years were considered poor in 2006-2008, 4% more than the National average of 19%. Only Mississippi and the District of Columbia exceeded this rate. When considering only children under the age of 6 years, 25% of LA's young children were considered poor, 3% more than the National average of 22%.

Healthcare Access

Approximately 25% of LA residents live in rural areas, but only 14% of primary care physicians practice in rural areas. Health Professional Shortage Area designations (HPSA), are areas which lack access to primary care providers (i.e., family practice, OB/GYN, pediatrics, internal medicine, and/or general practice), dental providers, and/or mental health providers. Of the 64 LA parishes, there are 60 primary care HPSAs; 52 mental health HPSAs, and 56 dental HPSAs. In LA, 87.5% of the state is a Dental Health Professional Shortage Area, having on average, 40% less dentists and 42% less dental hygienists than other states. There are 34 parishes without access to a Medicaid OB/GYN provider and 6 parishes which only have access to 1 Medicaid OB/GYN provider (See Appendix C, Map 5).

The Louisiana Medicaid 2007-08 Annual Report indicated that approximately 27% of LA's population received Medicaid services, which is an increase from 25% in 2006. According to 2009 Louisiana Health Insurance Survey (LAHIS), the estimate for uninsured children under age 19 years who were eligible for LA Medicaid in 2009 was 5.3% (39,765) statewide, a decline from 5.5% in 2007. Medicaid is a source of coverage for 43.4% (510,266) of children under age 19 years in LA. However, the LAHIS 2009 statewide uninsured estimate for non-elderly adults (19-64) less than 200% of the federal poverty level was 20.1% (540,490)-only a 0.1% decline from 2007. According to the 2007 and 2009 AAP State Reports on Children's Health Insurance Status & Medicaid/CHIP Eligibility & Enrollment, the percentage of uninsured adolescents decreased from an estimated 13.8% in 2006 to 12.6% in 2008, respectively, whereas the National Survey of Children's Health also showed a decrease in the percentage of uninsured adolescents ages 12-17 years from 9.5% in 2003 to 6.2% in 2007.//2012//The percentage of the population enrolled in LA Medicaid has generally increased over time; during SFY 2009/10, 29% of Louisianans were enrolled in Medicaid.//2012//

Revenue shortfalls continue to challenge the delivery of state services to Louisianans. Recurring revenues are insufficient to cover expenses, and the FY2011 budget eliminates nearly 3,000 state jobs, including 1,300 filled positions. It also reduces spending in nearly every state department and agency. Streamlining recommendations include the consolidation of agencies to eliminate duplication of services, and outsourcing or privatizing state services. In accordance with LA's 2009 legislative Act 384, the Office of Behavioral Health within DHH was formed on July 1, 2010 by consolidating the existing Office for Addictive Disorders and Office of Mental Health. The Healthcare Reform Act of 2007 mandated DHH to redesign the healthcare system based on the Medical Home model to create a more cost-efficient system with more emphasis on preventive care. DHH is planning to establish a managed care system of Coordinated Care Networks (CCNs) and phase out the current fee-for-service delivery system.

Most preventive health services for children and adolescents with Medicaid and LaCHIP are rendered by private healthcare providers. Federally Qualified Health Centers, Rural Health Centers, and the 65 School-based Health Centers (SBHCs) also provide preventive and primary healthcare services. However, only 8% of public school students receive services through SBHC's. According to Medicaid data, there were over 500 providers that provided services to 354,887 KIDMED or EPSDT recipients from the state fiscal year of July 2007-June 2008. Medicaid-eligible children who received a paid service by Medicaid increased from 70.7% in 2001 to 83.2% in 2006 to 89.9% in 2008. Medicaid enrollees under age 1 year who received at least one periodic screen increased from 88.7% in 2004 to 89.9% in 2008, and LaCHIP enrollees under age 1 year who received at least one periodic screen increased from 86.4% in 2004 to 91.3% in 2008. Also, The National Immunization Survey showed that more children were immunized, an increase to 81.9% in 2008 from 61.9% in 2002 in the percent of 19 to 35 month olds who received the full schedule of age appropriate immunizations. LA Medicaid-eligible adolescents ages 15-18 years who received at least one initial or periodic screen increased from 52% in FY 05 to 67% in FY09 and from 52% to 72% for ages 10-14 years. However, according to the National Survey of Children's Health, only 49.1% of children ages 12-17 years received health care that meets the AAP definition of medical home in 2007 compared to 65.8% in 2003. Not all adolescents receive the recommended course of immunizations, but in 2008, estimated immunization coverage for LA adolescents ages 13-17 years was at the national average for MMR; above national average for TDaP/TD and MCV4; and just below national average for VAR (with no varicella history), Hep B, and HPV./2012/Medicaid will begin transitioning to the CCNs in the Fall of 2011. In addition, the state has undertaken efforts to increase enrollment of eligible children-the MaxEnroll initiative implemented Express Lane Eligibility in March '10 using Supplemental Nutrition Assistance Program data to facilitate automatic Medicaid enrollment of thousands of previously unenrolled children.//2012//**2013/Between February 1 and June 1, 2012, all regions of the state transitioned to the Medicaid coordinated care network (CCN) system, BAYOU Health. Of the state's 1.2 million recipients, nearly 900,000 now access care through 1 of 5 BAYOU health carriers. Children comprise the majority of enrollees; the system also covers approximately 70% of deliveries each year. BAYOU Health plans are required to ensure access to needed care and provide support with care coordination, follow up and transportation. The health plans are accountable to over 47 healthcare quality outcome measures. In 2011, the LAHIS showed that a record low 3.5% of children are uninsured. ExpressLane eligibility, increased awareness of LaCHIP, expanded access through the LaCHIP affordable plan have been credited with this achievement.//2013//**

MCH Health Status Indicators

Risk-appropriate prenatal care services play an important role in identifying medical and behavioral factors that can cause poor birth outcomes. Low income women often enter pregnancy with poor management of pre-existing health problems, face a burden of illness stemming from poverty that cannot be reversed or adequately modified during prenatal care, and are at greater risk for experiencing poor maternal and birth outcomes. Therefore, women with pre-existing chronic health conditions must receive disease and medication management prior to conception in order to improve birth outcomes in LA.

Early access to prenatal care and adequacy of prenatal care services are important in reducing poor birth outcomes. The percent of women entering prenatal care in the 1st trimester has risen from 84.1% in 2004 to 86.9% in 2007. The Black to White disparity ratio for 1st trimester entry into prenatal care has remained around 1.5 each year from 2004 to 2007. A 2009 United Health Foundation report ranked LA as 3rd in the nation for adequacy of prenatal care. Based on the Kotelchuck index, which measures early and adequate prenatal care, 84.8% of women received early and adequate prenatal care during pregnancy in 2007. The Black to White ratio of early and adequate prenatal care remained constant at 1.1 from 2004 to 2007, with 88.8% of White women and 79.2% of Black women receiving early and adequate care in 2007. Medicaid is currently the primary mechanism for women to access prenatal services in LA. In 2007, Medicaid covered 68.4% of all deliveries, which includes 90.1% of all Black births and 53.8% of White births.

Between 2000 and 2007, LA experienced a 2.6% decline in the number of live births. In 2007, LA had 66,063 live births (See Appendix A, Figure 3 for additional years). In 2007, 13.8 % of all LA resident births were to teens, and there was a decrease in the rate of LA teen births age 15-17 years, from 34.8 per 1,000 female teens in 2000, to 26.8 per 1,000 in 2005, with an increase to 29.5 per 1,000 in 2006. A greater decrease in teen births from 2000 to 2007 occurred to Black teens of 21.4% compared to a 3.6 decrease for White teens.

The infant mortality rate in LA decreased from 10.4 in 2004 to 9.0 per 1,000 live births in 2007. The 2007 IMR (rate=9.0 per 1,000) was the lowest reported since the year 2000 rate of 8.9 per 1000 live births, in part due to underreporting of infant deaths weighing less than 500-grams at birth. For the 2005-2007 combined periods, the Black IMR of 14.9 was more than twice that of the rate of 6.5. The ratios of Black to White IMR for the state were 2.1, 2.5, and 2.2 in 2005, 2006, and 2007, respectively. Disparities in the IMR are seen when looking at the 9 different regions of the state which reflect differences in socioeconomic status and resource availability throughout the State.

Very low (VLBW) and low birth weight (LBW) are major risk factors associated with infant mortality and with preterm births (PTBs). There has been little change in the VLBW or LBW rates in LA (See Appendix A, Figure 6). A very slight decrease in VLBW was noted from 2.3% in 2001 to 2.2% in 2006 and 2007. The 2007 rate of VLBW births among Whites was 1.3% compared to 3.7% for Blacks. The racial disparity of VLBW births, indicated by the Black to White ratio, fell from 2.9 in 2004 to 2.5 in 2005, but rose to 2.7 in 2006 and returned to 2.9 in 2007. The percentage of LBW infants were 10.5% in 2001 to 11.0 in 2004, 11.5 in 2005, 11.4 in 2006, and 11.3 in 2007, with 15.8% of Black infants delivered LBW in 2007, compared to 8.4% of White infants. From 2004 to 2006, the rate of LBW births was approximately 2 times higher among Black women as compared to White women. LA has very high rate of PTB and infant mortality. The 2007 rate of PTB was 13.0% compared to 13.8% in 2006. Rates of late PTB have risen from 8.4% in 2002 to 9.3% in 2004 to 9.8% in 2006. The first decrease in several years was seen in 2007, with a rate of 9.1%. ***//2013/LBW will be an indicator tracked on the Governor's new "Kid's Dashboard."//2013//***

Injuries are the leading causes of death for Louisianans ages 1 month-44 years. The most common causes of pregnancy-associated death were motor vehicle accidents, homicide and obstetric causes of death occurring while pregnant or within 42 days after delivery, and rates of the pregnancy-associated deaths for LA have fallen in recent years, from 89.2 in 2005 to 83.9 in 2006 to 80.2 per 100,000 in 2007. Child death rate increased from 30.8 deaths per 100,000 children in 2000 to a high of 35.5 in 2004 to a low of 21.7 in 2006, rebounding slightly to 25.3 in 2007. The 2005-2007 leading causes of deaths to children aged 1 to 14 years were unintentional injury followed by homicide and diseases of the nervous system. For 2005-2007 combined, Motor vehicle crash (MVC) deaths accounted for the largest number of unintentional injury deaths (rate=5.2 per 100,000) followed by drowning and fire (rates=2.1 and 1.8 per 100,000, respectively). Rates of child abuse and neglect increased from 9.3 per 1,000 for under 18 years of age in 2008 to 11.7 per 1,000 in 2006 and decreased to 9.2 per 1,000 in 2008. The top 3

leading causes of death for adolescents in LA from 2005-2007 were unintentional injury (44% of deaths, rate=41.8 per 100,000), intentional injury/homicide (30%, rate=28.4), and diseases of the circulatory system (4%, rate=4.2). In 2007, the leading cause of death for all adolescents was injury, with unintentional injury as the leading cause of death among White adolescents and intentional injury among Black adolescents. .

/2012/1st trimester prenatal care (NPM 18) remained stable over the past few years. After achieving the Healthy People goal of 90% of VLBW infants delivered in facilities for high risk neonates (NPM 17) in 2008, 2009 indicated a slight drop in this measure. Compared to 2007, 2009 data indicates improvement for adolescent suicide rates (NPM 16) and child motor vehicle accident mortality (NPM 10).//2012//

Behavioral Health

Substance use during pregnancy is routinely monitored in LA in an effort to target resources to improve pregnancy outcomes. According to PRAMS data, the percent of women reported smoking during the last trimester of pregnancy increased from 11.8% in 2002 to 12.6% in 2007, with such associated factors as low educational attainment, being unmarried, and life stressors such as having a lot of unpaid bills, being in a physical fight, and having someone close with a drinking or other substance use problem. Women reported drinking during the third trimester increased from approximately 4.9% in 2002 to 6.8% in 2004, and then to 5.5% in 2007, with being in a physical fight as an associated factor. A 2000-2004 PRAMS study indicated that White women were 6.6 times as likely to report cigarette use in the last trimester compared to Black women, and White women were 70% more likely to report alcohol use compared to Black women. Screening, Brief Intervention, Referral and Treatment 4PsPlus screening tool, showed that among women screened in private obstetrical provider sites cumulative between 5/05/05-12/30/09, 18.3% used tobacco cigarettes, 6.7% used alcohol, 3.2% used marijuana, 0.5% used drugs since they knew they were pregnant. Among women in WIC sites cumulative between 7/16/05-12/30/09, 14.4% used tobacco cigarettes, 3.7% used alcohol, 1.8% used marijuana, 0.1% used drugs since they knew they were pregnant. Results also showed that 7.1% of all screened pregnant women identified at risk for domestic violence and 16.4% identified at risk for depression in 2009./2012/Compared to 2007, 2008-09 data indicate a higher percent of smoking and alcohol use in the last 3 months of pregnancy (NPM 15 and SPM 7), although prenatal screenings for substance use have increased (SPM 6).//2012//

LA children have a higher prevalence of behavioral, emotional, and developmental issues than the national average (35% vs.26%). Rates of child abuse and neglect increased from 9.3 per 1,000 for under 18 years of age in 2008 to 11.7 per 1,000 in 2006 and decreased to 9.2 per 1,000 in 2008. Historically, cases of child neglect comprise approximately one third of the validated cases. According to the 2007 National Survey of Children's Health, 10.2% of children live with parents who experience high levels of stress from parenting. High stress is reported more often by the parents of children living in single-mother households. Based on the Federal Office of Special Education Programs school exit categories, 72% of students with emotional disturbance dropped out of school for the 2006-07 school year while 45% of special education students dropped out./2012/2009 data indicates improvement for rates of abused/neglected children (SPM 3).//2012//

According to the 2008 Communities that Care Survey, alcohol is the most commonly used substance among adolescents in LA. The average age for initiation of alcohol use was 12.5 years. About 26.8% of 6th, 8th, 10th and 12th graders surveyed stated that they had used alcohol in the past month and 50.8% reported using alcohol at least once in their lifetime. Cigarettes were the second most commonly used substance among adolescents in LA. The 2008 LA CCYS showed that 28.6% of students in grades 6th, 8th, 10th, and 12th used cigarettes at least once in their lifetime and 10.7% of students in the same grades used cigarettes at least once in the past 30 days; the average age for initiation of cigarette use was 12.1 years.

/2013/Over the past year, DHH launched the Behavioral Health Partnership, a cross-agency

partnership responsible for planning and overseeing behavioral health services in LA. In March 2012, the state transitioned the management of Medicaid behavioral health services to a Statewide Management Organization (SMO), Magellan. Magellan is now responsible for coordinating mental health and addictive disorder care services for over 150,000 residents -100,000 adults and 50,000 children. Included is the new Coordinated System of Care (CSoC), which will provide services to 2,500 children with significant behavioral health challenges or co-occurring disorders who are in or at risk for out-of-home placement.//2013//

Nutritional Health

Louisiana PRAMS data collected from 2002-2004 and 2007, identified that only 34.8 % of LA women achieved appropriate weight gain as recommended by the Institute of Medicine, with 23.1% under-gaining and 42.1% over-gaining. The percent of women in the overweight category (pre-pregnancy BMI=25 to <30) was 22.9%, 22.8% and 21.2% in 2002, 2004, and 2007, respectively. The percent of women in the obese category (pre-pregnancy BMI= 30+) was 19.5%, 21.5% and 21.3% in 2002, 2004, and 2007, respectively.

The Pediatric Nutrition Surveillance System collects information on nutritional parameters among children under 5 years who are enrolled in the Women, Infants, and Children Supplemental Food Program (WIC). In 2007 the percent of children (2 to 5 years) who were obese (at or above the 95th percentile) in LA was 13.8% compared with a national percentage of 14.9%. During the 2007-2008 school year, height and weight taken on approximately 12,000 children (2-19 yrs old) seen in School Based Health Centers in Louisiana revealed 46.5% are considered overweight or obese. In Louisiana the most common WIC nutrition risk codes include inappropriate feeding practices for children (20.75 %), environmental tobacco smoke exposure (9.0%), low hemoglobin or hematocrit values (7.88%), and pre-pregnancy or postpartum overweight (6.48%).

Oral Health

Only 41% of LA residents receive fluoridated water, and only three of seven urban areas have fluoridated water. According to the 2008 Behavioral Risk Factor Surveillance System, 54.5% of LA residents with an annual income of less than \$15,000 per year did not visit a dentist or dental clinic. Access to Medicaid dental providers is very limited, especially in rural areas and for Medicaid-eligible pregnant women. Medicaid-eligible children from low income families have more untreated dental caries than children from higher income families, and they suffer from dental disease at a rate almost 5 times greater than their more affluent counterparts. Also, racial disparities in dental care were evident; with 32.4% of Black women reported seeing a dentist during their pregnancy in 2007 compared to 39.8% of White women, according to LaPRAMS.

Current Priorities and MCH Roles and Responsibilities

Louisiana DHH has begun to implement the new "Birth Outcomes Initiative"(BOI). This collaborative effort of the all DHH agencies will provide policy and service changes to address the primary health care, chronic disease management and social support needed to produce improvements in LA's birth outcomes. Plans are being developed to expand care coordination for subsequent poor pregnancy outcomes to Medicaid-eligible high risk women who had a preterm or low birth weight delivery and have diabetes, hypertension, or other chronic diseases. The Family Planning Program will provide such MCH-funded services as the distribution of multivitamins which include folic acid, referrals to the FAX to Quit Tobacco Cessation Program which provides follow up to women interested in stopping smoking. MCH continues to fund Nurse Family Partnership, social marketing efforts of Partners for Healthy Babies and the SIDS Risk Reduction and Safe Sleep Program, Fetal-Infant Mortality Review, sudden unexpected infant death case reviews of Louisiana Child Death Review, and the MCH Child Safety Coordinators' community efforts to reduce unintentional injury deaths of infants.

Despite extensive planning and preparations after the storms of 2005, natural, biological, and manmade events, recently and over the last two years, continue to pose challenges for public health, especially in meeting the needs of the MCH population. During the 2008 storms,

Hurricanes Gustav and Ike, safe sleep surfaces/portable cribs and items to meet the immediate basic personal hygiene and nutritional needs of infants and toddlers were again absent or inadequate. To assure that the needs of infants and toddlers will be met during disasters, the state has begun to incorporate the recommendations outlined in Appendix C of the National Commission on Children and Disasters' 2009 Interim Report to U.S. Congress. DHH's Office of Public Health addressed the challenge of the H1N1 pandemic by prioritizing the availability of vaccine for pregnant women, young children, and parents and other caregivers of children under 6 months of age at state public health units, in mobile public health strike teams services to schools, at qualified pharmacies statewide, and at private healthcare delivery sites who received vaccines through the state. With the massive British Petroleum oil spill in the Gulf of Mexico, LA is burdened with another manmade disaster of mass proportions, and its financial impact on the state and its long term implications on the health and well-being of its citizens are still unknown.

Louisiana MCH Program, along with key stakeholders, performed the 2010 Title V Needs Assessment to identify leading and emerging health and safety issues impacting women, infants, and children (including those with special health care needs) in LA. Survey findings from consumers and stakeholders, state and local level capacity assessment results, and currently available MCH and CYSHCN data trends were used to determine the top 10 priority needs of LA's MCH and CYSHCN population groups. The next steps are to create an action plan for the period of 2010-2015 that addresses the top 10 priority needs; to allocate MCH Title V Block Grant funding and other resources in a manner that reflects the concerns of LA citizens and health/safety experts, data trends, and the state's capacity to meet the priority needs; to monitor progress using State Performance Measures, National Performance Measures, Outcome Measures, Health Status Indicators, Health System Capacity Indicators; and to report back to stakeholders on a regular basis. Despite some improvements, results from the 2010 needs assessment process showed that leading problems identified in 2005, such as infant mortality, child injuries, care coordination for the CYSHCN population and oral health, persist today, while underscoring the need for greater emphasis on obesity prevention and interconceptional healthcare. Also, the 2010 Needs Assessment showed that such contributing factors as geography as well as racial and ethnic disparities in health status, poverty, and low education levels continue to pose unique challenges to the delivery of Title V services in LA.

/2012/The MCH Program is in the process of reviewing all program activities to ensure they are as robust and efficient as possible. With the reductions in federal and state funds across OPH for programs, as well as with the possible opportunity to partner with the state's Medicaid CCNs for some maternal and child health public health services, the Title V Director is expecting to work closely with MCH staff and OPH center staff in the coming months to reassess how to structure the MCH Program's activities. //2012// **2013/Additional funding reductions in August 2011 prompted further review of key functions and priorities. With technical assistance support through HRSA, LA has been afforded the opportunity to work with an external facilitator to assist in developing a plan for the consolidation of the CSHS and Genetics Programs, and separately, the unification of the MCH and Family Planning (FP) programs. The MCH/FP programs will be combining to become the Bureau of Family Health. This external support has been a great benefit in defining a new structure and approach that will strengthen program strategies and operations. While budget constraints continue, there are many opportunities for Title V to help shape the major systems touching the health and well-being of children and families-in addition to cross-agency efforts to redefine health and behavioral health services, other systems including education and early care are also in a period of significant realignment. Now, more than ever, MCH has to be prepared to seize the opportunities to partner and engage at the statewide system level. //2013//**

Children and Youth with Special Health Care Needs
Overall Population of CYSHCN in LA

According to NS-CSHCN 05/06, 14.8% of children in LA are CYSHCN. LA ranks 26th in the nation for percent of CYSHCN, which is a decrease from the 2001 NS-CSHCN when LA was ranked 2nd at 15.9%. This decrease is thought to be due at least in part to shifts in the population after Hurricanes Katrina and Rita, when CYSHCN with severe, chronic conditions were less likely

to return to LA when the healthcare infrastructure was greatly disrupted. The largest reported proportion of CYSHCN in LA is 6-11 year olds, followed closely by 12-17 year olds. The largest proportion is Non-Hispanic (NH) multi-race (23.7%), followed by NH-White (15.7%), then NH-Black (12.8%). Among Hispanic children (14%), the majority report English as the primary language. There is little variation in percent CYSHCN by income strata, although there is a slightly higher percent among those living below 100% FPL./2013/2010 NS-CSHCN data indicates the %CYSHCN in LA has increased between survey years, from 2006: 14.8%(US 13.9%) to 2010: 18.6%(US 15.1%); hence LA's rank has moved from 26th to 47th. As health and educational services slowly returned to LA following Hurricanes Katrina and Rita, so did families with CYSHCN. Returning CYSHCN were older with the largest proportion age 12-17 years, more likely to be non-Hispanic black, and more likely to live below 200%FPL. Health condition severity among CYSHCN has increased (2010: 10.5% with 4+ criteria vs. 2006: 14.8%).//2013//

Between the 2 NS-CSHCN years, health outcomes among LA's CYSHCN population, as reflected by the MCHB Core Outcome Measures, have greatly improved. LA moved from below the national average in all 6 NPMs in 2001 to above the national average in all but early and continuous screening and transition in 2005/06./2013/With the return of older CYSHCN with increased health severity, only two NPMs remain above the US average; adequate insurance and services are easy to use. While LA ranks slightly below the US in % YSHCN who met all 6 NPMs and higher in % CSHCN who meet all 5, neither difference was significant.//2013//

Health Insurance

The percent CYSHCN with health insurance has improved greatly in recent years due to CSHS, Medicaid, LaCHIP outreach efforts, expansion of LaCHIP coverage through the LaCHIP affordable plan, and new programs for CYSHCN, including the Medicaid Purchase plan and the Family Opportunity Act. Overall, 65.5% of CYSHCN families say they have adequate insurance (US 62%) (NPM 4). Of those with insurance, a greater percent say it is adequate (71.8% LA vs. 66.9% US). CYSHCN with functional limitations and those with emotional, behavioral or developmental issues were more likely to say their insurance was inadequate./2013/In the 2010 NS-CSHCN, LA is higher than the US average in CYSHCN who report adequate health insurance (63.4% LA vs. 60.6% US); however, for LA this is a decrease from 65.5% in 2006, as CYSHCN moved from private to public insurance.//2013//

About 45% of CYSHCN in LA are publically insured, which is much higher than the national average of 28.6%*./2013/2010 NS-CSHCN data indicate CYSHCN with public insurance alone increased from 45% to 50% between survey years, and those without insurance decreased to only 3.2%. This can be attributed to both new Medicaid programs as well as successful outreach.//2013//Unfortunately, having health insurance does not guarantee access to care or quality of services. The top 5 priority needs among CYSHCN families who answered the Family Survey is providers that take Medicaid, specifically pediatricians, subspecialists, dentists, and Occupational and Physical Therapists (OT, PT). Results were similar across geographic areas, race, and age. When questioned about difficulties associated with access to subspecialists, overall 24% said the needed subspecialist was not in their geographic area. Approximately one-fifth relayed that the subspecialist did not accept their type of health insurance. Physicians also ranked this as a top priority need of families with CYSHCN. The subspecialties where more than 50% of the physicians relayed difficulties in accessing were psychiatry, developmental/ behavioral pediatrician, neurology, orthopedic, and dermatology. Because of this lack of access despite an increase in public insurance coverage, CSHS will continue to provide a safety net of select subspecialty clinics according to regional need. CSHS will also continue to assist families in identifying appropriate health insurance options./2012/State budget cuts resulted in a proposal to close some CSHS clinics. CSHS families and physicians protested saying they had no way to obtain subspecialty care, and clinics were restored. CSHS will contract with FHF to provide transportation for families to medical appointments through a new State Implementation Grant.//2012///2013/CSHS continues to provide sub-specialty

clinics in Regions 2-8. Smaller clinics are closed, and CYSHCN transitioned to the private sector where possible. The transportation service through FHF is active in Region 6, and will expand to Regions 2-5 and 7-9 in FY 2013. Medicaid has launched Bayou Health. CSHS clients can elect to "opt out" and keep "legacy Medicaid". Health plans are mandated to have all types of in-network providers and to provide care coordination (CC). However, provider shortages continue and many families are having difficulty accessing services because their providers do not all accept the same health plan.//2013//

Morbidity

The most common conditions among CYSHCN in LA in decreasing order are allergies (54.5%), Attention Deficit Hyperactivity Disorder (ADHD) (40.5%), asthma (36%), emotional problems (20%), headaches (20.8%), and Developmental Delay (DD), or intellectual disability (10.9%). The percent receiving SSI for these conditions is allergies 45%, ADHD 53.5%, asthma 43%, emotional condition 33%, headaches 25%, and DD 50%. Having any of these conditions is associated with having other conditions as well, and all but asthma are associated with four or more functional difficulties. Of these, ADHD, asthma, and DD are more common among the publically insured than privately insured, and all but allergies and asthma are more common among the uninsured than the insured. While none of these diagnoses qualifies for CSHS subspecialty clinics, CSHS serves these CYSHCN through its Medical Home (MH) Care Coordination (CC) program and other population based and infrastructure building activities.

Disparities exist among CYSHCN with functional difficulties and among those with emotional, behavioral, or developmental issues. While the rate of functional difficulties is similar to the national average, a larger proportion of NH-Black CYSHCN reported having a functional difficulty compared with NH-White (91.6% vs.80.5%*). Also, CYSHCN living at less than 200% FPL were twice as likely to have a functional impairment as those living above 200% FPL*. CYSHCN without health insurance (5.1%) were twice as likely to have four or more functional difficulties*.

LA children have a higher prevalence of behavioral, emotional, and developmental issues than the national average (35% vs. 26%). NH-Black CYSHCN are 50% more likely to report having a behavioral, emotional or developmental issue than NH-White CYSHCN (36% vs. 23%), and CYSHCN living below the 100% FPL were more likely than those living above 200% FPL (35.9% vs. 20.4%*). Those with a behavioral, emotional or developmental issue are three times more likely to say the service system is not organized, and were more likely to need their physician to communicate with the school or other programs (56.1% vs. 16.6%*). Those with functional difficulties or emotional, behavioral or developmental issues were also more likely to say their condition caused financial burden on the family.

LA's CYSHCN had a higher proportion who needed Durable Medical Equipment (DME) during the 12 months prior to the survey (11.4% vs. 15.7% US*). The need was greater in younger children. There is a two-fold gap for need between NH-Black CYSHCN and their NH-White counterparts (23.3% vs. 11.2%*), and the need was greater in publically insured CYSHCN than those with private insurance (22.6% vs. 9.8%*). CSHS will continue to provide DME in its regional subspecialty clinics, and to assist families with inadequate insurance.

Geographic Disparities and NPMs

LA is above the national average for 4 of the 6 NPMs. CYSHCN living in suburban and rural areas are more likely to meet all 6 NPMs, despite the concentration of providers in urban areas. For NPM 2, over 62.2% of families felt like partners in decision making vs. 67.2% US. For suburban CYSHCN, 75.9% met this measure and for rural, 71.1%, which was higher than urban CYSHCN (58.4%*), and higher than those living in large towns (51.9%*). Coordinated care in a MH (NPM 3) was obtained by 49.6% of LA's CYSHCN vs. 47.1% US. Suburban and rural CYSHCN had 57.9% and 59.6% respectively, compared with urban 49.6% and large town 48.2%. Urban CYSHCN were also more likely than rural or suburban to say they had no usual source of care when sick. More than 65% reported adequate insurance coverage (NPM 4) vs. 62% US. Urban CYSHCN had the lowest rate (58.1%), but this was not statistically different from the other

three groups (suburban: 72.7%; large town: 74.2%; rural: 74%). A higher proportion of urban families said their insurance was inadequate compared to rural. Early and continuous screening (NPM 1) was met by 54.3% of CYSHCN vs. 63.8% US. The rate was highest among suburban CYSHCN (60.4%), followed by rural respondents (58.5%), urban (55.7%), and lastly large town CYSHCN (40.7%). For services are easy to use (NPM 5), 89.3% of CYSHCN met this goal vs. 89.1% US. This was highest for rural and suburban CYSHCN (94.1% and 93.2% respectively). Among YSHCN, 40.9% received the transition services necessary to make the appropriate transitions to adult healthcare, work, and independence (NPM 6) vs. 41.2% US. This rate was highest for rural (58.5%), followed by suburban (48.6%), urban (36.5%), and large town youth (36.4%). In summary, percent CYSHCN meeting the NPMs was lower in urban areas and large towns than suburban and rural areas for all 6 NPMs, although not all differences were statistically significant.//2012/CSHS clinics in New Orleans were closed in December 2010. CSHS opened a Family Resource Center (FRC) to address the care coordination needs of this urban population.//2012//

Medical Home

Equal proportions of CYSHCN and non-CYSHCN met the AAP definition of receiving care within a MH (51.3% vs. 56.6%), and while LA does well compared to other states (49.6% vs. 47.1% US) (NPM3), more than half of CYSHCN are without a MH. Those with a single mother had half the prevalence than CYSHCN living with two parents. The prevalence also increase with income, and was significantly different from the lowest level compared to the two highest levels (34.6% vs. 56.7%, and 60.8%*). Only 44% of publically insured CYSHCN received MH services, compared to 61.1% of privately insured*. This is surprising since receipt of KIDMED services in LA requires linkage with a MH. CYSHCN with a MH were more than 3 times as likely to say the system is easy to use, were 2.5 times more likely to say their provider spent enough time with them, were 2 times more likely to say they were satisfied with their provider communication, and were almost 2 times less likely to need their providers to communicate with schools/other programs. **2013/2010 NS-CSHCN indicates 40.4% LA CYSHCN received CC in a MH, similar to the US (43.0%). Both declined between survey years (2006: LA 49.6% vs. US 47.1%). LA follows a similar distribution as the US rates by race/ethnicity, sex, insurance type, and income. Rate among CYSHCN with highest health condition severity was also similar. However, YSHCN in LA are more likely to not have a MH (YSHCN: LA-38.0% vs. US-43.1%) as are CYSHCN with milder emotional/behavioral/DD condition or milder health condition severity.** //2013// Physician surveys reveal many areas where MH capacity in the state can be improved. Less than one-third of physicians referred to FHF or other family/parent support groups. Pediatricians were significantly more likely to refer than were Family Physicians (FPs). When looking at referral to other resources, more than 50% of physicians referred to OT, PT, and speech therapy, WIC, DME, Part C early intervention, Medicaid, Head Start, and special education. Half referred for 504 Accommodations. Less than half referred for assistive transportation, Title V programs, SSI/SSI-DI, respite care, LA Rehabilitation Services, and Family Supports and Services/Waivers. Pediatricians were more likely to discuss referral for therapies, WIC, Part C, Head Start, IEPs and 504 Accommodations. FPs were more likely to discuss referral for Medicaid. Family Survey results indicate that almost two-fifths of families reported difficulties accessing community resources/supports because their doctor did not know about resources and/or eligibility requirements. CSHS will increase infrastructure building/enabling service activities by working with MHs statewide to increase their capacity for CC, including improving physician knowledge of Public Health (PH) and community resources. CSHS will also work with FHF and F2FHICs to provide enabling services for families related to advocacy and service system navigation and to improve coordination and knowledge of services among regional program staff.//2012/CSHS has trained 3 new MHs in CC for a total of 7 practices trained. CSHS continues to train all Tulane and LSU pediatric residents in the MH model emphasizing CC.//2012// **2013/CSHS trained 4 new academic practices in CC in FY 2012, and will contract with 3 additional MHs in July 2012. CSHS continues to train all Tulane and LSU pediatric residents in MH and CC.** //2013//

Usual Source of Care

LA's PH system is historically based on a Charity Hospital system as opposed to a preventive

outpatient clinic system of care. A significantly larger proportion of LA's CYSHCN had two or more visits to a hospital emergency room (26.1% vs. 19.3% US*) and the prevalence rate for those who do not have a usual source for sick and/or preventive care is significantly higher than the US (10.1% vs. 6.4% US*). This was more common among NH-Black CYSHCN than NH-White (18.7% vs. 2.9 %*). Usual source of care when sick varies with insurance type; 66% of publically insured used a doctor's office vs. 89.3%* of privately insured. Significant differences were also seen for these two groups for citing a clinic, health center, or other regular source of care (7.4% vs. 22.7%*). CYSHCN below the 100% FPL were less likely to have a usual source of care than those at higher income brackets (66.9% vs. 88.6-91.1%*).

While 88.6% of LA children/youth received a preventive visit in the year prior to the NS-CSHCN survey, similar to the US (88.5%), perception of need for routine preventive care was lower. Only 69.8% of LA's CYSHCN parents responded that their child/youth needed routine preventive care in the 12 months prior to the survey (US 77.9%*). CSHS staff work with families of CYSHCN to stress the importance of preventive care and help families without a usual source of care to find a MH.

Oral Health

Compared to non-CYSHCN, a lower prevalence of CYSHCN reported their teeth were in excellent or very good condition (71.4% vs. 63.5%). More CYSHCN experienced two or more problems in the 6 months prior to the survey than non-CYSHCN (16.1% vs. 7.8%*). In LA, 97.3% of CYSHCN reported that they received needed preventive dental care. CSHS clinics assist CYSHCN to obtain dental care in the private sector. In Region 1, CSHS supports a dental clinic for CYSHCN provided by LSU Dental School.

Provider Cultural Competence

Most physicians claimed to consider family educational level, cultural background, household composition, religion, gender roles, ethnicity and language in communicating healthcare information. Only 29.5% said they consider the need for a translator. Most (78.5%) also said their patients could speak directly to the physician when needed, and most (65.1%) say that they schedule extra time for CYSHCN when needed. This was more common among pediatricians than FPs. However, disparities do exist for whether families felt that providers sometimes or never spent enough time. Based on LA data from NS-CSHCN, a greater proportion of NH-Black CYSHCN than NH-White CYSHCN felt as though their doctors and other healthcare providers sometimes or never spent enough time with them (47.3% vs. 12.7%*). Those living below the 100% FPL were almost twice as likely to say providers spent insufficient time compared to the upper two income levels, and those with public insurance were half as likely to say doctors spent enough time. Similarly, more NH-Black than NH-White CYSHCN relayed that their doctors/other health care providers sometimes or never listened carefully to them (20.6% vs. 8.8%*), indicating that disparities exist.//2012/CSHS staff reflect the cultural diversity in each region. CSHS brochures are printed in Spanish and English at a sixth grade reading level or less. Recently the HSV program hired a parent consultant who is fluent in English, Spanish and American Sign Language. CSHS supports a Hispanic, bilingual care coordinator for a Region 1 clinic serving a Hispanic population.//2012//

Care Coordination

Compared to non-CYSHCN, CYSHCN had almost 5 times the prevalence rate for not receiving needed CC (7.9% vs. 34.4%*). CC is an important part of MH for CYSHCN, yet data shows there were no differences in receipt of help with CC by MH status; those without a MH have a 7.5% decreased rate for help compared to those with a MH (32.5% vs. 40.0%). Compared to the US, LA's CYSHCN families spend significantly more hours each week providing and/or coordinating their child/youth's health care (5-10 hours/week: 12.9% vs. 8.9%*). More time is spent for younger children. Publically insured CYSHCNs' families are more likely to spend 11+ hours each week spent coordinating care compared to privately insured (18.9% vs. 4.9%*). CYSHCN with functional limitations required the most time (27%).

Physician Surveys revealed that of respondents, only 39.3% reported they provided their patients with a written plan of care. Many also do not refer to PH and community resources (see MH section). Only 49.1% reported that their patients' plans of care involve coordination with schools. Yet almost all respondents relayed that they helped communicate clinical information to the subspecialist (92%), and most reported (93.5%) that they discuss subspecialist findings with the CYSHCN/family and integrate them into the care plan.

In addition to providing CC in CSHS clinics, CSHS works with medical practices to improve their capacity to provide CC. By focusing on teaching clinics and large private practices, CSHS hopes to improve CC in existing as well as future MHs. This priority is reflected in the new CSHS SPM of increasing the capacity for CC in PH systems. The goal is to decrease the disparity between percent publically insured and privately insured CYSHCN who receive CC from by 11%. /2012/CSHS has developed laminated region-specific resource guides which are widely distributed to physician offices, SBHC's, and FQHC's.//2012//**2013/Resource Guides are updated annually and distributed widely by mail, website, and at conferences.**//2013//

Transition

Based on data from the NS-CSHCN 40.9% of LA's YSHCN receive services to make appropriate transitions (US 41.2%), although data also indicates disparities. Comparing YSHCN by race/ethnicity, data showed that more NH-Black YSHCN did not receive the needed transition services compared to NH-White YSHCN (78.4% vs. 47.5%*). Youth who live at or below 99% FPL and 100-199% FPL were less likely to receive transition services than those at or above 400% FPL (29.9%, and 29% vs. 59.1%*). YSHCN with functional limitations were 20% less likely to receive transition services than those whose conditions were managed by prescriptions.

Unlike CC, NS-CSHCN survey results indicate that YSHCN in LA with a MH have a 30% higher prevalence rate for receipt of transition services compared to those without (59.4% vs. 27.1%*). Family surveys indicate that the percent of YSHCN that have a MH varies greatly by region, from 61.5% in Region 5 to 100% in Region 7. This indicates a need to link YSHCN to PCPs to increase receipt of transition services. The Family Survey also indicates many areas where transition services can be improved in MHs. Among 87% of respondents that have a PCP, only 47% said their PCP discussed health/dental insurance options, 34% reported their PCP discussed finding an adult PCP, only about 29% relayed that their PCP discussed community-based resources, slightly more discussed future work/education choices, and 42.1% reported their PCP discussed the youth's role in managing their health care routine. When answers were stratified by race, a lower proportion of NH-Black YSHCN reported they had a PCP than NH-White YSHCN; however, NH-Black YSHCN with a PCP reported a greater proportion in receipt of services for all five transition questions than NH-White YSHCN.

Among providers, 72% of FPs, and 10.7% of pediatricians relayed that transition services were not applicable because they serve patients from childhood through adulthood. However, transition services are not necessarily contingent upon the patient transferring from their care. Less than one-fifth of physicians reported that they discussed all the independent living skills with their YSHCN patients (16.9%). Of these three skills, less than one-quarter relayed that they discussed community-based resources, 45.4% said they discussed educational/vocation choices, while 61% discussed the patient's role in managing their health care. The more frequently reported services were providing counseling directly to YSHCN (64.9%), and ensuring that their patients have established an adult PCP (79.2%). Discussion about health/dental insurance options was low (36.4%). This is consistent with NS-CSHCN data that only 27.9% of families report that anyone had discussed insurance options, despite the fact that CYSHCN in LA are mostly in older age groups that will soon age out of Medicaid. CSHS will use this information to enhance its CC program in MHs by increasing technical assistance on transition./2012/CSHS has developed brochures on transition for YSHCN and their parents for distribution in physician offices, FQHCs, SBHCs, and CSHS clinics.//2012//**2013/In the 2010 NS-CSHCN, less than 1/3 of LA YSHCN met NPM 6 (32.8% vs. US 40.0%), yet the largest percent of LA CYSHCN are youth. LA is similar to US for youth age 15-17 who received transition services (LA 36.2% vs. US**

39.4%), but 11% lower among the 12-14 group (LA-29.6% vs. US 40.7%). This suggests that transition services in LA need to target younger YSHCN.//2013//

Community/Service System

Despite an overall high rate (89.3%) for LA CYSHCN reporting that services were organized in ways that families could easily use (NPM 5), NS-CYSHCN indicates about 12,823 CYSHCN experienced difficulty accessing a needed service. This type of difficulty is experienced equally for all income levels, and is higher for the publically insured than privately or uninsured. This may in part be explained by the Agency Survey, which indicates that the 9 PH programs serving CYSHCN do not collaborate with each other to serve families. On average, about one-fifth of respondents cited a lack of knowledge about other programs as a reason for not referring clients to other programs' services. Only FHF, a community agency, reported to collaborate with all public health programs.

CSHS has a new stakeholder group with representatives from each of these programs which are working to improve collaboration. FHF has agreed to do in-services for regional program staff to improve referral/collaboration between programs. CSHS also participates in a DSS-DHH Data Integration Project to develop a master patient database between the two agencies. The database will indicate which programs clients are enrolled in/eligible for./2012/This project has been discontinued by administration.//2012//**2013/NPM 5 questions differ between survey years. The 2010 survey reports 65.5% of LA CYSHCN met this standard (US 65.1%). Risk factors for NPM 5 are also similar to the US: needing more healthcare resources (NPM 48.9%), having highest health condition severity (4+ conditions: 45.0%), reporting disruptions in insurance coverage (31.6%), reporting insurance is inadequate (49.9%), and not having a MH (53.9%).//2013//**

Special Education

CYSHCN represented 13% of LA schoolchildren. Among public school students, 16.3% were enrolled in special education; among private school students, only 2.5% were enrolled. The most common type of disability was a specific learning disability, followed by a speech or language impairment. Equal proportions were represented for DD, other health impairment, and mental disability. Among public school students, prevalence rates for special education enrollment differed by race/ethnicity category. Among American-Indian students, almost 14% were in special education, shortly followed by African-American students. The third highest rate was 12.6% among White students. Approximately 7.2% of Hispanic and slightly fewer than 5% of Asian students received special education./2012/In 2009-2010, CYSHCN represented 11.8% of LA public school children. The proportion of male students receiving special education services is almost double that of females (13.6% vs. 7.1%).//2012//

Based on the Federal Office of Special Education Programs school exit categories, 45% of special education students dropped out of school for the 2006-07 year. Among students with emotional disturbance, 72% dropped out. Similarly, among students with profound mental disabilities, 66% did not complete school. Slightly more than half of students completed school among those with a specific learning disability, speech/language impairment, other health impairment, and mild mental disability. The remaining disability categories have a dropout rate which ranges from 38.1% for severe mental disability to 12.2% for autism./2012/For 2009-2010, 31.0%, and 29.8% of youth with a disability received a high school diploma or a certificate, respectively, and 37.2% dropped out of school. Higher proportions of youth with a hearing, orthopedic, or a visual impairment received a diploma and higher proportions of students with a mental disability, multiple disabilities, or autism received a certificate of achievement. Among students with a specific learning disability, 28.0% dropped out and 43.1% completed high school. Among students with an emotional disturbance, approximately 45.5% dropped out. This reflects an improvement in high school completion, reflecting reorganization of the school system after Katrina.//2012//

CC and transition services in the MH include working with schools to be sure CYSHCN receive

needed educational services to optimize success and independence. CSHS is working with MHs, FHF, and other public health programs to optimize success of CYSHCN in school and ensure that they receive appropriate educational, vocational and transitional services.

CSHS and DHH Priorities

The Healthcare Reform Act of 2007 mandated DHH to redesign the healthcare system based on the MH model to create a more cost-efficient system with more emphasis on preventive care. DHH submitted a waiver to CMS in December 2008 to convert Medicaid into a managed care system of Coordinated Care Networks (CCNs). The waiver is waiting CMS approval. CSHS has participated on various healthcare reform committees including the MH Committee of the LA Healthcare Quality Forum, the state's legislated stakeholder group to advise administration on implementation of MH concepts. CSHS presented its data demonstrating success of CC in a MH post-Katrina to the state's first MH Summit, and continues to be involved in committee activities to ensure that the needs of CYSHCN are met./2012/CCNs are currently submitting applications to DHH. Implementation will be by Geographic Service Areas (GSAs). The first GSA is scheduled to "go live" January 1, 2012, the second in March 2012, and the last GSA in May 2012./2012//

note: *p<.05 statistically significant

An attachment is included in this section. IIIA - Overview

B. Agency Capacity

The State Maternal and Child Health Program is housed in the Office of Public Health (OPH), Department of Health and Hospitals (DHH). The mission of DHH is "to protect and promote health and to ensure access to medical, preventive, and rehabilitative services for all citizens of the State of Louisiana. The Department fulfills its mission through direct provision of quality services, the development and stimulation of services of others, and the utilization of available resources in the most effective manner." The other agencies under the Department include the Office of Mental Health, Office for Citizens with Developmental Disabilities, Office of Aging and Adult Services, and the Office for Addictive Disorders. Other related sections of DHH include the Bureau of Health Services Financing (Medicaid), Bureau of Primary Care and Rural Health, and the Bureau of Minority Health Access. The Assistant Secretaries for each of these Offices meet weekly to collaborate and coordinate services./2012/Mental Health and Addictive Disorders merged as the Office of Behavioral Health (OBH), the Bureau of Primary Care and Rural Health came under Public Health (OPH) and DHH launched the Birth Outcomes Initiative (BOI), housed in the DHH Office of the Secretary./2012//

Personal health services and local public health functions are provided by 68 OPH parish health units distributed throughout 62 of the 64 parishes in the state, except in New Orleans and Plaquemines Parish, which have their own independent health departments (See Map 1 parish health units). OPH has 9 Regional Directors who supervise the health units, regional CSHS clinic sites, and regional health staff in their respective regions. The Adolescent School Health Initiative provides funding and technical assistance to 65 contract school-based health centers, and 1 federally funded school-based health center. Orleans Parish operates an independent health department and receives support from MCH to enhance Healthy Start services and provide Lead Poisoning Prevention services. MCH services are also provided through other medical and social services entities. Plaquemines Parish operates a health department which provides pregnancy testing, immunizations, and infectious disease services./2012/The primary services offered through the PHUs are family planning, TB, STD treatment, HIV testing, and limited maternity and child health services. Within OPH, the Center for Community Health (overseeing health services provided in the PHUs) and the Center for Preventive Health (overseeing the programs, such as WIC, MCH, CSHS, HIV, Lead, etc.) combined in May 2011 to become the Center for Community and Preventive Health. The Adolescent School Health Program recently came under Bureau of Primary Care and Rural Health; the STD and HIV programs consolidated and the sexual violence program came under MCH./2012

In the past decade there has been a dramatic increase in Medicaid coverage of the maternal and child population in Louisiana through the Child Health Insurance Program, LaCHIP and LaMOMS (pregnant women coverage), expanding eligibility to 200% of the federal poverty guidelines. This health coverage and the statewide expansion of Community Care, Louisiana's Medicaid Managed Care system using a primary care case manager model has reduced the need for MCH to provide direct medical services in most areas of the state. Pregnant women and children ages 0-21, who live in areas with no access to prenatal or preventive health care in the private sector, are served by MCH in parish health units whose services are linked with Women, Infants, and Children (WIC) Supplemental Food Program, Immunization, Family Planning, and Sexually Transmitted Disease services. The majority of the parishes with poor access to MCH services are in the northern regions of Louisiana. MCH provides pregnancy testing; and screening, brief intervention, and referral for maternal substance abuse, depression, and intimate partner violence, in collaboration with the state Offices of Addictive Disorders and Mental Health. The OPH parish health units primarily provide the following services including, WIC, Tuberculosis and Sexually Transmitted Disease Control Programs, Immunization Program, Family Planning Program. As parish health unit based maternity and preventive child health services were transitioning to the private sector with Medicaid eligibility changes in the 1990's, MCH shifted funding to enabling, population-based, and infrastructure building services.

Understanding the social determinants of health, MCH invested in social marketing campaigns since 1994, to promote early access to prenatal care, healthy prenatal behaviors, and safe sleep environments for infants. More recently, MCH added a lifespan approach by including pre/interconceptional health messaging to the social marketing campaigns. In 1999, MCH began to invest in the evidence-based Nurse Family Partnership (NFP) Program, initiating the program in 2 regions of the state. Today NFP services exist in 52 of the 64 parishes. The NFP Program's enabling services address workforce participation, family violence, childhood injuries, substance abuse, as well as preventive health practices such as healthy nutrition, infant health and development, and optimally spaced pregnancies. The MCH-NFP program capacity includes a program manager, clinical director, contract monitor, and a nurse consultant for every 5-6 teams of 9 NFP nurses per team. NFP has become MCH's largest single investment due to the proven effectiveness of this intervention.//2012/For evidence-based home visiting, MCH applied for the new ACA home visiting formula and competitive grants. MCH plans to expand NFP and support the establishment of other home visiting programs in Louisiana.//2012//**2013/Currently, Louisiana has 18 NFP teams (approximately 113 nurse home visitors, 16 supervisors, and 4.5 FTE infant mental health consultants). Louisiana was awarded the competitive home visiting funds. One of the first priorities has been a thorough review of the operations, structure, and financing of the program. By August the program will have completed a "practice management" type of assessment and will be considering how to structure the program moving forward.//2013//**

MCH staff and contracts dedicated to preventive and primary care for pregnant women, mothers and infants include Maternal Health Medical Director, Nurse Consultant, Health Communication Coordinator, four Epidemiologists, two program managers, nine regional nurse coordinators of the Fetal Infant Mortality Review program and a contract for the social marketing campaign Partners for Healthy Babies. Other contracts include Healthy Start agencies and Office of Addictive Disorders. Infant Mortality Reduction Initiatives (IMRI) were established by MCH in each of the 9 regions of Louisiana, including a staff person to coordinate and direct Fetal-Infant Mortality Review with a Case Review Team made up of public and private obstetric and pediatric providers and a Community Action Team made up of local community leaders. The IMRIs have become the regional maternal and infant health infrastructure that conducts needs assessment, strategic planning, and implementation of preventive interventions. DHH has funded a new Birth Outcomes Initiative. MCH will work in close collaboration with this initiative to add pre and interconceptional health and late preterm birth prevention approaches to addressing Louisiana's high infant mortality rate.//2012/Staff roles and contracts have changed due to staff changes and budget reductions as described in "Other MCH Capacity."//2012//

Screening, brief intervention and treatment of pregnant women for alcohol use, substance use, tobacco use, depression, and domestic violence offers opportunity for improved outcomes. In response, MCH collaborates with the Louisiana Office of Addictive Disorders (OAD) and Office of Mental Health (OMH) to implement and evaluate a screening and treatment program for pregnant women of Louisiana. Other partners include Louisiana Medicaid, and American College of Obstetricians and Gynecologists -Louisiana Section, and March of Dimes. OPH WIC sites provide SBIRT services. A small proportion of private clinics and providers participate in the SBIRT program. Efforts are underway to initiate a Pay for Performance to encourage private Medicaid providers to participate./2012/MCH is working closely with the DHH BOI to develop the protocols for reimbursable screening.//2012//**2013/MCH has been working with BOI to support their development of the Louisiana Health Assessment and Referral Tool (LaHART), an on-line platform to support screening for tobacco, substance use and domestic violence based on a World Health Organization model. Eventually this tool will be the sole mechanism for providers to receive reimbursement for the screening.**//2013//

MCH addresses gaps in smoking cessation services for perinatal populations through a jointly funded initiative with the Louisiana Tobacco Control Program and Louisiana Public Health Institutes' Tobacco Free Living program.

MCH staff and contracts dedicated to preventive and primary care services for children including injury prevention consist of a Child Health Medical Director, two program managers, nine regional Child Safety Coordinators, three injury prevention program managers, two epidemiologists, over 100 Nurse Family Partnership nurses, and a contract for social marketing campaign addressing safe sleep environments for infants. The MCH Program provides funding for a State level Child Safety Coordinator who works to decrease unintentional injury-related morbidity and mortality of children ages 0-14 years, and Sudden Infant Death Syndrome (SIDS)-related deaths. The MCH Regional Child Safety Coordinators, who are certified in injury prevention through the University of Delaware, coordinate community-based systems of unintentional injury prevention initiatives in the 9 OPH regions of the state to address the leading causes of unintentional injury-related mortality and morbidity of children under 15 years of age. As Nationally Certified Child Passenger Safety Technicians, these Coordinators perform motor vehicle child restraint inspections to ensure that children ages 0-16 years are properly restrained. As certified Louisiana Child Care Health Consultants, the Child Safety Coordinators provide to child care center staff the child safety training needed to obtain or maintain their child care center licensure with the Department of Social Services. The coordinators work collaboratively with the Office of Public Health's Injury Research Prevention Program and with Emergency Medical Services for Children (EMSC) to deliver injury preventive services in their communities.

The MCH Program provides the staff support for the 25-member State Child Death Review Panel, which is legislatively mandated to review unexpected deaths of children 14 years of age and younger, including SIDS. The State Panel makes mortality prevention recommendations to the Legislature. Louisiana Child Death Review has incorporated into its process the National Center for Child Death Review's recommendations for effective reviews. Louisiana Child Death Review has worked to establish linkages with local coroners, law enforcement, fire departments, child protective services, emergency medical services, and other professionals involved in the investigation of sudden unexpected infant and child deaths to use the CDC Sudden Unexpected Infant Death Investigation Reporting Form to standardize and improve data collection at infant death scenes. The Panels also use the National Center for Child Death Review's data reporting for case reviews to promote consistent diagnosis and reporting of the findings of infant and child deaths. MCH provides outreach and training of the coroners, death scene investigators, and first responders on recommended death scene investigation procedures to better determine causes of death of infants who die suddenly and unexpectedly./2012/Preventive and primary care for children remain a priority, however staff and staff roles have changed as described in "Other MCH Capacity."//2012//

The Child Care Health Consultant Program begun by MCH provides certification-based training

for public and private health and safety professionals to become Louisiana Child Care Health Consultants. The training is based on child care standards from the Second edition of Caring for Our Children's National Health and Safety Performance Standards. The Child Care Health Consultants provide the mandated health and safety trainings to out-of-home child care centers and early education facilities.

BrightStart is Louisiana's Early Childhood Comprehensive Systems Grant Initiative, which is a framework for service systems integration and partnerships. To maintain this framework, BrightStart functions under the auspices of the Louisiana Governor's Children's Cabinet and the Advisory Board, with the MCH Program providing administrative support and direction for the management of the grant initiative. Two contract coordinators oversee all activities of the grant that are carried out by the 5 workgroups addressing medical home, parenting education, family support, early care and education, and social-emotional health./2012/BrightStart is now the governor's Early Childhood Advisory Council (ECAC).//2012//**2013/ The MCH Director serves as the Chair of the Executive Committee. The CYSHCN Director serves on ECAC.**//2013//

To improve Louisiana's low breastfeeding rate, MCH funds The Gift, a program to certify hospitals as breastfeeding-friendly facilities if they comply with a list of breastfeeding related policies and activities. Educational materials, training, and incentives are included in this intervention. The MCH Nutrition Consultant participates with the Louisiana Obesity Council and is the co-chair of the council subcommittee Louisiana Action for Healthy Kids (LA AFHK). LA AFHK addresses the epidemic of childhood obesity by focusing on changes in schools to improve nutrition and increase physical activity. MCH will implement a childhood obesity prevention program, Nutrition and Physical Activity Self- Assessment for Child Care program, an evidence-based program designed to enhance policies, practices, and environments in child care settings by improving the nutritional quality of food served, the amount and quality of physical activity, staff-child interactions, and the facility nutrition and physical activity policies and practices and related environmental characteristics. MCH will also collaborate with Louisiana Department of Social Services to ensure Louisiana childcare licensure regulations include strong nutrition and physical activity policies./2012/MCH will partner with WIC and BOI to continue to grow the program. MCH is expecting to continue to work to promote nutrition and activity policies in childcare centers and schools through both the NAP SACC and AFHK programs.//2012//**2013/MCH worked with community partners and universities to submit two applications to the highly competitive Blue Cross/Blue Shield obesity prevention challenge grant. The proposals include expansion of breastfeeding promotion efforts and expansion of NAPSACC. If awarded, these grants will allow Louisiana to leverage Title V Block Grant funds against commitments from other partners towards common goals.**//2013//

The Adolescent and School Health Program staff and contracts include a Program Manager, five Contract Monitors, a data manager, and contracts for operation of School Based Health Centers statewide. The 27 members of the School-Based Health Center (SBHC) Sponsor Network engage in infrastructure building through participation on medical, behavioral health, and administrative subcommittees of the Network. These subcommittees assist the central OPH office in formulating policy related to best practices and standards of care for medical and behavioral health services in SBHCs. The SBHC Sponsor Network has been involved in changing laws related to including protection for nurse practitioners and physician assistants within minor consent law language and advocacy efforts at the state and national level for increased funding for SBHCs. As part of its efforts to build infrastructure, OPH certifies non-OPH funded entities to enroll as Medicaid providers based on an evaluation of that entity's adherence to OPH/ASHP standards of care for SBHCs. OPH petitioned Medicaid at both the state and national level to permit Medicaid reimbursement for behavioral health services provided in SBHCs./2012/Under the direction of the Bureau of Primary Care and Rural Health (BPCRHR) and assistance from the BPCRHR Practice Managers, OPH is seeking to expand the number of SBHCs with existing resources through efficiencies and maximizing 3rd party reimbursement.//2012//**2013/The state's transition to managed care for health and behavioral health services is expanding the options for SBHCs to become more independently sustainable.**//2013//

MCH staff and contracts dedicated to oral health include two program managers, an epidemiologist, a health educator, fluoridation engineer, an Oral Health Advisory Council, and contracts for dentists and dental hygienists to apply dental sealants in elementary schools, for 2nd and 6th grade students in schools where over 50% of students are eligible for a free or reduced lunch. The school-based sealant program conducts preliminary dental screenings by a dentist and then applies sealants on appropriate teeth./2012/In 2010, the OPH Oral Health Program (OHP) assumed the staff positions formerly supported by MCH./2012//

The state mandated Newborn Screening and Follow-up Program ensures that all newborns are screened before discharge from the hospital and at greater than 24 hours of age. The newborn screening battery consists of 28 tests, as recommended by the American College of Medical Genetics. For infants with abnormal tests, Genetics Program staff assist the primary medical provider to ensure timely and appropriate confirmatory testing and if necessary, treatment. The Genetics Program follows patients until their diagnosis is confirmed. Contracts with three Louisiana medical schools provide confirmatory laboratory testing and specialized treatment for these patients./2013/***This program was recently moved under the Title V CYSHCN programs. In 2011, 99% of newborns were screened.***//2013//

MCH provides supplemental funding to the OPH Family Planning Program, which provides comprehensive medical, educational, nutritional, and family planning services to adolescents and adults. The Family Planning waiver was implemented in Louisiana October 2006. MCH also supplements the OPH Immunization Program funding./2013/ ***The Family Planning Program was recently moved under MCH.***//2013//

The development of information systems that are capable of providing timely and appropriate data for planning and evaluation of programs and policies is a key component of MCH. The Epidemiology, Assessment, and Evaluation (EAE) unit within the MCH Program is composed of a CDC assigned MCH Epidemiologist, a State Systems Development Initiative (SSDI) Coordinator/senior MCH Epidemiologist, a Needs Assessment Epidemiology Coordinator, a Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS) Coordinator, a PRAMS Operations Assistant, and various interns and graduate master level students of Tulane and LSU schools of public health. The EAE unit holds ultimate responsibility for facilitating access to, analyzing, and translating program-relevant data. The unit conducts epidemiological studies; Block Grant data analysis and translation; objective data preparation for policy-building process and other specific projects; analyses of data from national and state-based data. Ongoing agreements are in place to obtain annual data files from Louisiana sources, including vital records (births, deaths, fetal deaths, and inpatient hospital discharge), Medicaid eligibility files, WIC eligibility files, newborn screening data, and birth defects surveillance data.

The MCH and CSHCN epidemiologists work with program coordinators, providers, and other stakeholders to share information obtained from the analysis of surveillance system data, linked data sets, and other MCH relevant surveys, and to seek program input on the policy implications of the findings. The MCH EAE unit works closely with internal partners at the Department of Health and Hospitals (DHH) to establish and improve linkages between vital records surveillance files and the MCH related databases.

The Louisiana SSDI program focuses on increasing the data/epidemiologic capacity of Louisiana's MCH and CSHCN programs to monitor and address MCH health problems. The project improves data linkages and surveillance systems outlined in the Title V Block Grant Health System Capacity Indicator #9A. Access to existing and newly acquired data sets and information provided by their analyses and linkages allow MCH and CSHCN Programs to identify priority needs through needs assessment processes, report on national and state performance measures, target resources, and develop and evaluate programs. The joint effort between epidemiologists and program staff help develop future interventions for these programs as well as assess their respective National and State Performance Measures.

From the linked data, surveys, and registries, MCH epidemiologists conduct studies that provide relevant information to program staff and policy makers in order to develop interventions that will help the state to meet national and state performance targets. EAE unit analyses and results are disseminated at the state and local levels in the form of: 1) presentations to the State Perinatal Commission, internal and external meetings and conferences, 2) publications, such as peer reviewed journals, the Louisiana State Medical Society Journal, Baby Talk Newsletter, and The Louisiana Morbidity Report, 3) data and information on the state intranet and internet sites.

EAE collects Louisiana-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. The Louisiana Pregnancy Risk Assessment Monitoring System (LaPRAMS), which began in Louisiana in 1997, provides data for planning and assessing health programs and for describing maternal experiences that may contribute to maternal and infant health. Findings from LaPRAMS are used to enhance the understanding of maternal behaviors and their relationship with adverse pregnancy outcomes and aid in the development and assessment of programs designed to identify high-risk pregnancies and reduce adverse pregnancy outcomes.

EAE provides the race specific data that help target resources to the highest risk populations. To enhance cultural competence among its service providers and administrative staff, Nurse Family Partnership Program, Child Care Health Consultants, FIMR and Child Safety Coordinators, MCH provides trainings which increase self-awareness to inter-personal attitudes and behaviors as well as an understanding of cultural, racial, economic, and linguistic challenges encountered by MCH populations. Prior to implementing MCH health education strategies, formative and evaluative research is conducted with consumers to receive feedback on specific messages and to test relevance, appropriateness, and effectiveness of campaigns and materials. The campaigns and materials are simultaneously developed, produced and printed for Spanish-speaking audiences. Effective messages targeting African American women are of particular importance in reducing the racial disparities seen with SIDS and preterm births. DHH offers language translation services to public health unit clients and offers online and paper Medicaid enrollment and educational information in Spanish and Vietnamese.

The CSHS program provides family-centered, comprehensive, coordinated services for CSHCN through regionally based subspecialty clinics, including rehabilitation services for CSHCN who receive SSI Disability benefits. Clinics are staffed with contracted subspecialists, nurses, social workers, social service consultants, nutritionists, and audiologists. The increase in Medicaid coverage through LaCHIP, LaCHIP Affordable Plan, and new Medicaid programs for children with disabilities, including the Medicaid Purchase plan and the Family Opportunity Act, have increased access to care through the private sector for many CSHCN. As a result, the number of CSHCN coming to CSHS clinics has decreased rapidly until recently. In 2009, the number increased slightly with 4515 CSHCN receiving 20,780 visits/encounters. Although 91.2% of Louisiana CSHCN have health insurance, the shortage of Medicaid providers in the state has limited access to primary and subspecialty care for many CSHCN. Therefore, CSHS continues its regional subspecialty clinics to address these shortages. 98% of CSHCN in CSHS clinics are linked to medical homes (MHs). **2013/In mid FY 2010 Region 1 CSHS clinics were closed. Staff shortages from budget cuts have lead to additional clinic closures, limiting safety-net capacity.** 2013/In addition to subspecialty clinics, the Hearing, Speech and Vision (HSV) program provides audiology evaluation and hearing aids in CSHS clinics and infant and toddler hearing and speech screenings in MCH clinics in Regions IV and V. Both clinics coordinate with the Newborn Hearing Screening Program, the Part C Early Intervention Program (Early Steps), and the Parent-Pupil Education Program (PPEP) of the School for the Deaf. In 2009 the program provided 820 audiology evaluations and 569 infant and toddler screenings and dispensed 147 hearing aids. Access to private audiologists has greatly improved with increased insurance coverage, but shortage areas exist. The number of program audiologists decreased to two for the entire state in 2009. The audiologist in Region IX will be promoted to HSV Program Manager when the current program manager retires at the end of June, and children served in Regions II,

VI and IX transitioned to private sector clinics. Audiology consults in Region VII will be handled by LSU Shreveport./2012/The Program Manager continues to see patients in Region IX. A second audiologist serves Regions IV and V. In 2010 the program provided 762 audiology evaluations, 404 screenings, and 73 hearing aids.//2012//**2013/In FFY 2012 one audiologist served 146 children and dispensed 29 hearing aids.//2013//**

The HSV program also provides training for vision screening. In 2009 two contracted vision specialists trained over 1,020 school nurses, daycare providers, Head Start providers, preschool providers and volunteers to do preschool and school vision screening using Titmus testing and photo-screening. The Louisiana Lions Cubsight Program, supported by HSV funds, screened over 19,000 preschool children using photo-screening.//2012//In 2010 the two vision specialists trained over 1065 school volunteers in vision screening. Over 22,200 preschoolers were screened with photo-screening.//2012//**2013/In 2011, 811 school volunteers were trained and over 26,535 preschoolers were screened.//2013//**

Another shortage area addressed by the CSHS program is dental care. CSHS funds a CSHCN dental clinic in Region I with services provided by LSU School of Dentistry. CSHS also provides assistance through its regional offices for CSHS eligible children without Medicaid to access dental care in the private sector.

CSHS has two newborn screening programs: the Universal Newborn Hearing Screening Program and the Louisiana Birth Defects Monitoring Network (LBDMN). In 2009 over 97% of newborns were screened for hearing loss before hospital discharge. The program coordinates with private audiologists, Early Steps, and the Parent Pupil Education Program (PPEP) to ensure that infants receive early intervention by six months of age, as per AAP guidelines. Health literacy sensitive brochures in English and Spanish are distributed to birthing hospitals to encourage follow-up. Brochures will also soon be available in Vietnamese as well. //2012//In 2010 98% of newborns were screened.//2012//**2013/In 2011 97.4% of newborns were screened and in 2012 98.5% of newborns were screened for hearing.//2013//**

The LBDMN is an active surveillance system that was mandated without funding in 2001. Data collection began in 2005 for 40% of births and in 2009 covered 80% of births. In 2010 the program was awarded a \$947,403 CDC five year grant for statewide expansion and further development of its database. The LBDMN Program Manager resigned in December 2009 and a new Program Manager with experience in surveillance systems and clinical medicine was hired in June 2010. The program will be statewide by the end of 2011./2012/LBDMN is statewide and converting to a web-based software system from CDC. Data extraction forms from 2006 forward will be manually entered into the new software system.//2012//**2013/The CDC software is not available. The LBDMN epidemiologist now has access to vital records data. LBDMN will contract for a LA Electronic Event Registration System (LEERS) module to automate this linkage. LBDMN is working with CDC to identify a web-based software system to integrate with LEERS.//2013//**

CSHS provides comprehensive care coordination in CSHS subspecialty clinics. A new web-based care coordination program in CSHS clinics focuses on youth in transition to encourage self-determination and independence. This has been piloted in regions 1 and 6 and is ready for statewide expansion over the next few years. Care plans for CSHCN with complex needs are mailed to PCP's./2012/The CC transition program was expanded to Region III. The new FRC at Children's Hospital provides care coordination for families transitioning to private clinics, and is beginning to see other CYSHCN attending clinics at Children's Hospital.//2012//**2013/The CC transition program has expanded to regions 2,3,7 and 8. The FRC hired a nurse supervisor and is in the process of hiring parent and youth liaisons. The center has been renovated and opened officially in January.//2013//**

Two statewide CSHS parent consultants advise on all CSHS policies and program decisions to ensure that services are family-centered, and work with Families Helping Families (FHF) to hire,

train, and supervise parent liaisons (PL's) for CSHS clinics. PL's are paid parents of CSHCN who receive in depth leadership training to provide parent to parent support. They also work with CSHS staff to identify culturally appropriate services for the diverse population served in CSHS clinics. PL's have also provided community programs on cultural diversity. In June 2010, 12 new PL's graduated from the "Parent Leadership Skills Training." F2F HICS provide region specific resource consultation for PL's statewide./2012/In FY 2010 12 PL's attended the training./2012//**2013/In 2011 9 PL's participated in 24 hours of training./2013//**

CSHS is part of a DHH-DSS data integration project to make services easier to use. The goal is to create a master patient database of clients served by the two agencies. The database will indicate which programs clients are linked to and which programs they are eligible for. When completed, it will provide CSHCN families with single point of entry into public health programs./2012/DHH administration has discontinued the data integration project./2012//

CSHS has a new CSHS stakeholder group composed of program managers from DHH and DSS programs that serve CSHCN as well as representatives from FHF and Family to Family Health Information Centers (F2FHICs). The purpose of the stakeholder group is to improve collaboration between programs. CSHS will contracted with FHF to provide in-services for public health program staff at the regional level to foster referral between programs./**2013/In June 2012 FHF will have completed 3 Resource Information Workshops per region for public health program staff./2013//**

CSHS has had MH initiatives since 2000 to increase the MH capacity of PCP's. CSHS works with the Louisiana American Academy of Pediatrics (AAP) chapter and the Louisiana Academy of Family Practice (LAFP) to increase the MH capacity of its members. The 2010 Needs Assessment Physicians Survey provided valuable information regarding gaps in knowledge and practice of providers serving CSHCN in the community, which will be used for future education and training activities. CSHS provides articles for the academy newsletters to improve physician awareness of various MH issues. Physician survey questions addressing cultural competence among PCP's did not reveal any specific areas of weakness, however NS-CSHCN survey questions did indicate a greater proportion of non-Hispanic Black than white CSHCN families felt that providers sometimes or never spent enough time with them and did not listen carefully. Data also indicate that non-Hispanic Blacks were less likely to have a usual source of care, and that CSHCN with a MH were more likely to say their doctor always listened carefully and to receive transition services. Therefore, CSHS will work to link all CSHCN, and in particular non-Hispanic Black CSHCN, with MHs.

CSHS provides financial incentives for practices to designate a culturally competent care coordinator in the practice and work with CSHS for technical assistance. In 2009 a statewide care coordinator supervisor was hired for this program. A successful model for care coordination in MHs has been implemented in five practices and will be expanded, giving priority to teaching practices and large Medicaid practices. In 2009 the program added a care coordinator to two LSU teaching practices. One was opened to address healthcare needs of Spanish speaking families who have moved into the New Orleans area since Hurricane Katrina. CSHS provides a bilingual, Latino care coordinator for this clinic./2012/In 2010 CSHS contracted with three new practices to provide technical assistance with care coordination: two LSU pediatric practices in Regions 9 (Bogalusa) and 4 (Lafayette) that train family physician residents and one Tulane mobile clinic in New Orleans with pediatric residents./2012//**2013/Care coordination (CC) contracts including transition services began with Tulane medicine-pediatric, LSU family medicine, and 2 LSU pediatric clinics./2013//**

In addition to MHs, in 2009 CSHS collaborated with the diabetes clinic at Children's Hospital and the Tulane cystic fibrosis clinic, both in Region 1, and NICU follow-up clinics in Regions 2 and 7. CSHS funding is used to ensure that clinic staff is adequate to provide comprehensive, coordinated care. When the staff to patient ratio was increased, the diabetes clinic was able to demonstrate a decrease in average Hgb A1C for clinic patients, indicating improved long term

diabetes control. The total number of CSHCN served in non-CSHS clinics that receive CSHS funding was 5776 for 2009 for a total of 10,291 CSHCN served./2012/In 2010 the number of CSHCN served in non-CSHS clinics was 8548 for a total of 13,282 CSHCN served./2012//**2013/In 2011 21,493 CSHCN were served in non-CSHS clinics, for a total of 25,570 served. This increase is due to CC contracts./2013//**

CSHS works with the two medical schools in the state, Tulane and LSU, to ensure that all pediatric residents are trained in MH. The CSHS Director is responsible for coordinating the developmental rotation for both schools. The CSHS Statewide Care Coordinator Supervisor gives a monthly didactic session on MH, and residents are required to do a MH case presentation demonstrating understanding of community and public health resources. Residents participate in "Operation Housecall" where they conduct a structured family interview during a CSHCN home visit to increase their sensitivity to families. Residents work with the CSHS funded care coordinator in their continuity clinic MH's to link patients to community resources.

CSHS is represented on Louisiana's Healthcare Quality Forum (LHCQF) MH Committee. This is the legislated stakeholder group to advise administration on healthcare reform initiatives. Through this committee as well as direct meetings with Medicaid, CSHS is able to advocate for improved receipt of MH services, including care coordination, for CSHCN. LHCQF has adopted the NCQA MH criteria for Louisiana. Through a HRSA Primary Care Stabilization Grant, 37 clinics became NCQA certified. DHH has submitted a waiver to CMS for a new managed Medicaid system of Care Coordination Networks (CCNs). Networks would be required to provide comprehensive care based on the MH model using a capitated reimbursement based on risk. The waiver was submitted in December 2008 and is still pending CMS approval. CSHS will continue to monitor access to services for CSHCN as healthcare reform initiatives are implemented./2012/DHH is advancing with the CCN model. CCNs are submitting applications to DHH and recruiting providers. DHH programs will contract with CCNs to provide public health services and receive reimbursement for services that are currently paid by Medicaid./2012//**2013/Five CCNs were selected and together are called Bayou Health. Bayou Health began in February in Regions 1 and 9, in April in Regions 2, 3 and 4, and will begin in June in the remaining regions./2013//**

The following State statutes are relevant to the Title V program:

1. LSA-R.S. 46:971-973 - Administration of MCH Services in State of Louisiana - Health Department Responsible
2. LSA-R.S. 17:2111-2112 - Vision and hearing screening - Health Department and Department of Education Responsible
3. LSA-R.S. 33:1563 - SIDS autopsy; reporting to Health Department Required
4. LSA-R.S. 40:1299 - Mandated Genetics - Newborn screening - Health Department Responsible
5. LSA-R.S. 40:1299.111-.120 - Children's Special Health Services - Health Department Responsible
6. LSA-R.S. 40:5 - State Board of Health authority to create MCH & CC Agency
7. LSA-R.S. 40:31.3 - Adolescent School Health - School Based Clinics - Health Department Responsible
8. LSA-R.S. 46:2261 - The Identification of Hearing Impairment in Infants Law - Health Department Responsible
9. LSA-R.S. 40:31.41-.48 -- The Births Defects Monitoring Network -- Health Department Responsible
10. LSA-R.S. 40:2019 -- Child death investigation State Child Death Review Panel
2008 Senate Concurrent Resolution 83

To urge state agencies which participate in BrightStart, formerly known as the Early Childhood Comprehensive Systems initiative, to coordinate policy, budget planning, and services that support early childhood development.

2008 Senate Concurrent Resolution 70

To urge the Nurse-Family Partnership Advisory Council and Department of Health and Hospitals

to study the expansion of Nurse-Family Partnership program and to report to the House and Senate committees on health and welfare.
2009 House Concurrent Resolution 226; Senate Concurrent Resolution 113
To urge and request BrightStart, an interagency collaboration, to establish the Home Visiting Advisory Council in preparation for potential new federal funding of home visiting programs.

C. Organizational Structure

The Department of Health and Hospitals is one of twenty two departments under the direct control of the Governor. The State Health Agency, the Office of Public Health is one of the five major agencies within the Department of Health and Hospitals (DHH). The State Medicaid Agency, Bureau of Health Services Financing, is also located in this Department as well as the Office of Mental Health, Office of Addictive Disorders and the Office for Citizens with Developmental Disabilities. The Office of Public Health is organized into five centers, Center for Preventive Health; Center for Environmental Health; Center for Records and Statistics; Center for Community Preparedness; and Center for Community Health. The Title V programs, the Maternal and Child Health Program and Children's Special Health Services, are located in the Center for Preventive Health in the Office of Public Health, along with Family Planning, Nutrition, Genetics, Lead Poisoning Prevention, Speech and Hearing, Oral Health, Tuberculosis Control, Immunization, Sexually Transmitted Diseases and HIV/AIDS, and Adolescent and School Health Programs. The organizational charts in Figure 1 of the attachment illustrate the structure of the departments under the Governor, DHH, Office of Public Health, Center for Preventive Health, MCH, and CSHS./2012/ The Centers for Community Medicine and Preventive Health are now combined under the leadership of Takeisha Davis, MD, MPH./2012//

The Children's Cabinet in the Office of the Governor provides a monthly forum for the Secretaries of the child serving departments to meet and address the needs of children in Louisiana. The Children's Cabinet Advisory Board consists of the Assistant Secretaries of the agencies within the departments that serve children, as well as non-profit and advocacy organizations. This Board meets monthly and makes recommendations for policy, program development, and funding for child issues. MCH is represented on subcommittees of the Board. The Early Childhood Comprehensive Systems grant is being administered as a joint project of the Children's Cabinet and the MCH Program.

The MCH and CHSCN Program and Medical Directors are the individuals primarily responsible for administering the programs funded by Title V. These staff report to the Director of the Center for Preventive Health, who in turn reports to the Assistant Secretary of OPH. The Directors of the Family Planning, Immunization, Genetics, Oral Health, and Adolescent and School Health Programs are responsible for the proper administration of the Title V funds allocated to these programs and provide to the Title V Director annual reports and plans related to their particular performance measures./2012/Sharon Howard, previous Center Director, recently retired. Preventive Medicine programs now report to Matt Valliere, MPA, Interim Program Manager 4, who reports to Dr. Davis./2012//**2013/The Genetics Program has been moved under the Title V CYSHCN Director. The Family Planning Program Director will be moving under the Title V Director in the summer of 2012./2013//**

The MCH Program is organized by population and functional areas including Maternal Health, Child Health, Nurse Family Partnership, Epidemiology, and Health Education/Communication. The Team Leaders for each of these areas as well as the MCH Nutritionist and Assistant MCH Administrator meet with the MCH Director every month for a MCH Management Team meeting to foster collaboration among these programmatic and functional areas and to keep the MCH Director and each other informed. Each of the Team Leaders meets with their core team 1-2 times per month. The Maternal Health Team includes a Perinatal Director, Medical Director, MCH Health Education/Communication Coordinator, MCH Nutritionist, Maternal Health Program

Monitor, Maternal Health Epidemiologist, and CDC assigned MCH Epidemiologist. The Child Health Team consists of a Medical Director, Child Health Educator, Child Safety/Child Death Review Coordinator, Child Health Epidemiologist, MCH Nutritionist, Mental Health Consultant. The Health Education/Communication (HEC) Team includes the HEC Coordinator, Child Health Educator, Child Safety/Child Death Review Coordinator, Nurse Family Partnership Health Educator, Oral Health Educator, Breastfeeding Health Educator, PRAMS Epidemiologist, and MCH Nutritionist. The Epidemiology consists of the 4 epidemiologists listed in the other Teams. The Nurse Family Partnership Team consists of a Program Manager, Clinical Director, State Nurse Consultant, Contract Monitor, and 2 Regional Nurse consultants. MCH conducts a bi-monthly continuing education and program update meeting for all MCH and related staff. ***2013/The MCH Program is in the process of combining with the Family Planning Program to become the Bureau of Family Health. Please refer to the Bureau "concept" organizational chart that shows the new proposed units and their roles, and the anticipated personnel organizational chart (not final). The new program structure is intended to ensure that the various areas of expertise embedded within the program-epidemiology/data; policy; communications; population and systems "behavior change"; clinical; and business operations-are able to support the other activities occurring within the Bureau.2013//***

The Regional Infant Mortality Reduction Initiative coordinators meet quarterly. The Regional Child Safety Coordinators meet monthly via teleconference and meet face-to-face quarterly with state MCH Child Safety leadership. Facilitated by these Regional Coordinators, health status information is shared with local public and private health and community leaders in an effort to engage stakeholders to partner with MCH to improve the maternal, infant, child, and adolescent morbidity and mortality rates. State MCH staff provides technical assistance and consultation to help local stakeholders in assessing needs and developing plans to address the needs. ***2013/In September 2011, the Regional Child Safety Coordinator positions were discontinued due to budget constraints. The regional FIMR coordinator role, held by nurses, was expanded to be a full-time Regional MCH Coordinator position responsible for FIMR, Child Death, and pregnancy associated mortality roles. Technical assistance provided through HRSA allowed for the regional coordinators, along with other MCH staff, to be trained in the Technologies of Participation facilitation methodology to help ensure that action processes are effective. Strategic planning to ensure effective regional operations is ongoing.2013//***

The state is divided into nine administrative regions (see Map 1), with OPH Regional Directors in each of the regions responsible for identifying and addressing the health needs of the population, assuring the quality of care, and providing monitoring and reporting of MCH services delivered through parish health units and contracts. State MCH Medical Directors and Perinatal Nurse Consultants are responsible for the quality of the prenatal services funded by MCH. Each contract funded by MCH has an MCH staff member responsible for ongoing performance monitoring. The Nurse Family Partnership (NFP) team meets quarterly with the supervisors of the OPH and contract sites and conducts annual site visits and training with all NFP nurses. Program and contract monitoring consists of monthly review of fiscal information and performance indicators; and quarterly to annual on-site meetings with contract agencies to determine the quality of the service. Training and technical assistance is provided on a regular basis by MCH staff.

The CSHS central office staff are organized into three programs, with the CSHS Medical Director overseeing all three. The programs are CSHS, Hearing Speech and Vision (HSV), and the Louisiana Birth Defects Monitoring Network (LBDMN). The three programs share two budget and contracts personnel, a Nurse Consultant, and an Administrative Assistant. The CSHS and HSV programs have their own epidemiologists. The LBDMN will contract with LSU for an epidemiologist in 2011, giving each program their own epidemiologist. CSHS collaborates with the MCH epidemiology section for epidemiology technical assistance as needed. The CSHS Executive Staff including the Director, the three Program managers, the CSHS Nurse Consultant, the Social Worker, and CSHS epidemiologists meet frequently to discuss regional issues,

software system development and integration, billing issues, budget issues, and other topics of joint concern. CSHS holds staff meetings for all central office staff quarterly and as needed. Each program manager holds regular staff meetings for their program staff as needed. CSHS staff attend the MCH "Issues and Approaches" meetings to provide opportunities for updates and collaborative activities between CSHS and MCH programs./2012/The CSHS Nurse Consultant, Betsey Snider, recently retired. The position will be moved to Region 4 (Lafayette), to be filled by Stephanie Whiting, RN. LBDMN now has its own epidemiologist./2012//**2013/The Nurse Consultant position was not filled due to budget restraints, and one CSHS budget position was cut. The CYSHCN budget and contracts and administrative assistant personnel now assist the Genetics Program as well as CSHS, LBDMN and HSV./2013//**

The CSHS Program central office management team consists of a the Program Manager, Nurse Consultant, Social Work Consultant, Parent Consultant, Epidemiologist, and CSHS Nutritionist, who is shared with MCH. These staff make periodic visits to regional clinic sites to offer technical assistance and to gain input for program planning. CSHS regional clinic staff including nurses, social workers, social service counselors, nutritionists, audiologist, speech pathologist, and clerical staff receive direct supervision from Regional Administrators and/or Regional Medical Directors, and program supervision from CSHS central office staff. The Social Work Consultant supervises the Care Coordinator Supervisor, who is a nurse and a certified case manager contracted through LSU. They make periodic visits to pediatric practices to oversee care coordination contracts and to provide technical assistance to practices. The CSHS Nurse Consultant organizes an Annual Nurse Conference to train new CSHS nurses to work in CSHS subspecialty clinics. The conference frequently is used to provide updates and opportunities for collaboration for CSHS social workers and other field staff as needed, depending on current CSHS initiatives./2012/The CSHS clinics in Region I (New Orleans) were closed in mid-December cuts and CYSHCN were transitioned to private clinics. A Family Resource Center was established in the same location to assist with the transition and with care coordination for CYSHCN attending clinics at Children's Hospital, New Orleans./2012//

The HSV central office management staff consists of the Program Manager, Epidemiologist, Follow-up Coordinator, and Parent Consultant. They are assisted by the Statistical Technician and Administrative Assistant. Additional statewide staff for the newborn hearing screening program include the Newborn Hearing Program Coordinator (audiologist located in Region IV), the HSV Systems Development Coordinator (deaf educator located in Region 1), and the Tracking Specialist (early interventionist located in Region VI). An audiologist in Region IV provides audiology services for CSHS clinics, primarily in Regions IV and V. The program's only speech pathologist, located in Region IV, is retiring this year. Her services will be replaced by a contracted agency. The HSV Program Manager is retiring this year and will be replaced by the audiologist in Region IX./2012/The HSV Program Manager resides in Region IX (Mandeville) but comes into central office at least weekly. She continues to see audiology patients in Region IX./2012//**2013/The HSV and LBDMN epidemiologists resigned. CSHS hired a senior MCH epidemiologist to assist all CYSHCN program epidemiologists (CSHS and Genetics) and to support the LBDMN and HSV programs./2013//**

The LBDMN central office management staff consists of the Program Manager and the Program Monitor (or Family Resource Guide Coordinator). A contracted Epidemiologist and a Coding Specialist will be added in FY 2011. Regional Data Collection Specialists (DCS's) are located in the Parish Health Offices in regions I, II, IV, V, and VII. They extract data from birthing hospital medical records in all regions listed plus Region IX. Two new DCS's will be added in Regions III and VI in FY 2011. The LBDMN Program Manager resigned in December 2009. A new Program Manager was hired in June 2010 who is a physician with disaster surveillance system expertise./2012/ The LBDMN program is now statewide with DCS's covering all regions of the state. A web-based software system from CDC is being adapted for Louisiana./2012//**2013/The Program Monitor resigned and the position was lost. LBDMN will contract for development of a LA Electronic Event Registry System (LEERS) module and work with CDC to identify web-based software that can be adapted for the program.**

The Genetics Program staff consist of the Program Manager, 3 Program Monitors, nutritionist, epidemiologist, social worker, and administrative coordinator. These staff administer Newborn Metabolic Screening, Regional Genetics Clinics, Lead, Sickle Cell, and Hemophilia programs. Program monitors are cross-strained to strengthen follow-up of newborn metabolic conditions. Genetics staff meet quarterly with each other and will begin to meet quarterly with staff from the three other Title V CYSHCN programs.//2013//

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

D. Other MCH Capacity

The State MCH Program staff that provides program planning, implementation, and evaluation includes a MCH Program-Title V Director, MCH Assistant Administrator, Maternity Program Medical Director (60% Full-time Equivalent -FTE), Perinatal Health Director (100% FTE), Maternal Health Program Monitor (100% FTE), Maternal Smoking Cessation Coordinator (100% FTE-36% funded by MCH), Child Health Medical Director (100% FTE), Child Safety/Child Death Review Coordinator (100% FTE), Child Health Program Health Educator (100% FTE), Early Childhood Comprehensive Systems (ECCS) Coordinator (37% FTE), ECCS Associate Coordinator (50% FTE), Mental Health Coordinator (90% FTE), MCH Nutritionist (50% for MCH and 50 % CSHS FTE), Hospital Breastfeeding Initiative Coordinator (100% FTE), MCH Health Education Coordinator (75% FTE), Nurse Family Partnership (NFP) Program Manager (100%), NFP Clinical Director (53%), NFP State Nursing Consultant (100% FTE), 2 NFP Regional Nursing Consultants (100% FTE each). A contract for NFP training includes 36% FTE. MCH clerical support includes an MCH Contract Coordinator and an Administrative Assistant. MCH staff providing data analysis include CDC assignee MCH epidemiologist (100% FTE), Child Health Epidemiologist (100% FTE), Maternal Health Epidemiologist (100% FTE), Pregnancy Risk Assessment Monitoring System (PRAMS) Epidemiologist-Coordinator (100% FTE), and a PRAMS Data Manager (100% FTE). A PRAMS contract funds surveys conducted by phone. MCH has a contract with Tulane University School of Public Health for a 5% FTE biostatistician. MCH has been assigned a epidemiology fellow from the Council of State and Territorial Epidemiologists and an intern from the Graduate Student Internship Program. A contract with the National Training Institute provides data management, analysis, and reports for the SBIRT Program (Screening, Brief Intervention, Referral, and Treatment)./2012/The MCH/Title V Director is new as of January 2011. The MCH Assistant Administrator changed roles and is now with the NFP Program; the MCH Director will seek to replace this position. The Maternity Program Medical Director was promoted to the Medical Director of Medicaid; currently the program has a 20% FTE Medical Director. The Perinatal Health Director retired in January; the MCH Director is seeking to have an OPH Public Health Nurse assigned to the program for this role. The Maternal Smoking Cessation Coordinator position was eliminated due to budget reductions. The Child Health Medical Director was moved to a regional OPH office in the process of OPH scaling back on medical staff serving as program administrators. The Child Safety/Child Death Review Coordinator was promoted in her contract agency in January and resigned. The Child Health Program Health Educator has assumed the role of Child Safety/Child Death Review Coordinator in addition to her other role with health education. The Mental Health Coordinator is now working 100% FTE, but primarily with the NFP Program. The Hospital Breastfeeding Initiative Coordinator (100% FTE) moved out of state but is continuing to support the program remotely; the MCH Director will be assessing how best to staff that position in the new grant year. The Administrative Assistant retired in the Fall of 2010, and the MCH Contract Coordinator has assumed all of the program clerical duties; it is unlikely that position will be replaced due to budget constraints. A new Accountant position (100%) was established in the winter to provide support to the NFP Program (75%) and MCH (25%). Changes have also occurred in MCH staff providing data analysis support: the Child Health Epidemiologist (100% FTE) position is currently vacant to be filled in the Fall, possibly in combination with a Maternal Health Epidemiologist position; the Maternal Health Epidemiologist (100% FTE) position was vacated in the Fall of 2010 and not replaced; and the MCH epidemiology fellow from the Council of State and Territorial

Epidemiologists left the state. MCH did not have a the Graduate Student Internship Program placement this year, but will likely apply for an intern for next year. The contract with the National Training Institute provides data management, analysis, and reports for the SBIRT Program (Screening, Brief Intervention, Referral, and Treatment) was discontinued in June 2011 with the discontinuation of the SBIRT Program as a stand-alone screening program. The MCH Program will need to begin a formal strategic planning process to restructure the program and determine how to most effectively and efficiently address the state's established priority needs with more limited resources.//2012//**2013/As explained in other sections, MCH and Family Planning are combining as the Bureau of Family Health. In the upcoming year, a primary emphasis for staffing will be on building a strong epidemiology foundation and focusing on health equity and policy capacity.**//2013//

The CSHS Program staffing includes a CSHS Program Title V Director, CSHS Nursing Consultant, CSHS Social Work Consultant, CSHS Statewide Parent Training Coordinator, and Parent Consultant, CSHS Statewide Care Coordinator Supervisor, CSHS Nutritionist, Hearing, Speech, and Vision (HSV) Program Director, HSV Follow-up Coordinator, Newborn Hearing Screening Statewide Parent Consultant, Newborn Hearing Screening Statistical Technician, two contracted Vision Specialists, two CSHS accounting and contract monitoring staff, two CSHS clerical staff, a Louisiana Birth Defects Monitoring Network (LBDMN) Program Manager, and a LBDMN Program Monitor. Through HSV MCH and CDC grants, HSV Newborn Hearing Screening Program has a Statewide Program Coordinator, a Statewide Tracking Specialist, a Statewide Systems Development Coordinator./2012/The CSHS Nursing Consultant retired in May, 2011. CSHS has permission to fill this position. The LBDMN Program Monitor position was taken during December 2010 budget cuts and will not be refilled. HSV has hired 2 outreach specialists, a data entry/follow-up assistant, and bilingual parent consultant through its new MCHB grant.//2012//

CSHS Program staff providing data analysis include a CSHS epidemiologist, a Newborn Hearing Screening program Epidemiologist, and a LBDMN Epidemiologist (to begin in 2010). The CSHS epidemiologists receive technical assistance from the MCH epidemiology section./2012/The LBDMN epidemiologist began in February 2011.//2012//**2013/Both the HSV and the LBDMN epidemiologists resigned. CSHS hired a senior epidemiologist from MCH at 70% time, who will support all of the CYSHCN programs and provide data analysis for the LBDMN program.**//2013//

The Adolescent and School Health Program staff includes a Program Manager, 4 Program Monitors, a Data Manager, and Administrative Assistant. The Oral Health Program staff includes a Program Manager, Fluoridation Engineer, Health Educator, Epidemiologist and a vacant Dental Director position. The Injury Prevention Program will become part of MCH in July 2010 and includes a program manager, 2 health educators, 2 epidemiologists, a contract monitor, and an administrative assistant./2012/The Injury Prevention Program is moving to the Louisiana Emergency Response Network program; MCH has assumed the sexual violence component of the program.//2012//**2013/MCH has remained the central point of contact for injury prevention for OPH.**//2013//

In each of the 9 Department of Health and Hospitals administrative regions, the Office of Public Health has a Regional Administrator, a Medical Director, Nurse Consultant, Administrative Manager, Social Worker, and Nutritionist responsible for the planning, implementation, monitoring and evaluation of public health services in their respective regions. Working under the direction of the Regional Medical Director, MCH contracts for 9 Child Safety/Child Death Review Coordinators (100% FTE each) and 9 Infant Mortality Reduction Initiative RNs (50-60% FTE each). Regional CSHS Staff for all nine regions include 24 nurses, 14 social workers, 1 social service consultant, 13 parent liaisons, 2 audiologists, 1 speech pathologist and 16 clerks. These 74 CSHS staff are the equivalent of 32 FTE, since with the decrease in staff due to budget cuts, regional staff are frequently "cross-trained" to work in several programs. Although policy development and programmatic direction are provided by the State MCH Program staff, regional

and local staff provide significant input. In addition, CSHS contracts with 74 subspecialty physicians who conduct monthly or bi-monthly CSHS clinics. Other regional staff not included in parish health unit operations include 9 Newborn Screening Regional Task Force Leaders and 5 Birth Defects Data Collection Specialists. CSHS also contracts with a social worker, an occupational therapist, and a Spanish speaking care coordinator to be full time care coordinators for 2 large pediatric practices, one of which is a key teaching practice for pediatric residents.//2012/In December 2011, mid-year budget reductions resulted in the layoff of approximately 140 civil-service staff, primarily from the regional health units (PHUs). Two PHUs closed and many reduced hours. Region 1 (New Orleans) CSHS clinics were closed in December 2010 and the clerk, two nurses and a social worker were either let go or moved to other programs. CSHS retained a Social Service Counselor, a Parent Liaison, and office rental space at Children's Hospital to open a Family Resource Center for care coordination. CSHS also lost two nurses and a social worker from other regions in midyear 2011 cuts. Currently CSHS has 15 nurses, 12 social workers, 9 parent liaisons, 1 audiologist, 5 nutritionists, and 14 clerks in regional CSHS clinics, although many of these staff are part-time with CSHS. Additional personnel cuts are anticipated in June. Administration proposed cutting physician contracts; however, stakeholders protested the closure of CSHS clinics resulting in their restoration for the 2012 budget. LBDMN staff have increased to 9 contracted Data Collection Specialists funded by a CDC grant, giving the program statewide coverage. One DCS has since resigned. LBDMN contracts for temporary assistance with data entry and employs two student workers. In addition, LBMDN contracts with two agencies, one for web-based software development, adaptation and maintenance and one for Microsoft Access database development and maintenance. CSHS has added care coordination contracts to three additional pediatric teaching practices. Two practices train family physician residents and one trains pediatric residents.//2012//**2013/DHH has continued to reduce public health staff due to budget deficits. In December 2011, CSHS and Genetics each lost an office administrative position and duties were consolidated between the two programs. Key regional staff have resigned due to fear of job instability, including a social worker and 2 lead CSHS nurses. This resulted in the closing of 10 subspecialty clinics due to staff shortages. Currently regional clinics have 12.5 nurses, 9 social workers, 1 audiologist, 5 nutritionists, 9 clerks, and 9 parent liaisons.//2013//**

The number of OPH Parish Health Unit staff (FTEs) funded by the MCH to provide preventive pediatric services, prenatal care; pregnancy testing; and prenatal screening, brief intervention, referral to treatment for substance abuse, mental disorders, and intimate partner violence is 27 FTEs, plus 124 FTE Nurse Family Partnership home visiting nurses hired by OPH.//2012/The number of PHU staff has been reduced and clinical activities are currently in transition. Currently there are 107 FTE filled nurse home visitor positions, including 8 FTE nurse home visitors funded with the Affordable Care Act grant. An additional 8.5 FTE nurse home visitors funded via the ACA grant will be hired this upcoming year.//2012//**2013/OPH continues to contract, with a new round of layoffs announced July 6, 2012. The Maternal, Infant, Early Childhood Home Visiting (MIECHV) NFP Program, however, continues to grow, primarily via contracts for the teams.//2013//**

To enhance MCH capacity, staff has been added at the parish or regional level through contract agencies. Contracts have been used increasingly because there is a strict limit on the number of state employees that can be hired. In the four Healthy Start projects, MCH has supplemented those programs with funding for enabling services such as outreach and case management (4 FTEs), or infrastructure including Fetal-Infant Mortality Review or Program Management (.85 FTE). In addition to the OPH staff working in NFP, another 91 positions are hired through contracts in each region of the state. Contracts for prenatal providers and support staff in areas with access problems fund approximately 5.5 FTEs. Mental health professionals are hired to provide maternal, infant and early childhood mental health services through contracts with social service agencies in Baton Rouge region, Lake Charles, New Orleans metropolitan area, and Monroe region (4.25 FTEs). MCH funds an FTE in 2 of the 9 regional Screening, Brief Intervention, Referral, and Treatment program for maternal substance abuse, mental illness, and intimate partner violence. The state Office of Addictive Disorders funds the other 7 regional

coordinators. MCH has contracts to operate the toll-free information and referral line as well as the social marketing campaigns promoting early prenatal care, pre/interconceptional health, and safe sleep environment for infants. In the coming year a contract with Louisiana State University School of Public Health will hire 1.4 FTEs to implement an early childhood obesity prevention program in childcare centers./2012/NFP has 74 staff hired through contracts in each region of the state, in addition to the OPH staff working in NFP. There are now 4.5 FTE Infant Mental Health Consultants. As of January 2011, MCH is no longer supporting regional SBIRT coordinators, though MCH is working to ensure that screening continues in OPH clinics, and eventually as a Medicaid reimbursable service for prenatal care providers.//2012//

Please refer to the attachment for brief biographies of the MCH Senior Level Management Team (Table 1).

The MCH Management Team consists of the Maternity and Child Health Medical Directors, Director of Perinatal Health, MCH Program Director, Assistant MCH Administrator, MCH Epidemiologist, Nurse Family Partnership Director, MCH Nutritionist, and Health Education/Communication Coordinator. Management Team meetings are held monthly. A Maternal Health Medical Consultant will be hired to lead MCH's pre/interconceptional health initiatives./2012/Many staff changes have occurred that impact the management team, as previously described. Since January, the MCH Director has asked the Program Monitor now overseeing Child Death/Child Safety to attend management meetings, along with the Maternity Program Monitor who is supporting many maternity initiatives.//2012//**2013/The MCH Program has operated without a defined "management team" but rather an expanded leadership team of key supervisors and staff leaders during the past 18 months of transition. During this time other staff have emerged as clear leaders in the program. In the spring of 2012, the Title V Director instituted quarterly all-staff meetings, now including key regional MIECHV personnel and the regional MCH Coordinators; as well as brief optional weekly update calls. With the transition to the Bureau of Family Health, there will be a more defined management structure, but the program will be seeking an organizational model that retains the active contribution, participation, and leadership of all staff that has been so valuable over the past 18 months.**//2013//

The CSHS Management team consists of the CSHS Director, the CSHS, HSV and LBDMM Program Managers, the CSHS Nurse Consultant, the CSHS Social Worker Consultant, the CSHS Epidemiologist, and the CSHS contracts and budget person. The team meets frequently throughout the month. All CSHS central office staff meet quarterly./2013/**The Nurse Consultant Position is still vacant due to budget restraints. The Genetics Program Manager has been added to the management team. The collective programs are renamed the "Title V CSHCN Programs."**//2013//

CSHS has CSHCN parent involvement at all levels. Thirteen parent liaisons contracted from Families Helping Families attend all CSHS clinics and participate on Care Coordination teams to provide parent to parent support and to link families with community resources. A 14th parent has been hired for HSV. All parents are supervised by the statewide CSHS Parent Consultant (PC) and the Parent Training Coordinator, who hold annual in depth trainings for parent liaisons that span several days over a three month period of time. The PC participates in central office executive staff meetings and is consulted on all CSHS policies and program activities./2012/The Parent Training Coordinator is retiring in December 2011. A parent liaison from Region 6 (Alexandria) has begun training for the position. Two part-time parent liaisons in Region 4 (Lafayette) resigned in May 2011 but will be replaced.//2012//**2013/The Parent Training Coordinator received a 2011 Gold Award for Volunteer of the Year from the Governor's Office of Disability Affairs. She retired and the parent liaison from Region 6 has assumed the duties of the Parent Training Coordinator. A new parent liaison has been hired in Region 4.**//2013//

An attachment is included in this section. IIID - Other MCH Capacity

E. State Agency Coordination

The Maternal and Child Health (MCH) Program has a long history of extensive coordination with public and private agencies and organizations serving reproductive age women and children. The State Title V Maternal and Child Health Program is housed in the Office of Public Health (OPH), Department of Health and Hospitals (DHH). The other agencies under the Department include the Office of Mental Health, Office for Citizens with Developmental Disabilities, Office of Aging and Adult Services, and the Office for Addictive Disorders. Other related sections of DHH include the Bureau of Health Services Financing (Medicaid), Bureau of Primary Care and Rural Health, and the Bureau of Minority Health Access./2012/OMH and OAD joined to become the Office of Behavioral Health (OBH). Another key partner for MCH is the DHH Birth Outcomes Initiative (BOI)./2012//

Personal health services and local public health functions are provided by OPH parish health units (PHU) distributed throughout 62 of the 64 parishes in the state, except in New Orleans and Plaquemines Parish, which have their own independent health departments. PHU WIC patients who receive prenatal or child health care from private providers, receive health counseling, education, and referral from MCH funded staff. Public health nurses and social workers provide a home visit to families that lose an infant to Sudden Infant Death Syndrome (SIDS). The state Title X Family Planning Program receives funding from MCH. In 2006, the Family Planning Waiver began in Louisiana and MCH is conducting the evaluation for this Waiver. Family Planning and MCH Programs are collaborating on a pre/interconceptional health initiative and MCH provides funding for folic acid distribution to Family Planning Program clients./2012/PHU staff and services were reduced, but not discontinued, with the 2010 mid-year budget cuts. MCH is seeking to reinstate sufficient epidemiologic capacity to assist with the evaluation of the Family Planning Waiver, to be conducted in conjunction with the BOI./2012//**2013/The MCH and Family Planning programs are consolidating to become the Bureau of Family Health. At the regional level, family planning services are consolidating with STD services to ensure more effective, comprehensive clinical encounters for patients accessing health services in the PHUs.**/2013//

MCH coordinates with the state Ryan White and Title IV AIDS through joint planning and assessment of the perinatal population. Both programs participate in the regional infant mortality review process (FIMR). MCH has a longstanding collaboration with the OPH-STD program, identifying and reviewing records of infants born with syphilis and HIV, as well as coordinating programmatic aspects of sexually transmitted diseases that impact birth outcomes. The MCH Director currently serves as the co-lead with the Perinatal HIV Epidemiologist to coordinate a CityMatCH-funded project to review perinatal HIV exposure and infection cases and drive community action utilizing the FIMR prevention methodology. In addition, the MCH Director and senior MCH Epidemiologist participate in a cross-program HIV, syphilis, and hepatitis B perinatal surveillance and prevention workgroup./2013/**The MCH Program will be working with the STD/HIV Program to address congenital syphilis.**/2013//

MCH provides funding to the Immunization Program. Shots for Tots, Louisiana's Infant Immunization Initiative, is a network of public and private entities working cooperatively to update and educate parents and providers to ensure the highest level of immunizations possible.

Approximately one-third of the Nurse Family Partnership Program staff is hired through OPH. The remaining staff are hired through contracts and partners with a variety of state and local entities including Louisiana State University Health Sciences Center in New Orleans, Shreveport, Monroe, and Alexandria; Local Governmental Entities in Baton Rouge region, Tangipahoa and Jefferson Parishes; Nicholls State University School of Nursing in southeast Louisiana; Medical Resources and Guidance, Inc.; Southwest Louisiana Area Health Education; and St. Tammany Parish Hospital. Funding for support of NFP has come from community resources including the Institute of Mental Hygiene in New Orleans, Baptist Community Ministries (BCM), and the New Orleans United Way./2012/MCH has applied for the ACA Maternal, Infant, and Early Childhood Home Visiting (MIECHV) formula and competitive grants to expand evidence based home visiting

in Louisiana. NFP is the primary model but MCH seeks to support the development of other complementary models and their integration in the state's early childhood system.//2012//

The Medicaid Agency, the Bureau of Health Service Financing, and MCH coordinate in program development and data sharing. MCH is a Medicaid provider of EPSDT services, prenatal care, and case management. Local PHU assist pregnant women, family planning patients, and parents with the eligibility process for Medicaid and CHIP. In large PHUs, Medicaid has out-stationed an eligibility worker to expedite applications for pregnant women. MCH provided the data that showed the severe access problems facing the undocumented pregnant women who arrived in Louisiana post-Hurricane Katrina. Medicaid coverage for undocumented pregnant women was implemented May 2007. MCH Nurse Family Partnership Program is a Medicaid Targeted Case Management provider.

Infant Mortality Reduction Initiatives (IMRI) are funded by MCH in each of the 9 regions of Louisiana, including a staff person to coordinate and direct Fetal-Infant Mortality Review with a Case Review Team made up of public and private obstetric and pediatric providers and a Community Action Team made up of local community leaders. Regional coordinators are hired by social service agencies. MCH funds a Fetal Infant Mortality Review (FIMR) nurse through the New Orleans Health Department's Healthy Start Program. MCH provides funding for women with mental disorders in collaboration with the City of New Orleans Healthy Start program, local human service agencies, Nurse Family Partnership, and Parish Health Units. MCH has contracts with a New Orleans non-profit counseling agency to provide mental health services for children exposed to extreme violence including murder, families with a loss due to Sudden Infant Death Syndrome, and at-risk families with children age 0-5. MCH funds outreach, case management, and FIMR staff in the Baton Rouge, North Louisiana, and Lafayette Healthy Start Programs./2012/MCH is no longer funding case management in Baton Rouge.//2012//**2013/Support for Healthy Start in other regions of the state was discontinued. The regional IMRIs are now coordinated by a single Regional MCH Coordinator in each region, who is responsible for FIMR, CDR, and PAMR.//2013//**

A contract between MCH, the state Office of Addictive Disorders (OAD), and Ira Chasnoff, National Training Institute has been established to develop a statewide system addressing maternal substance abuse. The Screening, Brief Intervention, Referral, and Treatment (SBIRT) Program addresses prenatal substance abuse, mental disorders, and intimate partner violence. The state Office of Mental Health (OMH) is a key collaborator on SBIRT. OMH was awarded a grant for expansion of mental health services in Lake Charles for pregnant and postnatal women including those identified by the SBIRT initiative. The WIC Program provides SBIRT screening of pregnant women. MCH has a memorandum of agreement with the state OAD to provide pregnancy testing and prenatal care referral for women served by OAD. MCH provides the test kits, training, and access to services of the PHU for pregnant women./2012/SBIRT screening is being transitioned to routine PHU clinic protocols and reimbursable services via Medicaid.//2012//

Louisiana's Children's Cabinet, established by the legislature in 1998 as a policy office within the Office of the Governor, coordinates policy, planning, and budgeting that affects programs and services for children. It is composed of the Secretaries of the Departments of Social Services (DSS), Health and Hospitals, Public Safety and Corrections, and Labor; the Superintendent of Education; the Commissioner of Administration; a member of the Louisiana Council of Juvenile and Family Court Judges, and a representative of the Office of the Governor, and a representative of the Children's Cabinet Advisory Board. The Advisory Board provides information and recommendations from the perspective of advocacy groups, service providers, and parents. Advisory Board members represent a wide variety of non-profit agencies, health and educational institutions, assistant secretaries from agencies within the Departments listed above, and juvenile court. The Early Childhood Comprehensive System (ECCS) grant is administered as a joint venture between the Children's Cabinet and MCH. Legislation exists that request the following entities work together in the ECCS initiative: Office of Family Support and Office of Community Services (OCS) within the DSS; OPH, Office of Mental Health, Office of Citizens with

Developmental Disabilities, Office of Addictive Disorders, and the Bureau of Health Services Financing (Medicaid) within the Department of Health and Hospitals; State Department of Education (DOE) including the Pre-K and Early Childhood Education Programs section; Board of Elementary and Secondary Education; Division of Administration; and Office of Youth Development within the Department of Public Safety and Corrections. An Early Childhood System Integration Budget was written into statute during the 2008 state legislative session, requiring the creation of a budget reporting the spending on children ages 0-5 years in the four early childhood system component areas of ECCS Initiative now entitled BrightStart.***2013/The Title V Director is serving as the Chair of the Early Childhood Advisory Council (ECAC) executive committee.//2013//***

The MCH Program works closely with the Office of Community Services (OCS) within the Department of Social Services (DSS) to prevent child abuse and neglect. A Memorandum of Understanding (MOU) between the agencies exists to provide public health nursing assessments for children under investigation by the Office of Community Services (OCS) for suspected failure to thrive, malnutrition, or other medical neglect. The MCH Program works with OCS' High Risk Infant strategic planning committee to reduce infant morbidity and mortality due to intentional and unintentional injuries. Also, MCH collaborates with the Department of Social Services Child Care Licensing Section and the Office of Public Health, Center for Environmental Health to ensure that child care centers continue to receive the three hours of DHH-mandated health and safety training. The MCH Program works collaboratively with OCS in the promoting awareness of Louisiana's Safe Haven Law, which provides a legal means for parents to safely relinquish custody of unwanted infants up to 31 days of age without the threat of prosecution for neglect, abandonment or child cruelty. DSS provides TANF funding for MCH's Nurse Family Partnership Program.***2012/DSS is now the Department of Family and Children's Services (DCFS).//2012//2013/In June 2012, "Act 3"-The Early Childhood Education Act was signed into law. This law codifies the work that DCFS and Department of Education (DOE) have undertaken to align standards, financing, and supports across systems. DHH is actively contributing to the revision of the Tiered Quality Rating System for early care and education, revision of the child care regulations, and the development of a longitudinal early childhood data system. A priority for the coming year is to see how activities supported through Title V, such as the Child Care Health Consultant program, infant mental health training for early childhood professionals, the MCH parenting newsletter, can align to support the state's overall goals for young children's health, well-being, and readiness to enter school.//2013//***

The Child Death Review Panel, established by the State Legislature in 1993, reviews all unexpected deaths in children under the age of 15. This panel includes representatives from MCH, OCS-Child Protection Agency, Coroners Association, Attorney General's Office, American Academy of Pediatrics, State Medical Society, Vital Registrar, State Police, Fire Marshall, the Legislature and the general public. The MCH Program currently staffs a full time position for the Child Death Review Panel. MCH sponsors trainings on infant and child fatality investigation to educate coroners, death scene investigators, first responders, and stakeholders on conducting death scene investigations in a culturally competent manner consistent with standard protocol. The MCH Program collaborates with the Children's Justice Act (CJA) Taskforce within the Department of Social Services. The Child Health Medical Director serves as a member of the CJA Taskforce, which works to improve the investigation, prosecution and judicial handling of cases of child abuse and neglect, particularly child sexual abuse and exploitation, in a manner that limits additional trauma to the child victim. This also includes the handling of child fatality cases in which child abuse or neglect. MCH serves on Emergency Medical Services for Children (EMSC) Advisory Council. MCH has contracts with a New Orleans non-profit counseling agency to provide mental health services for children exposed to extreme violence including murder, families with a loss due to Sudden Infant Death Syndrome, and at-risk families with children age 0-5.***2013/Regional Safety Coordinators were abolished with budget reductions.//2013//***

Collaboration with the Louisiana Chapter of the American Academy of Pediatrics (LA AAP), and

contractual partnerships with hospitals, community agencies, and the Louisiana Public Health Institute (LPHI) enable MCH to carry out its child health and safety efforts. MCH contractual partners for the Child Safety Coordinators/Local Child Death Review Panel Coordinators include Children's Hospital in New Orleans, MCH Coalition in Baton Rouge, Options for Independence in Lafourche Parish, Area Health Education Centers of Southeast, Southwest, and North Louisiana, and Christus Cabrini Hospital in Alexandria.

A key provider of MCH services across the state is Louisiana State University Health Sciences Center (LSU-HSC). LSU-HSC administers the services of the 9 state operated hospital located in each region of the state. MCH contracts with LSU-HSC in 4 of the 9 regions to provide Nurse Family Partnership services. LSU provides prenatal care in areas of Shreveport with poor access to private care. The LSU-HSC provides obstetric and mental health expertise and consultation to the MCH Program. Internships for LSU-HSC School of Public Health students are provided in the MCH Program.

Tulane University Health Sciences Center (TUHSC) collaborates with MCH to provide essential services. Evaluation, biostatistics, and health communication expertise is provided through contracts with the TUHSC School of Public Health and Tropical Medicine. Each semester at least 5 MPH students conduct their required internship in the MCH Program. Tulane Department of Psychiatry provides faculty for infant mental health training and technical assistance for the Nurse Family Partnership Program. Tulane provides program coordinators to carry out the efforts of the BrightStart (Louisiana Early Childhood Comprehensive Systems Grant Initiative). The partnership will expand to include a parenting education coordinator of an evidenced-based parenting education model. The Tulane University MCH Leadership Training grant is carried out in close collaboration with MCH state and local staff. ***2013/MCH partnered with Tulane's MCH Leadership Training program to become an AMCHP Life Course Metrics state team. In addition, staff from Tulane have secured a paid intern to support the MCH Program's exploration of life course.//2013//***

The MCH Director serves on the State Commission on Perinatal Care and Infant Mortality, standardizing the framework for regionalization of perinatal services by determining the level of hospital services provided. These standards are used by the Hospital Licensing Section and for Medicaid reimbursement. The MCH epidemiologists present findings from birth and infant death and PRAMS data

The child dental sealant program is administered through local schools and in collaboration with Federally Qualified Health Centers and local dentists and dental hygienists. The Fluoridation Program works with local government agencies to provide education and fund water systems that are initiating community water fluoridation.

CSHS utilized its 2010 Needs Assessment as an opportunity to build new partnerships and enhance state agency coordination. The purpose of this year's Needs Assessment was to capture the existing medical home infrastructure capacity among primary care providers and the coordination of enabling services among CYSHCN stakeholder agencies. As such, three stakeholder groups were identified as key contributors to the process. These were primary care pediatricians and family practice physicians, families with CYSHCN, and representatives from ten government and community programs that provide direct care and coordination of services for Louisiana's CYSHCN and their families. The ten programs represented in the stakeholder group were CSHS, Hearing Speech and Vision (HSV), Early Steps, Supports and Services, Greater New Orleans Resource Centers on Developmental Disabilities, Vocational Rehabilitation, Independent Living, Foster Care, Family Services, and Families Helping Families (FHF). Three survey instruments (Physician Survey, Agency Survey and Family Survey) were used to gather data from the corresponding stakeholder group. Each instrument involved collaborative stakeholder development and review.

Based on survey findings, a long range plan was developed to address needed improvements in

care management and collaboration among agencies and among families and service providers. The long range plan includes enhanced coordination with FHF and Family to Family Health Information Centers (F2FHICs) in regional CSHS clinics and statewide to provide families self-advocacy information. In addition, FHF will facilitate information workshops to front-line stakeholder staff to increase knowledge of available services and referral between Department of Health and Hospitals (DHH) and Department of Social Services (DSS) agencies. This activity is consistent with the DSS-DHH Data Integration Project, a current collaboration between the two agencies to create a master patient index to facilitate a single point of entry for multiple program eligibility and care coordination. CSHS volunteered to help pilot this project. CSHS will continue to increase Medical Home capacity by establishing incentive contracts with primary care teaching practices to conduct care coordination and by providing technical assistance with care coordination to providers who expressed interest as a result of the Physician Survey. CSHS and Louisiana Birth Defects Monitoring Network (LBDMN) will coordinate with primary care practices, Louisiana Federally Qualified Health Centers (LFQHCs) and School Based Health Centers (SBHCs) to send Regional Resource Guides and Family Resource Guides to facilitate referral to community-based resources among providers and increase knowledge of available resources among families, respectively. CSHS will enhance its coordination with AAP and the Louisiana Academy of Family Physicians (LAFP) to advocate for the needs of CYSHCN in health care reform, through its collaboration with Medicaid to increase care coordination reimbursement, and by submitting articles on community-based resources and transition for inclusion in each academy's newsletter. //2012/DSS-DHH Data Integration Project meetings have been discontinued. Care coordination incentive contracts began for 3 new teaching clinics in Lafayette, Bogalusa, and New Orleans. Updated Regional Resource Guides and other community-based resource information were mailed statewide to LFQHCs, SBHCs, NCQA-certified physician practices responding to the 2010 Needs Assessment physician survey, and Neurology and Orthopedic adult and pediatric physician practices. LBDMN staff advertised the Family Resource Guide to birthing hospitals. Results of the Physician's Survey were published in AAP and LAFP Newsletters, emphasizing the need for care coordinators in medical homes. //2012//**2013/CSHS contracts with 9 FHF offices for Regional Information Workshops for agencies serving CYSHCN.//2013//**

CSHS has maintained a long-standing partnership with many local and statewide public and private agencies and organizations to address the medical and community resource needs of Louisiana's CYSHCN. CSHS coordinates with Children's Hospital through its model program for specialized care of children with diabetes. CSHS assures a multi-disciplinary team of a pediatric diabetologist, pediatric diabetes nurse educator, pediatric nutritionist, pediatric psychologist, exercise trainer and visiting pediatric diabetes liaison nurse. The goal of the program is to reduce emergency room visits, improve growth and development of children, as well as decrease the average blood glucose level of the enrolled children. CSHS coordinates with Tulane University Hospital for Children to provide pediatric subspecialty medical treatment for CSHS eligible children who have or who are suspected of having Cystic Fibrosis. This program involves both inpatient and outpatient care and prescription coverage for CSHS eligible children. CSHS coordinates with Louisiana State University Health Sciences Center (LSUHSC) at Earl K. Long Medical Center in Baton Rouge as well as LSUHSC Shreveport to provide in-hospital and discharge planning for infants who receive Neonatal Intensive Care following birth, as well as follow-up in High Risk Clinics after discharge. CSHS coordinates with Southeast Louisiana Area Health Education Center for a Statewide Parent Consultant who coordinates all aspects of family support and input into the CSHS program. CSHS contracts with FHF to provide parent liaisons in each of its nine regional subspecialty clinics to link families with community resources. CSHS provides subspecialty care for CYSHCN and their families in its regional clinics through partnerships with LSUHSC, Tulane University Medical Center, Ochsner Hospital and Children's Hospital. CSHS regional subspecialty clinics coordinate with local agencies, including schools, hospitals, FHF, parent support groups, Office of Mental Health, Office for Citizens with Developmental Disabilities, and private sub-specialists. In partnership with both LSU and Tulane Schools of Medicine, CSHS ensures that all pediatric residents trained in Louisiana understand the Medical Home model of care for CYSHCN, thereby provide comprehensive, family-centered,

and coordinated care. Recently, CSHS has expanded this partnership to the LSU Family Practice residency program as well./2012/The Family Resource Center (FRC) was established at Children's Hospital after Region 1 CSHS clinics were closed in December 2010. The FRC provides care coordination and transition services to former CSHS patients and will expand to include CYSHCN from Children's Hospital clinics. CSHS served over 13,000 CYSHCN through its direct service clinics and clinics that receive CSHS funds. The care coordinator at the LSUHSC pediatric clinic at Earl K. Long Medical Center trained Tiger Care Pediatrics staff on the use of the software program she developed for care plans to manage referrals for patients with complex needs.//2012//**2013/CSHS contracts with AHEC for the FRC nurse supervisor and FHF for parent and youth liaisons. Its Advisory Board will have LA Rehabilitation Services and Office for Citizens with Developmental Disabilities representation. FHF is expanding its Region 6 transportation contract statewide via regional FHF offices.//2013//**

CSHS advocates for CYSHCN through representation on statewide councils and boards. The CSHS Director participates in the State Planning Council for Developmental Disabilities in Louisiana. Other members of this council include the Advocacy Center, LSUHSC Center for Excellence in Developmental Disabilities, self-advocates, parents, State DOE, Office of Mental Health, Office for Citizens with Developmental Disabilities, Louisiana Rehabilitation Services, Governor's Office on Disability Affairs, Governor's Office on Elderly Affairs, and others. This ongoing collaboration addresses issues related to all aspects of life for persons with disabilities. The CSHS Director and the Statewide Care Coordinator Supervisor are members of the Advisory Board of the Louisiana Healthcare Quality Forum (LHCQF) Medical Home Committee. The LHCQF has been legislatively mandated to implement the Medical Home in Louisiana.

CSHS provides a continuum of services beginning at birth with birth defects surveillance and screening for disabilities. CSHS is implementing the LBDMN. The LBDMN Advisory Board consists of nine members including representatives from the Louisiana State Medical Society, Ochsner Foundation Medical Center, Tulane University Medical Center, LSUHSC, March of Dimes, MCH Coalition, Louisiana Office of Public Health, a parent representative, and a consumer representative. LBDMN partners with Lake Charles Memorial Hospital and Louisiana Public Health Institute (LPHI) for surveillance staff, and Spina Bifida Association of Greater New Orleans for its advisory board. LBDMN works closely with MCH for systems development./2012/LBDMN partners with Southwest Louisiana Area Health Education Center and LPHI for surveillance staff.//2012//**2013/CSHS contracts with LSU for 2 epidemiologists.//2013//**

The HSV Program within CSHS works closely with all birthing hospitals in the state to ensure hearing screening for all newborns. CSHS also coordinates with private audiologists and the medical community for follow-up evaluations as well as to provide needed services for families who lack insurance or have no access to local community services. CSHS coordinates with the Parent Pupil Education Program and Early Steps to ensure identified infants receive early intervention by 6 months. The State Advisory Council for Newborn Hearing Screening is appointed by the Governor, and includes 14 stakeholders that advise the program on the Early Hearing Detection and Intervention (EHDI) system in the state. EHDI works with Louisiana chapters of the Association of the Deaf, Commission for the Deaf, Hospital Association, AAP, LAFP, Speech/Language Hearing Association, American Speech/Language Hearing Association, American Academy of Audiology, Speech Language Pathologists and Audiologists in Louisiana Schools, and Board of Examiners for Speech Language Pathology and Audiology. EHDI partners with Southeast Louisiana Area Health Education Center for its nine statewide regional taskforce leaders and a statewide parent consultant./2012/HSV coordinates with schools and daycares for vision screening. Two vision specialists trained over 1,065 school volunteers in vision screening. Over 22,000 preschoolers were screened with photo-screening.//2012//

/2013/The Genetics Program works with the State Laboratory for Newborn Metabolic Screening. Lab data is matched with MCH, vital records, WIC, and LINKS (immunization) data to produce population based data and to locate children with abnormal screens. Infants identified with

metabolic conditions are referred to regional genetics clinics, staffed by LSU and Tulane geneticists. It contracts with LSU and Tulane Medical Schools for sickle cell and hemophilia services.

F. Health Systems Capacity Indicators

HSCI#1

Final data shows a decrease in the rate of children hospitalized for asthma in 2007 at 55.3 per 10,000 children under 5 years of age compared to 57.1 per 10,000 in 2006 and 60.3 per 10,000 in 2005. Compared to the 2004 rate of 74.4 per 10,000, the 2007 asthma hospitalization rate of children <5 years of age had decreased by 25.6%.//2012/Final data show a decrease in the rate of children hospitalized for asthma in 2008 at 48.5 per 10,000 children under 5 years of age compared to 55.3 per 10,000 in 2007. The rate increased to 52.2 in 2009.//2012//**2013/Final data show a decrease in the rate of children hospitalized for asthma in 2010 at 45.2 per 10,000 children < 5 years of age vs. 48.53 per 10,000 in 2008.**//2013//

Factors influencing this indicator include access to data to identify risks and asthma triggers, quality disease prevention, and health/asthma education, access to and utilization of appropriate medical care and medication, and relevant health care policy and practice issues.

The LA Bureau of Primary Care's Asthma Control Program developed one of the state's first surveillance systems to focus on children with asthma. Surveillance data analysis of childhood asthma indicators can measure asthma prevalence among children < 18 years. LA childhood asthma data sources include: LA Vital Statistics, LA Medicaid paid claims, LA Hospital Inpatient Discharge Data, emergency room data, BRFSS- Optional Childhood Asthma Module, Office of Public Health's Environmental Epidemiology and Toxicology Section, LA. Department of Environmental Quality ozone and particulate data, and Edgear school asthma data.//2012/Edgear school asthma data is no longer used.//2012//

Enrollment of eligible children into LA Medicaid/LaCHIP/ LaCHIP Affordable Program for families with income between 200-250 percent of FPL, will increase access to medical homes, preventive medical management, and to Medicaid's asthma support services. LA CommunityCARE's "Achieving Better Care for Asthma" is a statewide project available to Medicaid recipients to promote healthy behaviors; to improve medical home management by providing education, office management tools, and utilization data to providers; and to develop patient self-care through education. "Asthma HELP" Program is a free telephone-based pharmacy care program that provides printed education materials, asthma action plans, guideline summaries, and monthly telephone counseling to LA Medicaid recipients from licensed LA pharmacists certified by the National Asthma Educators Certification Board as asthma educators.

The LA Asthma Surveillance Collaborative (LASC), within the Chronic Disease Prevention and Control Section with the DHH provides guidance and assists in assessing, evaluating, and determining correlations with current state asthma data to improve community collaborations, advocate for an asthma-friendly environments, and develop a comprehensive asthma education program for schools, providers, and other members of the community. LASC received a grant to fund regional coordinators to provide community education and outreach statewide to establish asthma friendly communities, including schools and child care centers.//2013/**The name of LASC was changed in SFY 2012 to the LA Asthma Management and Prevention (LAMP) Program.**//2013//

HSCI#4

Final 2007 data for this indicator was 90.1%, preliminary 2008 data is 90.2%. Prenatal care access and utilization serve several important roles in monitoring the maternity population as an indicator of overall prenatal services including availability, provider willingness to accept Medicaid, transportation to care issues, patient utilization of services and awareness of benefits of care. Prenatal care rates in LA are improving, and IMR remain high but have decreased from

10.4 in 2004, 10.1 in 2005, 10.0 in 2006 to 9.0 in 2007 and preliminary data of 9.2 in 2008./2012/Final 2008 data for this indicator was 90.2%, preliminary 2009 data is unchanged at 90.2%. Overall rates of prenatal care adequacy have remained stable since 2006. Although prenatal care rates have improved, IMR remain high but have stabilized and not demonstrated measurable increase since 2001./2012//

In 2008, 68.4% of births were covered by Medicaid. MCH works with Medicaid for early entry into prenatal care by housing Medicaid eligibility staff in the PHU system. Medicaid has expedited the application process and women are enrolled quickly. MCH has contracts to provide prenatal care in areas where private providers are not available. A number of providers in the New Orleans region employ bi-lingual Spanish speaking staff. The PHB media campaign targets prenatal care as one of its primary messages, promoting early access to prenatal care. MCH provides free pregnancy testing in all OAD clinics statewide, with 2093 pregnancy tests given last year. Of these 35 women had positive pregnancy tests and were referred to a prenatal provider./2012/Enhanced provider acceptance of Medicaid reimbursement for maternity services has expanded and MCH has only needed to maintain active clinical contracts for direct prenatal care services in limited areas./2012//

Data sharing agreements are ongoing with LA vital records, Medicaid, Hospital Inpatient Discharge Data (LaHIDD), and Pregnancy Risk Assessment Monitoring System (LaPRAMS). Access has also been granted to data from the LA Birth Defects surveillance program conducted by CSHCN and CCYS conducted by the OAD. These additional data sources expand capacity to increase data analysis and dissemination of information. A primary goal of the State Systems Development Initiative (SSDI) is to enhance the data capacity of LA's MCH and Children with Special Health Care Needs (CSHCN) Programs. Improving existing and establishing new data linkages and surveillance systems enhance data capacity. Linkages between the birth files, infant death files, Medicaid eligibility files, women, infant, and child program (WIC) eligibility files, and newborn screening data continue to allow in-depth analyses by MCH and CSHCN Programs, which identify priority needs for programs and interventions. Data on prenatal visits are collected and analyzed through vital records and LaPRAMS. Although LaPRAMS operations ceased following the 2005 hurricanes, LaPRAMS resumed data collection in mid-2006 and completed a full year in 2007.

/2013/LA infant mortality continues to decline, to 8.8 per 1,000 births in 2009 and 7.6 in 2010. While prenatal care alone cannot be expected to reverse a lifetime of poor health and behavior, prenatal care is an important indicator to monitor. LA has traditionally reported the percent of women who receive at least 80% of expected visits for gestation, regardless of the timing of entry of care. Data indicate this percentage increased from 90.2% in 2009 to 92.0% in 2010. These rates correspond to 85.5% of LA women receiving adequate or adequate plus care on the Kotelchuck index in 2009 and 87.1% in 2010. Additional analyses were performed to investigate prenatal care adequacy. Results indicated between 40% and 50% of women exceed the expected number of visits for gestation, falling in the greater than 110% of expected visits (adequate plus) category. This is likely an indicator of poor prenatal health or pregnancy complications. In fact, 68.1% of women with self-reported hypertension, 75.3% of women with diabetes, and 62.9% of women with a prior PTB were in this adequate plus group. Further, among women who delivered the current infant preterm, 80.3% were in the adequate plus group and 56.1% of infants admitted to the NICU were born to mothers receiving adequate plus prenatal care. As nine months of prenatal care is unlikely to overcome a history of poor health and habits, this information further underscores the need for LA to actively participate in life-course methods and measures in order to continue improving birth outcomes./2013//

HSCI#5A

Medicaid serves to increase access and provide care for otherwise unfunded citizens and implies that the Medicaid population may have higher risks, such as increased poverty, poorer access to care, less education opportunities, compared to the non-Medicaid population. Reflective of these

increased risks, the low birth weight (LBW) rate for the Medicaid population is significantly higher than the non-Medicaid population. Preliminary 2008 LBW rate was 12.6% vs. 7.9% respectively. The overall preliminary LBW rate for 2008 was 11.2% as compared to 11.3% for 2007./2012/Preliminary 2009 data indicate that 10.7% of infants weighed less than 2,500 grams at delivery. The rate of LBW has slowly decreased by approximately 7% since 2005, when the rate was 11.4%. The preliminary 2009 LBW rate among Medicaid vs. non-Medicaid recipients was 12.0% vs. 7.6% respectively. Small declines in LBW since 2006 have been observed regardless of patient funding population.//2012//**2013/Preliminary 2010 data indicate that 10.8% of infants weighed < 2,500 grams at delivery. The preliminary 2010 LBW rate among Medicaid vs. non-Medicaid recipients was 12.2% vs. 7.6% respectively.//2013//**

LBW can provide valuable information as a general indicator of the state's maternal health status and prenatal care provision. While a surrogate marker for prematurity, it can also identify infants who have intrauterine growth restriction. By analyzing LBW infants, by regions and specific population groups such as payer type, it can help direct resources to those areas in most need. Specific interventions include the IMRI, smoking cessation program, dental services program, substance abuse and depression screening programs and prenatal services in areas with increased infant mortality and prematurity rates. Data linkages are in place with LA Hospital Inpatient Discharge Data (La HIDD) and with the LA PRAMS. Efforts are established to access to the LA Birth Defects Survey conducted by CSHCN and CCYS conducted by the OAD, and increase data analysis and dissemination of information from PRAMS and its linked data. The SBIRT program screening for alcohol use, tobacco use, substance abuse, depression and domestic violence in pregnancy is actively screening in public and private prenatal clinics in 8 of 9 regions of the state. Medicaid will require screening all pregnant women for tobacco use, a risk for PTB in October 2010. MCH collaborations with the DHH Tobacco Control Program and additional staff in MCH will focus this effort in training private providers. Take Charge and Family Planning are providing increased access to services for Medicaid eligible women, including tobacco cessation counseling. MCH provides Folic Acid to all women in OPH Family Planning clinics and is now providing multi-vitamins with folic acid. An expanded focus on preconceptional/interconceptional health services is occurring, especially in regard to prevention of adverse pregnancy outcomes. The SSDI grant enhances the data capacity of MCH and Children with Special Health Care Needs (CSHCN) Programs. Current linkages between the birth files, infant death files, Medicaid eligibility files, WIC eligibility files, and newborn screening data continues.

HSCI#5B

The 2008 preliminary infant death rate of the Medicaid population was 10.6 per 1,000 compared to 5.6 per 1,000 for the non-Medicaid population. Both rates reveal a decline from 2005 rates of 11.9 and 6.6 per 1,000, respectively. The infant death rate for all groups remained steady at 9.1 in 2008 as compared to 9.0 in 2007./2012/The 2009 preliminary infant death rate of the Medicaid population was 10.1 per 1,000 compared to 5.8 per 1,000 for the non-Medicaid population. Both rates reveal a decline from 2006 rates of 11.6 and 6.7 per 1,000 respectively. The infant death rate of 8.8 per 1,000 in 2009 represents the lowest population estimate since 2001.//2012//**2013/The 2010 preliminary infant death rate of the Medicaid population was 9.0 per 1,000 compared to 4.3 per 1,000 for the non-Medicaid population. The rate for the non-Medicaid population continues to decline while there was a 1.1% increase in the rate for the Medicaid population from the rate reported in 2009.//2013//**

Medicaid provides access and care for otherwise unfunded citizens, implying that the Medicaid population may have higher risks, such as increased poverty, poor access to care, less education opportunities, and higher utilization of substances as compared to the non-Medicaid population who would be assumed to have commercial insurance. By comparison of the 2 groups, indicators of areas to target for intervention result. Infant mortality serves as a broad marker of health status and health care utilization for women and children. Many factors contribute to infant mortality, but PTB, especially those less than 1500 grams, contribute heavily to the measure and is recognized and utilized by the general public and provides valuable comparison of a state over time, and by

trending, can serve as a marker for intervention success. It is important in evaluation of specific groups, as in the disparity present in African American and white births. Comparison between regions, states, and other countries of this marker are common. Multiple interventions have begun, including FIMR in each region, collaboration with other state agencies (Office of Minority Health Access, Medicaid, Mental Health, Tobacco Control, Addictive Disorders), SIDS/SUID media and education on the local level, and smoking/addictive disorder screening and treatment, faith based groups. Regional FIMR groups have placed increased focus and interventions on infant mortality, preterm births, and racial disparities. The Family Planning waiver, Take Charge, provides increased access to services for Medicaid eligible women. The SSDI grant enhances data capacity of LA's MCH and CSHCN Programs. Improving existing and establishing new data linkages and surveillance systems will enhance data capacity. Current linkages between the birth files, infant death files, Medicaid eligibility files, WIC eligibility files, and newborn screening data continues to allow in depth analyses by MCH and CSHCN Programs, which identify priority needs for programs and interventions. Data linkages are developed with La HIDD)and with the LA PRAMS. Efforts are established to access LA Birth Defects Survey conducted by CSHCN and CCYS conducted by the OAD, and increase data analysis and dissemination of information from PRAMS and its linked data.

HSCI#5C

Preliminary 2008 data indicates percent of infant born to women receiving prenatal care in the first trimester is 86.8% and the Medicaid population rate was 82.5% compared to 96.6% among the non-Medicaid Population.***2013/Final 2009 data indicate 87.5% of infants were born to pregnant women receiving prenatal care beginning in the first trimester. The rate for the Medicaid population vs. the non-Medicaid population was 83.6% and 96.5% respectively. Preliminary 2010 data show an increase of 0.5% of infants born to women receiving prenatal care beginning in the first trimester. The rate for the Medicaid population was 84.4% compared to 96.1% among the non-Medicaid population.//2013//***

MCH program funds direct prenatal services to indigent pregnant women in areas where there are access to care problems. The statewide MCH PHB campaign promotes early prenatal care through all of its activities, including multimedia, public relations and other communication strategies. The PHB website is continuously being updated to reflect needs of both providers and parents.

FIMR programs have been established in all regions of the state. The FIMR program (staff and coalition structure) is charged with assessing service delivery gaps including prenatal care. Partners for Healthy Babies supports public relations efforts of Fetal & Infant Mortality Review coordinators to engage local media to highlight relevant issues. The Nurse Family Partnership (NFP), nurse home visiting program provides case management services for first time mothers statewide, assuring early and adequate care for its enrollees. FIMR programs collaborate with Healthy Start programs in 5 of 9 DHH regions and encourage providers to refer to Healthy Start and/or NFP.

FIMR programs, through the Community Action Teams, serve as umbrella organizations within the community for MCH issues. FIMRs provided regional Needs Assessment meetings. Parishes in the lowest quartile for first trimester entry into prenatal care are targeted by Regional IMRI Community Action Teams for the development of additional prenatal initiatives. OPH partnered with the March of Dimes to implement regional Centering Pregnancy Programs, one of which targets Latina clients; others are in areas where there is inadequate access to prenatal care. State MCH efforts have been successful in improving early and adequate prenatal care. However, in order to address unchanging disparities in infant mortality and LBW, programs will be specifically tailored to reach out to populations and areas in greatest need.

HSCI#5D

Preliminary 2008 data indicate that the rate was 90.2% and for the Medicaid population was 89.2% compared to 92.4% for the non-Medicaid population.

MCH program funds direct prenatal services to indigent pregnant women in areas where there are access to care problems. To assure adequate prenatal care in the Medicaid population, the MCH program collaborates with 4 Healthy Start programs covering 5 regions of the state. The statewide MCH PHB campaign promotes early prenatal care through all of its activities, including multimedia, public relations and other communication strategies. PHB messages are designed to resonate with target audiences that have limited access to resources, including the Medicaid population. FIMR are in all regions of the state. Regional FIMRs conducted Needs Assessment meetings. The FIMR program (staff and coalition structure) is charged with assessing service delivery gaps including prenatal care. NFP, nurse home visiting program provides case management services for first time Medicaid eligible mothers statewide, assuring early and adequate care for its enrollees.

State MCH efforts have been successful in improving early and adequate prenatal care. In order to address disparities, programs are being tailored to reach out to populations and areas in greatest need, in order to make further progress.

/2013/Although the disparity in achieving at least 80% of expected visits for gestation persists, it is relatively small and stable (2009 Medicaid=89.5%, non-Medicaid=91.8%; 2010 Medicaid=91.1%, non-Medicaid=94.0%). However, the Kotelchuck combined measure of adequate and adequate plus care, including a component of entering prenatal care early in pregnancy, indicates a greater disparity among Medicaid women (Medicaid= 84.7%; non-Medicaid=92.6%). This suggests that while Medicaid women are having at least the recommended number of visits for gestation, they may be less likely to enter care early. Further analyses were performed to investigate differences by Kotelchuck group. The percent of women in the five groups, no care, inadequate, intermediate, adequate, and adequate plus were as follows for 2010: 0.4, 10.1, 5.1, 38.9, and 45.4% among Medicaid and 0.2, 2.7, 4.7, 47.2, and 45.3% among non-Medicaid women. While about the same proportion of women were categorized in the adequate plus group, a high-risk group, more Medicaid women received inadequate care and fewer received adequate care, the best outcomes group, than non-Medicaid women. This disparity may contribute to the disparity seen in poor birth outcomes among Medicaid women. As nine months of prenatal care is unlikely to overcome a history of poor health, habits, and access to care, LA should work to both reduce the percent of Medicaid women in the inadequate care group while participating in life-course approaches and measures to improve health and birth outcomes among all LA women.//2013//

HSCI#8

CSHS provides direct care in sub-specialty clinics in each region of the state for CSHCN without access to care. Because the eligibility of the program is restricted financially and medically, not all children with SSI qualify for CSHS. In addition, because children with SSI have Medicaid, many of them are able to access care in the private sector. When the needed sub-specialist is not available, either because of provider shortages in the region or because providers that are available do not take Medicaid, CSHS provides the care.

The reporting of this indicator is also influenced by data collection. Data available to CSHS from the Medicaid program does not differentiate between CSHCN receiving Title II (including dependents of disabled individuals) and Title XVI (for disabled individuals) services, although most children receive Title XVI services. The estimate is therefore deflated.

Regional CSHS offices currently have working relationships with their Medicaid and SSI offices. Children attending CSHS clinics who are eligible for SSI benefits are referred to the SSI office. Attempts to receive SSI data directly from the SSI office in order to contact families who may be interested in CSHS services have not been successful because the data sharing agreement with the federal office does not include access by other agencies. CSHS has made repeated attempts to have this data sent to CSHS on a regular basis from Medicaid, which is the program within

DHH that receives SSI recipient data, but to date has not been successful.

Limited eligibility as well as inflation of the number of children with SSI disability will remain factors in preventing improvement of this indicator./2012/There are no updates to this report./2012//**2013/CSHS has a liaison in Medicaid who assists with obtaining Title XVI SSI for CYSHCN attending CSHS clinics. CSHS is now working with the Genetics Program to help children with metabolic disorders and sickle cell anemia who meet the Title XVI criteria apply. Only 3.2% of CYSHCN in LA lack health insurance. In addition to serving CYSHCN in CSHS clinics, CSHS increases care coordination capacity in medical homes, which helps eligible families access both SSI and CSHS services. In 2011 CSHS served 21,493 CYSHCN in private and academic clinics through care coordination contracts. CSHS distributed care coordination materials to 2743 providers from different disciplines, including 57 physicians./2013//**

HSCI#9A

The MCH Program employs its Epidemiology, Assessment and Evaluation (EAE) unit to provide relevant MCH data to monitor MCH health indicators, evaluate programs, and assist in Title V MCH Needs Assessments. The EAE unit includes a CDC assignee MCH epidemiology team leader, a SSDI coordinator/senior MCH epidemiologist, a junior MCH epidemiologist, a Pregnancy Risk Assessment Monitoring System (PRAMS) coordinator, and a PRAMS operations assistant. In August 2010, a master's level CSTE fellow will join the EAE unit for two years. The Title V-MCH Director oversees the EAE unit. In addition, the CSHCN Director supervises one full-time epidemiologist who collaborates with EAE staff.

LA has a State Systems Development Initiative (SSDI) in place to support HSCI 09A. The SSDI coordinator and other MCH/CSHCN epidemiologists provide the foundation, tools and structure to assure the MCH and CSHCN programs access to policy and program relevant data.

The LA SSDI project focuses on improving the data/epidemiologic capacity of LA's MCH and CSHCN programs to address MCH relevant health problems and outcomes. The main goals of SSDI are to: (1) improve data linkages, analyses, and dissemination utilizing birth records linked with infant death records, Medicaid eligibility files, WIC eligibility files, newborn screening data, PRAMS data, LA hospital inpatient discharge data, and birth defects surveillance data; and (2) maintain access to and analyze data from the Caring Communities Youth Survey (CCYS). This bi-annually collected survey provides opportunities to better understand the risk and protective factors and behaviors of LA youth. The SSDI project is responsible for maintaining all MCH related datasets obtained through the various programs and assuring that the MCH program has access to the most recent data available for each data source.

From the linked data, surveys, and registries, MCH/CSHCN epidemiologists conduct analyses and program evaluations that provide relevant information to program staff and policy makers. This information is used to help the state prioritize needs and resources for developing programs and interventions to improve performance on national and state goals. The MCH/CSHCN epidemiologists work with program coordinators, providers, and other stakeholders to share information obtained from the analysis of surveillance data, linked data sets, and other MCH relevant surveys, and to seek program input on policy implications of results.

Analytic results are disseminated at the local, state, and national levels in the form of 1) presentations to the LA Perinatal Commission, MCH Coalition, and internal and external meetings and conferences (e.g., CDC MCH EPI conference), 2) publications in peer reviewed journals (e.g., LA State Medical Society Journal and Maternal and Child Health Journal), and LA Morbidity Report and 3) MCH data profiles and MCH data book on the DHH/OPH/MCH website.

/2012/Staffing losses include the junior epidemiologist and CSTE fellow; a birth defects epidemiologist joined CSHS. Current staff remains adequately prepared to guide vital program-data needs with all key activities ongoing. Expanded capacity is needed to assure future

comprehensive quality data.//2012//

/2013/Assuring timely data and EAE staff capacity remains a priority for the MCH Program. All HSCI 09A data sources continue to be available to EAE staff, who provide critical capacity for data analyses to monitor and recommend improvements to HSCIs and other measures. The CDC assigned MCH epidemiologist continues to provide scientific guidance to EAE staff. The MCH senior epidemiologist who has been the SSDI coordinator for the past several years will split time between MCH and CSHS, maintaining a part-time role of SSDI coordinator and strengthening data systems for both programs. New positions are in process to augment data capacity, including a SSDI data analyst, home visiting data analyst, and EAE unit supervisor. The SSDI analyst will add capacity to continue providing MCH relevant data, performing timely data linkages, and completing program relevant analyses, under the guidance of the SSDI coordinator. The home visiting data analyst will add dedicated capacity to examine, assess, and monitor home visiting programs. The MCH epidemiology supervisor will provide administrative and technical support to EAE staff and work closely with the CDC assigned epidemiologist to promote data translation. The CSHS birth defects epidemiologist resigned, and capacity was replaced through the newly dedicated split time of the SSDI coordinator. A new MCH mortality surveillance epidemiologist was also hired in December with special focus on fetal, infant, child, and maternal mortality. A dedicated PRAMS telephone operations assistant was also added to replace a former external contract.//2013//

IV. Priorities, Performance and Program Activities

A. Background and Overview

Through extensive quantitative and qualitative analyses of the 2010 MCH Needs Assessment, leading priority needs for MCH and CYSHCN populations were determined while also assessing local, regional, and state capacity to address these priorities. Since the 2005 Needs Assessment, the 2010 needs assessment showed improvements in access to prenatal care and in insurance coverage for women, infants, children, and CYSHCN. MCH concerns for racial disparities in infant mortality; injury morbidity/mortality; behavioral health; and oral health, persist as do the CYSHCN concerns for medical homes, access to comprehensive healthcare, limited availability of Medicaid providers, and transportation services. New priorities include the need for MCH to address obesity prevention and inter-conception care with chronic disease management; and for CSHS to address gaps in care coordination and transition services for CYSHCN.

Louisiana's 10 Priority Needs for 2010-15 are: (1) Decrease infant mortality through the reduction of preterm births in the African-American population; (2) Decrease intentional and unintentional injuries in the maternal, child, adolescent, and children with special health care needs populations; (3) Improve preconception and inter-conception health among Louisiana women; (4) Reduce unintended pregnancies and reduce births spaced less than 24 months apart; (5) Increase care coordination statewide for CYSHCN and their families; (6) Improve the nutritional health of the maternal and child population with a focus on obesity prevention and breastfeeding; (7) Assure that strategies and methods in MCH programming are culturally competent to reduce racial disparities; (8) Improve oral health of MCH population by increasing access to preventive measures and access to oral health care; (9) Improve the behavioral health of the MCH population through prevention, early intervention, screening, referral, and treatment where appropriate; (10) Increase preventive services for adolescents and transition services for adolescents with special health care needs.

The continuing State Performance Measures are: (SPM 1) Percent of all children/adolescents enrolled in public schools in Louisiana with access to School Based Health Center services; (SPM 3) Rate (per 1,000) of children <18 who've been abused/neglected; (SPM 6) Percent of women giving birth who undergo screening for substance abuse, depression and domestic violence using Screening, Brief Intervention, Referral and Treatment (SBIRT) approved methods; (SPM 7) Percent of women who use alcohol during pregnancy. The new State Performance Measures for 2010-15 are: (SPM 2) Percent of unintended pregnancies among women who had a live birth; (SPM 4) The difference in the percent of publicly insured and percent of privately insured CYSHCN in Louisiana who need more care coordination services; (SPM 5) Percent of late preterm births; (SPM 8) Percent of African American women who most often lay their baby on their back to sleep; (SPM 9) Percent of women who visited a healthcare worker to be checked or treated for high blood pressure during the 12 months before pregnancy; and (SPM 10) Percent of women delivering a live birth in less than 24 months of a previous live birth.

Compared to 2005 data, 2007 data for National Performance Measures (NPMs) and State Performance Measures (SPMs) showed improvements in newborns who screened positive for the newborn screening program conditions, with timely follow-up (NPM 1), infants breastfeeding at 6 months (NPM 11), newborns with hearing screens before discharge (NPM 12), women smokers in last 3 months of pregnancy (NPM 15), pregnant women using alcohol (SPM 7), Very Low Birth Weight infants delivered in facilities for high risk neonates (NPM 17), suicide rates of 15-18 years (NPM 16), and Fetal Infant Mortality Reviews (SPM 9). Compared to 2005 data, 2008 data showed improvements in 19-35 month old children with full age appropriate immunizations (NPM 7) and Louisiana public school students with access to School Based Health Center services (SPM 1). Compared to 2005 data, 2009 data showed improvements in 3rd graders with sealants (NPM 9), WIC children 2-5 years with BMIs >85th percentile (NPM 14) and CYSHCN with case management follow-up (SPM 4).

Compared to 2005 data, 2007 data for National Performance Measures (NPMs) and State Performance Measures (SPMs) worsened for birth rates for teens (NPM 8), motor vehicle death rate of children <14 years (NPM 10), uninsured children <18 years (NPM 13). [No new data for NPMs 2-6 since 2005-06; SPM 5 is now NPM 14, and SPM 6 and 10 are no longer reported.]

Compared to 2005 data, the 2007 and/or 2008 data stayed the same for infant births to women with 1st trimester prenatal care (NPM 18), women who received publicly-funded family planning services (SPM 2), rates of abused/neglected children <18 years (SPM 3), and Sudden Infant Death Syndrome rate (SPM 8).

The 2010-15 Priority Needs reflect Louisiana's leading/emerging health issues impacting MCH and CYSHCN populations. MCH will ensure evidence-informed strategic planning and resource allocation that address the new priority needs to improve performance measures, and ultimately health outcomes.

//2012/Priority need 7 reflects an ongoing commitment to promote culturally appropriate messages. Inclusion of a race-based experiences question on the 2012 PRAMS survey will enable quantification of cultural competence. SPM 9 was modified from blood pressure to pre-pregnancy diabetes due to word clarity of available questions while maintaining monitoring of chronic disease.

CSHS extensively analyzes appropriate data to monitor health and guide program activities. The National Survey of Children with Special Healthcare Needs is conducted every four years, most recently in 2009-10. New data are expected next year, at which time CSHS analyses will resume.

Historical data are not reported for new 2010 performance measures. Changes in data sources and lack of new data for all CSHS NPMs and SPMs, immunizations (NPM 7), dental sealants (NPM 9), and WIC children (NPM 14) have delayed assessments of temporal trends until next year.

Data from 2009-10 indicates that 100% of children received timely follow-up for screen positive newborns (NPM 1). Compared to 2007, 2009 data indicates improvement for hearing screens before newborn discharge (NPM 12), adolescent suicide rates (NPM 16), and child motor vehicle accident mortality (NPM 10). Louisiana public school students with access to School Based Health Centers (SPM 1) and rates of abused/neglected children (SPM 3) have also improved.

Infant breastfeeding at 6 months (NPM 11) and 1st trimester prenatal care (NPM 18) remained stable over the past few years. After achieving the Healthy People goal of 90% of very low birth weight infants delivered in facilities for high risk neonates (NPM 17) in 2008, 2009 indicated a slight drop in this measure. Compared to 2007, 2008-09 data indicate a higher percent of smoking and alcohol use in the last 3 months of pregnancy (NPM 15 and SPM 7), although prenatal screenings for substance use have increased (SPM 6).//2012//

//2013/The 2010 NS-CSHCN Survey indicates a demographic shift as older CYSHCN with increased health severity returned after Hurricane Katrina. NPMs regarding MH, health insurance, and transition decreased. Adequate insurance and ease of service use are still above the US average. The decline in % CYSHCN with a MH and % receiving transition reflects the lack of PCPs who take Medicaid. This makes priorities 5 and 10 (care coordination and transition to adult services) even more critical.

MCH and Family Planning are merging as the "Bureau of Family Health." This change will more effectively tap staff expertise and help ensure that program efforts are effective now and future-thinking. In 2012-13, BFH will be working to focus on potentially fewer, but higher-impact, strategies.//2013//

B. State Priorities

Priority Need 1. Decrease Infant mortality through reduction of preterm births in the African American population.

NPM's 8, 15, 17, and 18 are linked to priority need 1. NPM 8 measures the birth rate for teenagers aged 15 through 17. Teens have higher rates of premature birth than women over 20. In Louisiana, the teen birth rate among African American's is nearly 2 times higher than that of whites. Because prematurity increases the risk of infant death, monitoring the teen birth rate is important in planning efforts to reduce infant mortality among African Americans. NPM 15 measures the percentage of women who smoke in the last three months of pregnancy. National performance measure 18 was selected because it provides an assessment of whether prenatal care is initiated early in pregnancy, increasing the likelihood of positive birth outcomes. NPM 17 measures the percent of very low birth weight infants delivered at facilities for high risk deliveries and neonates. This performance measure was linked with priority 1 because increasing the percentage of low birth weight deliveries at facilities with staff who have specialized training and technology to care for very low birth weight infants decreases the risk of infant death. SPM 5 measures the percent of late preterm births, those occurring at 34-36 weeks gestation. SPM 6 measures the percentage of women giving birth who have been screened for substance use, depression and domestic violence. SPM 7 measures the percent of women who use alcohol during pregnancy. These have all been shown to have a negative effect on birth outcomes. SMP8 measures the percent of African American women who most often lay their baby on their back to sleep.

MCH staff and contracts dedicated to reducing infant mortality and preterm births include Maternal Health Medical Director, Nurse Consultant, Health Communication Coordinator, four Epidemiologists, two program managers, nine regional nurse coordinators of the Fetal Infant Mortality Review program and a contract for the social marketing campaign Partners for Healthy Babies. Other contracts with Healthy Start agencies and Office of Addictive Disorders address preterm prevention. ***2013/LA's strategic focus on reduction of pre-term births through the Birth Outcomes Initiative (BOI) is now part of a visible national focus. Partnering with colleagues in other states through the HRSA COINs will strengthen LA's approaches; a timely shift with the anticipated conclusion of the LA BOI as a stand-alone initiative by 2014.//2013//***

Priority Need 2. Decrease intentional and unintentional injuries in the maternal, child adolescent and CYSHCN populations.

NPM's 10, 16 and SPM 3, 6 and 8 were linked to priority need 2. NPM 10 assesses the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes. This measure was linked to priority need 2 because motor vehicles are the leading external cause of injury related mortality among children. NPM 16 measures the rate of suicide deaths among youth ages 15 to 19. Suicide is the third leading cause of injury related mortality among children in this age range. SPM 3 measures the rate of children under 18 who have been abused or neglected. This performance measure was selected as a result of data which show that nearly 10% of children in Louisiana are reported to be abused or neglected. SMP8 measures the percent of African American women who most often lay their baby on their back to sleep. SPM 6 measures the percentage of women giving birth who have been screened for substance use, depression and domestic violence.

MCH staff and contracts dedicated to injury prevention include Child Health Medical Director, two program managers, nine regional Child Safety Coordinators, three injury prevention program managers, two epidemiologists, over 100 Nurse Family Partnership nurses addressing intentional and unintentional injury, and a contract for social marketing campaign addressing safe sleep

environments for infants. **//2013/MCH has transitioned to a single MCH Coordinator in each region of the state responsible for FIMR, child death review, and maternal mortality. The focus is on ensuring a strong surveillance foundation, and increasing capacity to facilitate local action.//2013//**

Priority Need 3. Improve preconception and interconception health among Louisiana women.

NPM 15 and SPM's 7 and 9 were linked to priority need 3. NPM 15 and SPM 7 assess the percent of women who smoke and drink in the last trimester of pregnancy respectively. As such they provide an assessment of the risky behaviors among women during pregnancy. SPM 9 measures the percent of women who visited a healthcare worker to be checked or treated for high blood pressure during the 12 months before pregnancy. This performance measure was linked to priority need 3 as it is a direct measure of the health of women prior to pregnancy. MCH staff and contracts dedicated to preconception and interconception health include Maternal Health Medical Director, Nurse Consultant, Health Communication Coordinator, four Epidemiologists, two program managers, nine regional nurse coordinators of the Fetal Infant Mortality Review program and a contract for the social marketing preconception health The Stork Reality. A new initiative at the Department of Health and Hospitals (DHH) to improve birth outcomes will allow for more resources to address this important area of unmet need. DHH is implementing a new managed care system, Coordinated Care Networks that includes care coordination for postpartum women with chronic conditions and preterm delivery that will cover the interconception period. **//2013/The merged FP/MCH program will strengthen LA's on-the-ground and policy approaches to interconception health and unintended pregnancies. MCH is also working with BOI to assist with the development of a Grady model pilot. //2013//**

Priority Need 4. Reduce unintended pregnancies and reduce births spaced less than 24 months apart.

SPM 2 measures the percent of unintended pregnancies among women who had a live birth. SPM 2 is linked to priority need 4 because it provides a direct measure of pregnancy intention. SPM 10 measures the percent of women delivering a live birth in less than 24 months of a previous live birth.

MCH provides funding for OPH Family Planning Program infrastructure at local and state health department. Four

MCH epidemiologists address this subject and one is responsible for the Family Planning Medicaid Waiver evaluation. A contract for the social marketing preconception health The Stork Reality educates the public on the high unintended pregnancy rate. The MCH funded Nurse Family Partnership Program is a proven to increase pregnancy spacing.

Priority Need 5. Increase care coordination for CYSHCN and their families.

SPM4 measures the discrepancy between publically and privately insured CYSHCN who have unmet need for care coordination. NPM 2 measures the percent of children with special health care needs age 0 to 18 whose families partner in decision-making at all levels and are satisfied with the services they receive. NPM 3 measures the percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. NPM 5- The percent of children with special health care needs age 0 to 5 whose families report the community-based service system are organized so that they can use them easily.

CSHS central office staff include the director who is a board certified developmental pediatrician, a nurse consultant with over 30 years experience with CYSHCN, a social worker specializing in

CYSHCN, a nurse certified case manager, a nutritionist, an audiologist who directs the hearing, speech, and vision program (HSV), and parent consultants for both the CSHS and HSV programs, and a strong epidemiology section. The Newborn Hearing Screening Program and the Louisiana Birth Defects Monitoring Network are programs within CSHS, permitting early identification of infants born with hearing loss and infants with birth defects for provision of care coordination. Parent liaisons contracted from Families Helping Families in all CSHS clinics meet with families to identify need for community resources. Collaboration with F2FHICs provides additional support for parent liaisons and families with CYSHCN requiring access to care coordination resources. CSHS provides financial incentives for MH's to designate a care coordinator, and provides technical assistance to practices through its nurse certified case manager and social worker. CSHS trains all pediatric residents from both medical schools in the role of MH in care coordination and in public health and community resources. CSHS has formed a new stakeholder advisory group with representatives from all public health programs from both Department of Health and Hospitals (DHH) and the Department of Social Services (DSS) that provide services for CYSHCN and their families, permitting improved coordination between programs. CSHS participates in a DSS-DHH data integration project to make public health services easier to access for families by providing single point of entry into multiple programs./2012/The CSHS nurse consultant has retired. In 2011 CSHS added care coordination to 3 new practices, for a total of 7 that have received training. The DSS-DHH data integration project has ended./2012///2013/**Care Coordination was added to 4 MHs, FHF offices held 27 Resource Information Workshops, FHF in Region 6 provided transportation to medical visits, and CSHS distributed Resource Guides to health professionals. Yet SPM 4 increased, and NPMs for family involvement and CYSHCN with a MH moved below the US average, in part due to population shifts. 2010 NS-CSHCN data indicate the % CYSHCN in LA and disease severity increased./2013//**

Priority Need 6. Improve the nutritional health of the maternal and child population with a focus on obesity prevention and breastfeeding.

NPM's 11 and 14 were linked to priority need 6. NPM 11 assesses the percentage of mothers who breastfeed their infants at 6 months of age. This performance measure was linked to priority need 6 because it provides an assessment of breastfeeding duration. NPM 14 measures the percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index at or above the 85th percentile. This measure provides insight into the percentage of obese children receiving WIC services. As such, this performance measure provides information important to developing interventions early in development that may stem the tide of obesity later in life.

MCH staff and contracts dedicated to nutritional health include an MCH Registered Dietician, a program manager of the breastfeeding promotion program in delivery hospitals, the Maternal and Child Health Medical Directors, the social marketing campaign Partners for Healthy Babies, the WIC Program, Louisiana Obesity Council, and collaborative initiatives with Tulane University School of Public Health and Louisiana State University (LSU) School of Public Health. A contract is being developed with LSU to establish an early childhood obesity prevention program through child care centers and the Louisiana Department of Social Services who administers child care quality assurance and licensing./2013/**PN6 is a focus across DHH. MCH has successfully partnered with universities and foundations to leverage block funds. Major proposals to Blue Cross/Blue Shield pending./2013//**

Priority Need 7. Assure that strategies and methods in MCH programs are culturally competent to reduce racial

disparities.

SPM 8 was linked to Priority Need 7. It measures the percentage of African American women who most often lay their baby on their back to sleep. This measure assess MCH's efforts to increase back sleeping among the African American population through targeted initiatives including the Safe Sleep social marketing campaign. MCH contracts and staff dedicated to providing culturally relevant and appropriate resources include the Partners for Health Babies and Safe Sleep social marketing campaigns, Nurse Family Partnership program, tobacco control initiative, child care health consultant initiative, and obesity prevention initiative. In addition, MCH staff and contracts dedicated to assuring cultural competency of its programming include four epidemiologists who provide the race specific data and analyses that guide program development. ***/2013/Prompted by the energizing CityMatCH health equity conference and participation in a Kellogg action learning collaborative, MCH is actively reconsidering the approaches to cultural competency in services and reducing disparities. A priority focus./2013/***

Priority Need 8. Improve oral health of MCH and CYSHCN populations by increasing access to preventive measures and access to oral health care.

NPM 9 was linked to priority need 8. NPM 9 measures the percent of third grade children who received protective sealants on at least one permanent molar tooth. This variable is a standard oral health measure collected by the state oral health program and used to examine the oral health of children. It is also a measure collected across states allowing for cross state comparisons.

MCH staff and contracts dedicated to oral health include two program managers, an epidemiologist, a health educator, fluoridation engineer, an Oral Health Advisory Council, and contracts for dentists and dental hygienists to apply dental sealants in elementary schools.

Priority Need 9. Improve the behavioral health of MCH and CYSHCN populations through prevention, screening referral, and treatment, where appropriate.

NPM 15 and SPM's 6 and 7 were linked to priority need 9. NPM 15 and SPM 7 measure the percentage of women who smoke and drink in the last 3 months of pregnancy respectively. These performance measures provide some indication of the extent to which behavioral health services and interventions are needed. SPM 6 measures the percent of Louisiana women giving birth who are screened for substance use, depression and domestic violence using SBIRT. This particular measure was selected because it provides an assessment of the magnitude of behavioral problems that affect Louisiana women.

MCH staff and contracts dedicated to behavioral health include Maternal Health Medical Director, Child Health Medical Director, Mental Health Coordinator (LCSW), Maternal Health Nurse Consultant, Health Communication Coordinator, four Epidemiologists, two program managers, a state Medical Director and state coordinator and nine regional coordinators of the Screening, Brief Intervention, Referral and Treatment program, a contract for the social marketing campaign

Partners for Healthy Babies, six contracts for mental health professionals throughout the regions, Early Childhood Comprehensive Systems director and coordinator addressing social and emotional health. The Nurse Family Partnership program targets behavioral health and MCH funds a Clinical Director with PhD in Psychology, Program Manager, State Nurse Consultant, two Regional Nurse Consultants, Contract Monitor, and over 100 nurse home visitors./2013/MCH is helping BOI to develop a new behavioral health screening tool with Medicaid reimbursement./2013//

Priority Need 10. Increase preventive services for adolescents and transition services for youth with special health care needs.

NPM 6 and SPM 1 were linked to priority need 10. NPM 6 measures 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. This measure comes from the CYSHCN survey and is worded to be identical to priority need 10. SPM1 measures the percent of all children and adolescents enrolled in public schools in Louisiana that have access to school based health center services. This measure was linked to priority need 10 because it provides some data on the extent to which preventive services are available in school based health centers. As such it is also an indirect assessment of preventive services needed. School Based Health Clinics provide preventive and acute healthcare for youth in elementary and high schools throughout the state. The OPH Adolescent School Health Program (ASHP) provides training and technical assistance to all 62 SBHC sites. SBHCs are required to coordinate care with the student's PCP/medical home. SBHC sites are SCHIP/Medicaid application centers. Medicaid outreach to enroll students has decreased the percent of students without health insurance to 8% in 2008-2009. Partners for Healthy Babies and Stork Reality conduct social marketing campaigns to improve reproductive health. The Nurse Family Partnership Program targets young mothers with a median age among program participants of 19 years.

CSHS has a long history of providing care coordination and transition services for YSHCN in CSHS subspecialty clinics. A new pilot in Regions 1 and 6 provides transition services using web-based software to develop a care plan for youth with more complex needs. The transition program will be expanded to at least two other regions in 2011. CSHS will augment transition services in private practices through its MH initiative placing coordinators in private practices and teaching clinics. CSHS will add components of transition to its MH didactic sessions with LSU and Tulane pediatric residents and will place articles on transition in the AAP and LAFP newsletters. Finally, collaboration with the Louisiana Rehabilitation Services Independent Living Program and Vocational Rehabilitation Program will be increased through the new CSHS stakeholder group. CSHS will contract with FHF to train public health regional program staff that serve CYSHCN to refer to each other's programs. Finally, the DHH-DSS Data Integration Project will help to facilitate this by providing information regarding linkage and eligibility for all appropriate public health programs in the two agencies./2012//2013/CSHS clinics expanded to 4 new regions for a total of 6 out of 8./2013//

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	2007	2008	2009	2010	2011
Annual Performance	99	99	100	100	100

Objective					
Annual Indicator	97.9	98.8	100.0	100.0	97.7
Numerator	137	159	144	166	130
Denominator	140	161	144	166	133
Data Source		Louisiana Genetics Database	Louisiana Genetics Database	Louisiana Genetics Database	Louisiana Genetics Database
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
	2012	2013	2014	2015	2016
Annual Performance Objective	100	100	100	100	100

Notes - 2011

Data is for calendar year.

Notes - 2010

Data is for calendar year.

Notes - 2009

Data is for calendar year.

a. Last Year's Accomplishments

Direct

The Genetics Program continued to contract with medical geneticists, endocrinologists, hematologists, and pulmonologists to conduct specialty clinics at over ten sites reaching over 500 families, ensuring early detection and initiation into specialized care.

Enabling

Genetics clinic staff assisted families in obtaining specialty formulas, medications, and medical follow-up. Contracts were continued with Sickle Cell Foundations in 7 regions to provide patient assistance to families affected by sickle cell disease.

Population

In 2011, newborns screens were conducted on 61,727 infants who were born and resided in Louisiana. Based on newborn population estimates of 61,920 for 2011, this represents a screening rate of 99.7%.

Table 1 in the Attachments indicates the number of infants detected with the diseases included in the newborn screening battery from 2007 through 2011. Of all the infants screened in 2011, 155 infants had a confirmed diagnosis of a genetic disease. Sickle cell disease and congenital hypothyroidism remained the two most often diagnosed heritable conditions. Tandem mass spectrometry (TMS) has continued to play a prominent role in the state's ability to screen for numerous metabolic disorders. Although metabolic disorders make up 10% of presumptive positive results on the newborn heel stick screen, this methodology has improved the state's ability to play a vital role in preventing some of the debilitating effects of some of these genetic

conditions.

The Genetics Section worked to ensure that greater than 95% of newborns are screened for all the diseases on the official battery by providing education to medical providers on the legislation and rule mandating screening, proper bloodspot collection techniques and by only allowing Office of Public Health (OPH) approved laboratories to perform the tests on newborns. In 2010, Genetics matched newborn screening records with 2008 birth record data. This project showed that 97% of infants born in Louisiana in 2008 received a newborn screen. The results of the match have been used to assess and correct barriers to newborn screening.

The Genetics Program has been working to ensure that all infants who are presumptive positive for a genetic condition on the newborn screen receive timely and appropriate follow-up. The program monitors these children until a diagnosis is confirmed. As indicated in the Data Objectives, 100% of screen positive newborns received timely follow up to definitive diagnosis and clinical management, except in the instance of 2 of 79 sickle cell cases. Timely treatment was not received for these infants due to non-compliance by parents/guardians. Child Protective Services has been contacted to ensure that these babies receive appropriate care.

Prematurity may cause a delay in obtaining a definitive diagnosis in some infants. Since medical staff must focus on maintaining a premature infant's viability before presumptive positive genetic conditions can be addressed, the Genetics staff follow the progress of these infants until further testing on the presumptive condition is done and a final diagnosis is made.

From October 1, 2010 to April 30, 2011, the Genetics Program, in conjunction with the OPH Laboratory and Children's Hospital, conducted a pilot study on Severe Combined Immunodeficiency Syndrome (SCID) to determine the feasibility of placing this condition on the newborn screening panel. Over 32,000 blood samples were tested and none of those samples tested positive for SCID. More samples are needed to fully assess the value of adding testing for immunodeficiency disorders to the panel.

Infrastructure

The OPH Laboratory has maintained capacity to conduct testing on all 28 conditions on the newborn screening panel. This has allowed Genetics to contact providers sooner regarding abnormal results. Follow-up coverage after hours and on week-ends is also critical to the infrastructure of the program.

The Louisiana Newborn Screening Advisory Committee (LANSAC) continued to meet to discuss the impact of the adoption of the American College of Medical Genetics' core panel, Severe Combined Immunodeficiency Syndrome (SCID) pilot testing, unsatisfactory samples and newborn screening policy issues. Also, the ad hoc committees such as the Metabolic Advisory Group and the Cystic Fibrosis Advisory Group continued to meet to discuss issues that pertain to these conditions.

An attachment is included in this section. IVC_NPM01_Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct regional genetics clinics at 10 sites staffed by a medical geneticist.	X			
2. Provide care coordination for genetics clinic patients, including provision of special formulas and medications		X		
3. Provide clinic-based wrap-around services by contracted sickle cell foundation staff.		X		
4. Provide an educational program for sickle cell patients and		X		

families.				
5. Conduct universal newborn screening and follow-up for 28 conditions.			X	
6. Report results of a pilot study on newborn screening for Severe Combined Immunodeficiency Syndrome (SCID)			X	
7. Conduct training sessions with hospitals to reduce unsatisfactory screening specimens.				X
8. Provide an educational program for medical providers on metabolic diseases detected through tandem mass spectrometry.				X
9. Change Newborn Screening Rule to better reflect conditions screened for on panel.				X
10.				

b. Current Activities

Direct and Enabling

The Genetics Program continues to conduct regional genetics clinics for evaluation, counseling, and treatment. Clinics provide families with subspecialty formulas and medications regardless of income, which are frequently not covered by private insurance. Social work staff will work to identify Medicaid coverage for eligible families. Cystic Fibrosis (CF) patients are referred to 2 certified CF centers supported by CSHS. Contracted clinics provide medical evaluation and consultation for endocrine disorders (Congenital Hypothyroidism and Congenital Adrenal Hyperplasia). Regional sickle cell foundations provide support for SS patients.

Population

The core panel recommended by the Secretary's Advisory Committee on Heritable Disorders Newborns and Children (SACHDNC) the American College of Medical Genetics (ACMG) continue to serve as the basis for newborn heel stick screening. The Genetics Program continues to work with advocacy groups such as the March of Dimes to obtain necessary resources to implement current recommendations of the SACHDNC and the ACMG.

Infrastructure

The Genetics Program has consolidated with the Children's Special Health Services Program to form the Title V Children & Youth with Special Health Care Needs. This consolidation will add medical consulting and additional assistance with reimbursements that were previously missing from the program.

c. Plan for the Coming Year

Objective: Increase to 100% the percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies). The program will work with the Newborn Screening Advisory Committee to identify facilities with low testing rates and to develop methods for helping these facilities increase their testing rates.

Direct and Enabling

The Genetics Section will ensure the provision of specialized medical and nutritional management for 100% of affected infants identified through newborn screening. Genetics will continue to contract with medical schools to provide consultation for patients identified through the expanded screening. Genetics clinic social work staff will continue to work with families of uninsured infants to identify and apply for appropriate insurance coverage.

Population

The Genetics Section will review the current panel of the SACHDNC and ACMG and participate in discussions on how new conditions might be added to the panel. Critical congenital heart

disease is currently under consideration.

Infrastructure

The Genetics Program is working with the Southeast Sickle Cell Center at Tulane Health Sciences Center to establish a system for trait testing and counseling contingent on funding from a grant from the CDC. The program will continue to meet with stakeholders to develop a plan for transitional and adult care, and to address improvements in the current regional pediatric sickle cell system.

The Genetics Program will use data from the match with birth records to determine the testing rates at hospitals. The program will counsel facilities with low testing rates to determine barriers to testing and to help improve their testing rates.

The Genetics Program will continue to work with the state laboratory and to submitters to reduce the rate of unsatisfactory sample submission. The Genetics Program and the state laboratory are developing in-service training for submitters for newborn screening to address proper collection techniques. These in-services will take place in the top 5 of the 9 regions across the state identified as having the highest unsatisfactory sample submission rates.

The Genetics Section will convene the Newborn Screening Advisory Committee to review the data from newborn screening and to address emerging issues such as new testing methodologies and new conditions recommended by the ACMG .

Website enhancements will be made to provide a venue for improving the knowledge level of medical providers on newborn screening topics.

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:	61920					
Reporting Year:	2011					
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)	61727	99.7	6	2	2	100.0
Congenital Hypothyroidism (Classical)	61727	99.7	18	16	16	100.0
Galactosemia (Classical)	61727	99.7	15	2	2	100.0
Sickle Cell Disease	61727	99.7	82	79	77	97.5
Biotinidase	61727	99.7	10	8	8	100.0

Deficiency						
Cystic Fibrosis	61727	99.7	138	10	10	100.0
Tyrosinemia Type I	61727	99.7	1	1	1	100.0
Methylmalonic acidemia (Cbl A,B)	61727	99.7	2	2	2	100.0
Glutaric Acidemia Type I	61727	99.7	1	1	1	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	61727	99.7	101	9	9	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	61727	99.7	3	3	3	100.0

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	2007	2008	2009	2010	2011
Annual Performance Objective	62	65	65	65	65
Annual Indicator	62.2	62.2	62.2	62.2	67
Numerator					
Denominator					
Data Source		National Survey of CSHCN			
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
	2012	2013	2014	2015	2016
Annual Performance Objective	65	68	69	70	71

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.

Notes - 2009

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

This NPM increased from 62.2% to 67.0%. Despite this increase, Louisiana ranks below the US (70.3%) for this measure. However, there was a change in how this question was assessed between survey years 05/06 and 09/10. Families of children age 0-5 years report significantly higher rates for this measure compared to other age groups (0-5 years: 77% , 6-11 years: 67.2%, 12-17 years, 62.1%). Privately insured patients report higher rates than publically insured (77.5% vs. 61.0%). Higher rates are also seen among those who report having a Medical Home (MH) (89.1% vs. 53.0%). Non-Hispanic Whites report the highest rates for this measure as compared to other race/ethnicity categories (NH White: 74.1%, NS Black: 59.0%, NS Other: 54.1%, Hispanic 58.4%). Lower rates are seen among the Medicaid-eligible population (0-99% FPL: 60.7%, 100-199% FPL: 64.1%) versus non-Medicaid eligible (200-399% FPL: 65.6%, 400%+ FPL 81.8%). As health severity increases, less CYSHCN and families feel they partner with their provider in decision-making (4+criteria: 45% vs. 1 criterion: 73.9%).

Direct

Nine parent Liaisons (PLs) made 8,516 contacts with CYSHCN and families in CSHS clinics and during community outreach events. During these contacts, PLs most often discussed available community based resources (4,843 times), assisted families with completing applications and forms (334 times), and provided families with the LBDMN brochure (259 times). The information most often provided during these contacts include health information regarding the CYSHCN's condition (6,119 times), school/college/vocation training information (3,089 times), information regarding health insurance options (Medicaid: 1,443 times), and available recreation/leisure activities (1,736 times). PLs provided one on one support in all 9 regional CSHS clinics both in-person and by telephone, and by accompanying families to meetings, when requested. PLs assisted YSHCN and families with completing the Information Referral and Request Form in CSHS clinics as part of CC (279 times).

Enabling

Quarterly trainings for PLs were conducted by the CSHS parent consultant and parent training coordinator (PCs). Regional PLs attended 24 hours of training offered by CSHS. Topics included information on changes to IDEA and 504 accommodations, care coordination and transition, networking, medical home, and skills for taking care of the caregiver. An extensive orientation was provided to new PLs before beginning work in CSHS regional clinics. PLs statewide served on numerous boards and committees, providing insight to impact policy and services that may affect the lives of CYSHCN and their families.

Population

PLs performed community outreach, participated in health and information fairs, conducted support groups and provided trainings in community settings, based on the interests of families of CYSHCN. PLs referred families to Information Specialists at regional F2FHICs to provide additional information on state and national resources. The CSHS website maintained an ongoing list of regional, state and national support resources for families, including website

highlights for Spanish-speaking families. Family Matters (FM), the statewide CSHS newsletter, was published quarterly and contained information on services, regional activities and educational information for CYSHCN and families. Family Matters was posted on the CSHS website and disseminated in FHF regional offices. Two PLs who are parents of children with hearing loss worked in central office with the HSV program to follow-up with families of infants that failed newborn hearing screening. One PL is fluent in Spanish, English, and American Sign; the other in English and American Sign. The LBDMN Data Collection Specialist Supervisor is the parent of a child with spina bifida. She assisted with the Family Resource Guide to help families of children with birth defects navigate the health care system.

Infrastructure

CSHS, LBDMN and HSV all employed PLs appropriate to the population served to ensure that the parent perspective was included in all policy making and program activity decision making, to enable parents to access resources, and to be active partners in decision making for their CYSHCN. CSHS employed the 2 PC's and regional PL, HSV employed 2 PLs in central office, and LBMDN employed a PL who among other duties, assists with education and prevention activities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide direct support services to all families attending CSHS clinics to include services related to self-advocacy.	X	X		
2. FHF will incorporate self-advocacy skills information into current community outreach events.		X		
3. Publish Family Matters newsletter quarterly with articles on self-advocacy skills.			X	
4. Provide quarterly trainings for PL staff.		X	X	
5. Provide support to families of CYSHCN through local trainings, workshops and health fairs.			X	
6. Include statewide parent consultants in policy decision making at all levels.				X
7. Provide funding for CSHS staff and Parent Liaisons in all CSHS offices.	X	X	X	X
8.				
9.				
10.				

b. Current Activities

Direct

PLs continue to provide CYSHCN and families with the information needed to partner in decision-making. To date, 2,498 contacts have been made within CSHS clinics and during community outreach events. Health information regarding the CYSHCN's condition (1,158 times) and school/college/vocation information (917 times) continue to be most often provided. PLs continue to discuss community resources (1,264 times). PLs provided 525 self-advocacy services to families/CYSHCN in 8 regional CSHS clinics. CSHS opened a Family Resource Center (FRC) at Children's Hospital New Orleans (CHNOLA) in January 2012 to help families become aware of and access needed community resources. FRC staff include a Nurse Coordinator, Social Service Counselor and PL.

Enabling

Quarterly trainings for PLs continue and include updates on state agency services, networking skills and TA to assure families are able to partner in decision making. CSHS amended the FHF

contract to include self-advocacy skills.

Population

PLs inform families/CYSHCN about services and support information on the CSHS website. To date, PLs provided community resource information and educational materials in 697 community events statewide. The FM quarterly newsletter included 4 articles on self-advocacy.

Infrastructure

Title V Programs continue to employ PLs in CSHS, HSV and LBDMN as above, ensuring a parent perspective in all program decision making at local and state levels.

c. Plan for the Coming Year

Objective: To increase to 70% children with special health care needs age 0-18 whose families partner in decision making at all levels and are satisfied with the services they receive.

Direct

PLs will continue to offer self-advocacy skills information to families and CYSHCN in all regional clinics and the FRC. PL Information Linkage Forms will be updated, as needed, with TA provided, to capture pertinent information and activities. CSHS social service staff will address the disparate rates seen for this measure between those with and without a medical home (89.1% vs. 53.0%) by continuing to provide MH information when status is unknown or none. An additional PL and Youth Liaison will be added in the FRC to reach more families who utilize services at CHNOLA.

Enabling

The statewide PL consultants will hold quarterly trainings for all regional PLs to keep them informed of updated information, best practice services available and updated TA on the Information Linkage Forms. PLs will provide self-advocacy skills support during community events. PLs will be encouraged to serve on local boards, providing insight to impact policy and services that may affect the lives of CYSHCN and their families and provide support to other parents in learning skills to partner in decision making. The FRC will evaluate services using client surveys, and will hold regular Advisory Council meetings to direct its activities. Advisory Council meetings are facilitated by an independent PL and YL. Parents of CYSHCN will make up > 50% of the council.

Population

CSHS will continue to update its website, including the family and transition sections. The quarterly Family Matters newsletters will be posted on the website and will include information on transition, self-advocacy skills and community based resources. Family Matters will be distributed at CSHS clinics, the FRC and FHF offices statewide. Regional and community based events for families will be posted on the CSHS website. PLs will participate in outreach events statewide (workshops/health fairs) to provide resource and support information to families of CYSHCN. CSHS staff will research existing publications on MH for inclusion in community outreach events. The HSV program will continue to use PLs to support and assist parents of children with hearing loss to find appropriate resources. LBDMN will develop new educational and preventive materials with input from its PL and Advisory Board.

Infrastructure

CSHS will continue to employ 2 PCs and regional PLs in all 9 regions to assist in family outreach statewide. CSHS will continue to provide the Family Matters newsletter to all PLs. Statewide Parent Consultants will continue to provide quarterly trainings to all CSHS PLs.

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	2007	2008	2009	2010	2011
Annual Performance Objective	55	55	55	55	55
Annual Indicator	49.6	49.6	49.6	49.6	40.4
Numerator					
Denominator					
Data Source		National Survey of CSHCN			
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
	2012	2013	2014	2015	2016
Annual Performance Objective	55	41	42	43	44

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.

Notes - 2009

The data reported in 2009 are pre-populated with the data from 2007 for this performance measure.

a. Last Year's Accomplishments

Direct and Enabling

This NPM decreased from 49.6% to 40.4%. The % uninsured CYSHCN decreased with Medicaid outreach from 8.1% in 2001 to 5.2% in 2006 to 3.2% in 2010. More CYSHCN families make < 200% FPL (49.0% in 2006 vs. 52.1% in 2010) and more have Medicaid (52.6% in 2006 vs. 58.0% in 2010). Despite the increase in insurance coverage, most of La is designated as a HPSA, and

cuts to Medicaid rates have decreased Medicaid providers. In CSHS clinics, 97.5% of CYSHCN seen were linked with a MH. MHs received clinic notes after every visit. All Region 1 (New Orleans) subspecialty clinics were closed in December 2010 due to midyear cuts. Agency-wide lay-offs to address the budget deficit in December 2010 and July 2011 resulted in staff cuts, which led to 10 more clinic closures. As a result, fewer children were served than in previous years: In 2008: 4421; 2009: 4515; 2010:4734; 2011:4077. With the closure of Region 1 clinics, CSHS retained office space for a Family Resource Center (FRC) at Children's Hospital. A Social Service Counselor and Parent Liaison were retained for the FRC, which assisted CYSHCN in the transition to private clinics. Most CYSHCN were discharged to the same physician's private clinic. YSHCN were transitioned to adult providers. CSHS contracted with Families Helping Families (FHF) in Region 6 to provide transportation/stipends for medical appointments to CSHS eligible families. Subspecialty clinics continued in Regions 2-9, with teams consisting of physician, nurse, social worker, social service counselor, and parent liaison providing medical care, care coordination (CC), parent support, and transition services. These 4077 patients had 17,552 encounters and received 43,524 services and 1036 referrals.

Population

The CSHS Care Coordinator Supervisor updated Regional Resource Guides (RRG's) for all 9 DHH regions of the state, as well as region-specific comprehensive resource binders for use by care coordinators (CCs) in academic practices. In July 2011, 659 updated RRG's were sent to selected PCPs, CSHS clinics, MHs with CSHS funded CCs, all SBHCs, neurologists, orthopedists, NCQA certified MHs, school nurses and allied health students. They were also updated on the CSHS website. Transition materials for MHs were added. Contracts with 6 pediatric clinics to increase CC capacity were continued. Practices received \$20,000 to designate a > 50% FTE care coordinator, incorporate our CC system into the practice, and conduct MH Indices (MHIs) and MH Transition Indices (MHTIs) every six months. \$10,000 was given in year 2 to assure sustainability. Transition services were added to all contracted clinics. An LSU Pediatric Clinic of the AAP Chapter President in Baton Rouge applied for Level 2 NCQA certification. The CC software developed by this clinic was adopted by 3 other clinics. The total seen in CSHS contracted clinics for FY 2011 was 21,493, up from 8548 in 2010. CSHS contracted with FHF to conduct 3 Resource Information Workshops (RIW's) in each of the 9 DHH regions by June 2012, to help staff from various agencies refer to each other's programs. Despite these efforts, the discrepancy in unmet need for CC by insurance type increased significantly (SPM4: 2006: 11% vs. 2010: 19.9%).

Infrastructure

Two papers were published in MCH J on effectiveness of CC at Tigercare post-Katrina and on racial and geographic disparities in receipt of transition services, and a third was accepted on characteristics of YSHCN in the MH who receive transition services. The Title V CYSHCN Director and CSHS Care Coordinator Supervisor served on the state's Advisory Board for the Healthcare Quality Forum (LHCQF) MH Committee, which is a legislated stakeholder group to advise administration on health care reform. The reform model requires PCPs to provide CC and health plans to provide targeted case management outside of the MH. Five health plans were selected for managed Medicaid services, called "Bayou Health". A revised EPSDT Community Care II program was implemented by Medicaid until Bayou Health began in February 2011. A monthly reimbursement per capita fee for CC was stopped with Bayou Health. All 38 Tulane and LSU residents completing developmental rotations (directed by the CYSHCN Director) were trained in MH, CC and transition services. By incorporating MH into residency training, CSHS hopes to inspire physicians to incorporate MH concepts into their future practices.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide subspecialty care in shortage areas. Update policy	X			

manual.				
2. Link CSHCN in CSHS clinics to medical homes and send copies of subspecialty consults. Provide care coordination and transition services for adolescents.	X	X		
3. . Open Family Resource Center in Children’s Hospital, Region 1, to serve CYSHCN in outpatient clinics who come from all regions of the state. Link families with regional services including FHF offices for continued assistance.	X	X	X	
4. Provide transportation/transportation stipends for families to medical appointments/procedures.		X		
5. Provide care coordinators to pediatric and family practice teaching clinics.		X	X	X
6. Hold Regional Information Workshops in all 9 regions to improve coordination of referrals for services between agencies and programs for CYSHCN.		X	X	X
7. Provide updated Regional Resource Guides to PCP’s, FQHC’s, neurology and orthopedic practices annually.		X	X	
8. Work with administration and Medicaid to improve reimbursement for care coordination in medical homes by demonstrating effectiveness and publishing results				X
9. Participate in state HCQF Medical Home Advisory Group				X
10. Incorporate medical home model into LSU and Tulane pediatric and LSU family practice resident training.				X

b. Current Activities

Direct and Enabling

CC transition services expanded from Regions 3 and 6 to 2,7,8 and 9. A FRC nurse supervisor was hired. The FRC space was renovated and opened in January 2012. Parent and Youth Facilitators and Advisory Board members are being selected for the first Advisory Board meeting in June. By mid-April, the FRC had 456 client encounters with referrals to 653 resources. The FHF Transportation Service in Region 6 had served 10 families by March 30. CSHS clinics continue in Regions 2-9.

Population Based

Of 6 pediatric practices with CSHS CC, 2 were closed due to LSU budget cuts. Two other practice contracts will be ending with CC completely embedded in the practices. CSHS will continue to provide them resource materials. Four academic clinics were added: 2 LSU pediatric clinics, LSU Ochsner Family Medicine, and Tulane MedPeds. LSU MedPeds, Tulane Pediatric, and a third practice will begin in July. Resource binders and CSHS website were updated in April 2012. Updated RRG’s will be sent to FQHC’s, SBHC’s, school nurses, neurologists, orthopedists, NCQA certified MH’s, allied health students, and interested PCP’s. By June 28, all 27 RIW’s will be completed.

Infrastructure

The MH paper was published in MCHJ. Bayou Health began in Regions 1 and 9 in February and Regions 2, 3 and 4 in April. Regions 5, 6, 7 and 8 will begin in June. The Statewide CC Supervisor and CSHS Director remain on the Advisory Group of the LHCQF MH committee.

c. Plan for the Coming Year

Direct and Enabling

Only 38.0% of YSHCN age 12-17 have a MH compared with 43.1% of CSHCN age 0-5. Therefore CSHS will continue its new CC pilot in Regions 2,3,6-9 focusing on transition and expand to Regions 4 and 5 (Lafayette and Lake Charles). CSHS clinics will continue to provide

sub-specialty safety-net clinics in Regions 2-9, to link CYSHCN with MHs, and to send MHs copies of clinic notes. Staff shortages will continue to force smaller CSHS clinics and those with similar services in the private sector to close. Medicaid predicts more physicians will take Medicaid under Bayou Health. CSHS will expand services at the FRC and consider replication in other regions. The transportation stipends will be expanded statewide. CSHS will complete the revision of its clinic manual, and post revised sections on the CSHS website for staff.

Population

Because CC and transition were the priorities of the 2010 Needs Assessment, CSHS will continue to focus on CC activities in selected sub-specialty statewide clinics including cystic fibrosis, diabetes, and NICU follow-up clinics. FHF in each region will continue to hold 3 RIWs per year for the next two years. CSHS will continue to contract with 6 academic MHs for CC, and will begin 3 new 2-year \$20,000 CC contracts in July. CSHS supports 3 large teaching clinics continuously to assure sufficient staff for CC. The other 3 are in the second year of a 2 year contract and will receive \$10,000. Participating practices are required to provide transition services and to document progress with MHIs and MHTIs, and are encouraged to apply for NCQA certification. Bayou Health pays an increased monthly rate to NCQA certified clinics. Annually updated RRG's will be placed on the CSHS website and mailed to FQHC's, SBHC's, school nurses, neurologists, orthopedists, NCQA certified MH's, allied health students, interested PCP's, and family practitioners. CSHS will attempt to collaborate with Bayou Health Plans to offer CC tools, such as RRG's and resource binders, to all participating MHs.

Infrastructure

CSHS will continue to work with administration to ensure that the needs of CSHCN are considered in LA's health care reform, such as linking Medicaid reimbursement to NCQA criteria and providing financial incentives for CC in the MH. The CSHS Director and the statewide CC supervisor will continue to be active on the Advisory Stakeholder Group for the LHCQF MH committee. CSHS will ensure all LSU and Tulane pediatric and med-peds residents and LSU family practice residents receive training in MH and CC. The CC Supervisor will provide annual lectures to Allied Health Students at Delgado Community College on MH and CC. CSHS will draft a paper on the impact of CC on 11 MHs and their MH capacity for publication.

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	2007	2008	2009	2010	2011
Annual Performance Objective	57	70	70	70	70
Annual Indicator	65.5	65.5	65.5	65.5	63.4
Numerator					
Denominator					
Data Source		National Survey of CSHCN			
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
	2012	2013	2014	2015	2016
Annual Performance Objective	70	64	65	66	67

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.

Notes - 2009

The data reported in 2008 are pre-populated with the data from 2007 for this performance measure.

a. Last Year's Accomplishments

Direct and Enabling

This NPM decreased from 65.5% to 63.4%. Only 3.2% of LA CYSHCN were completely uninsured. Despite this decrease in adequate insurance, Louisiana is above the US average overall (61%), among all age groups, Medicaid-eligible families, and health severity levels. Among Non-Hispanic Other, only 61% report this measure and among Hispanic, 50%. Of CYSHCN in our state, 50% are publically insured and report the highest proportion for this measure (Private only: 61.9%, Public only: 70%, Private and Public: 60.1%). Those with a Medical Home (MH) report 75.3%, while those without report 56.5%. Increased health condition severity and older age are associated with less adequate health insurance (1 criteria: 66.7% vs. 4 criteria: 52.8%; age 0-5 years: 72% vs. age 12-17 years: 60.2%).

CSHS staff in all regions screened for Medicaid/insurance coverage for all CYSHCN as part of the nursing assessment and transition services. CSHS staff worked with families to determine insurance eligibility. CSHS staff linked 97.5% of CYSHCN to a MH that accepts their particular insurance plan. CSHS provided services to 4,077 patients. 91.4% of CSHS clients had Medicaid, 0.1% of CSHS clients had Medicare, 4.0% of CSHS clients had private insurance and 4.4% of CSHS clients were covered by CSHS as the payer of last resort. 7.7 % of CSHCN report not having insurance at some point in the past year, below the US average of 9.3%. CSHS paid \$ 11,757.90 in prescription insurance co-pays for CYSHCN. PLs and social service staff assisted families in applying for appropriate insurance/Medicaid coverage. Families were counseled on options including private insurance, plans such as Supplemental Security Income (SSI), LaCHIP Affordable Plan, Family Opportunity Act, Medicaid Purchase Plan (MPP) and Children's Healthcare Assistance Plan (CHAP) which assists families with limited resources to obtain services at Children's Hospital, New Orleans. PLs provided self-advocacy training on insurance to 156 families in CSHS clinics and 23 families at community outreach events. PLs provided insurance information to 96 CSHS patients and families and to 250 families at community outreach events. CSHS Central Office staff developed an insurance fact sheet to assist families with understanding insurance options. Medicaid mail-in applications were provided in CSHS clinic waiting areas. CSHS transition services included assisting clients with maintaining health insurance. Families of YSHCN =14 years were linked to Medicaid/insurance programs such as

SSI and MPP in all regions. Special focus was placed on patients with cystic fibrosis who are aging out of CSHS to address SSI and MPP applications that were denied. After the closure of all CSHS clinics in Region 1, the Family Resource Center (FRC) ensured that families transitioning to private clinics had adequate insurance.

Population

PLs provided CSHS brochures, health insurance brochures, and other information on insurance options to families and CYSHCN at health fairs and other community outreach events. CSHS staff communicated with Medicaid representatives to ensure coverage of CYSHCN, when needed. Regional Resource Guides (RRGs) listing services specific to CYSHCN were updated. CSHS mailed 756 RRGs, CSHS Physician Guides, Family Resource Guides(FRG), Families Helping Families, and CSHS brochures to Federally Qualified Health Centers(FQHC), School-Based Health Centers(SBHC), National Committee on Quality Assurance (NCQA) certified MHs, MD Needs Assessment survey respondents, and orthopedic and neurologic subspecialists, 265 school nurses, 14 CCs, and 18 School Linkage Committee (SLC) members. Among CSHS contracted practices, 88% of patients had Medicaid, 8% had Private Insurance and 4% were uninsured. The CSHS website was updated as needed with insurance resource information for families.

Infrastructure

The Title V CYSHCN Director and the CSHS Statewide CC Supervisor participated as active stakeholder advisors on the LA Health Care Quality Forum (LHCQF) MH Committee to try to ensure that new Medicaid reimbursement policies adequately covered the needs of CYSHCN, including care coordination. The Title V CYSHCN Director worked with the LA Chapter President of the American Academy of Pediatrics (AAP) to advocate for Medicaid reimbursement for CC. CSHS Central Office staff worked with the Medicaid contact to assist with SSI and MPP applications to reduce denial rates.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work directly with CYSHCN to link them to a Medical Home that accepts their insurance.	X	X		
2. Screen CYSHCN for health care coverage annually.		X		
3. Provide informational materials to families on Medicaid/insurance options.		X	X	
4. Update CSHS website with insurance resource information		X	X	
5. Update roster and mail RRGs, insurance and transition fact sheets and both FHF and CSHS Brochures to primary care providers, FQHCs, SBHCs, subspecialists (orthopedics, and neurologists), school nurses, CCs, pediatric residents, allied health students		X	X	
6. Collaborate with Medicaid representatives to address insurance application denials for CYSHCN.		X	X	X
7. Track and advocate for LA CYSHCN with regards to the Health Care Reform initiative.			X	X
8. Work with AAP to engage pediatricians in Medicaid healthcare reform policies.				X
9. Work to maximize the number of primary care providers for CYSHCN by advocating for increased Medicaid reimbursement for care coordination.				X
10.				

b. Current Activities

Direct and Enabling

CSHS PLs and CSHS staff assist families with selecting and applying for health insurance, including Medicaid's new managed care system, Bayou Health. PLs have provided self-advocacy training on insurance to 175 CSHS families and to 24 families at community events. PLs provided insurance information to 377 CSHS patients/families and to 101 families at community events. CSHS paid \$4,327.69 in prescription insurance co-pays for CYSHCN. Medicaid mail-in applications and insurance brochures and applications are available in CSHS clinic waiting areas. CSHS continues to address Medicaid denials for CSHS clients. The FRC is available to provide CYSHCN and families attending subspecialty clinics at Children's Hospital with resource information including insurance/Medicaid options.

Population

PLs disseminate information on Medicaid/insurance options at health fairs and other community events. The CSHS website is updated regularly with insurance resource information. CSHS regularly responds to website inquiries regarding access to health care services. CSHS mailed 659 updated RRGs, insurance and transition fact sheets, CSHS Physicians Guides, FRGs, CSHS brochures, and FHF brochures to FQHCs, SBHCs, and PCPs.

Infrastructure

The Title V CYSHCN Director works with DHH and Medicaid to increase reimbursement for CC services. CSHS continues to work with Medicaid Central Office to address insurance denial policies.

c. Plan for the Coming Year

Objective: 70% of families of CSHCN ages 0-18 will report that they have public or private insurance that is adequate to meet their needs. (CSHCN survey 2010)

Direct and Enabling

CSHS will continue to provide safety net sub-specialty clinical services. CSHS will pay insurance co-pays for prescriptions according to policy, and will continue to pay for uncovered medications, procedures, and durable medical equipment as needed. CSHS PLs and social service staff will assist patients and families with insurance plans and forms and direct them to other appropriate insurance resources. CSHS staff will continue to inform patients and families of available Bayou Health plans as roll outs continue in Southwest, Central and North Louisiana regions. PLs will provide self-advocacy skills information on navigating the health insurance system to CSHS patients and families. CSHS staff will target YSHCN who may be aging out of their current insurance coverage to help them obtain appropriate health insurance coverage with such programs as MPP, SSI, and Family Opportunity Act as only 60% of transition age youth report adequate insurance to pay for the services they need. CSHS will continue to provide mail-in Medicaid applications in all CSHS clinics as well as resource information on other insurance options. CSHS staff will continue to work with Medicaid to address/decrease denials. The FRC will continue to provide outpatients and families at Children's Hospital, New Orleans, with insurance/Medicaid resource options.

Population

PLs will provide and discuss health insurance resource information during health fairs and community outreach events. The CSHS website will be updated with current insurance resource information. The CSHS Insurance Fact Sheet will be updated as needed and translated into Spanish as only 50% of Hispanics report having adequate insurance to pay for the services they need. Both the English and Spanish insurance fact sheets will be disseminated to CSHS clinics, FQHCs, SBHCs, and Primary Care Providers. CSHS staff will continue to address website inquiries regarding access to services for CYSHCN. CSHS will continue to include information on insurance options to medical home practices with care coordination contracts, including special

emphasis on continuation of insurance for transition-age youth.

Infrastructure

The Title V CYSHCN Director will continue to work with liaisons to Medicaid to increase Medicaid reimbursement for CC services in the MH and to protect the needs of CYSHCN in healthcare reform. CSHS will work closely with administration to address Bayou Health issues for CYSHCN, such as CYSHN with multiple providers that accept different and non-overlapping Bayou Health plans. CSHS will work to minimize required referrals and other barriers to obtaining needed services as they arise in Bayou Health.

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	2007	2008	2009	2010	2011
Annual Performance Objective	75	90	90	90	90
Annual Indicator	89.3	89.3	89.3	89.3	65.5
Numerator					
Denominator					
Data Source		National Survey of CSHCN			
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
	2012	2013	2014	2015	2016
Annual Performance Objective	92	67	67	68	69

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.

Notes - 2009

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments

Direct and Enabling

This NPM decreased from 89.3% to 65.5% between National Survey of Children with Special Health Care Needs (NS-CSHCN) years; this reduction may reflect question changes. Despite the decline, Louisiana is above the US average (65.1%). There are disparities by family/CYSHCN characteristics: higher income improves the rate by 11% between <100% and 400%+ FPL incomes. The number of screening questions (health severity) decreases the rate from 73.9% (1) to 45% (4+). Moreover, this trend exhibits an interaction with age, where for each health severity increase, YSHCN report lower rates compared to their younger counterparts. The Medical Home (MH) and this NPM are associated: having a MH equates with an 82.9% rate, but without a MH it is 53.9%. These patterns are similar to the national rates. CSHS is addressing many of these disparities in programmatic activities. In December 2010, Region 1 clinics transitioned to a Care Coordination (CC) model through the CSHS Family Resource Center (FRC). CSHS retained two staff that assisted patients in transitioning to private practices. Medical services were provided to 4,077 CYSHCN in regional subspecialty clinics, addressing provider shortages in each area. PLs provided 1,036 referrals to Community-Based Resources (CBR) through direct consultations during clinics. The Statewide Parent Consultant and Training Coordinator (PCs) conducted quarterly trainings to PLs focusing on transition and self advocacy to enable family self-efficacy to navigate the service system. A special training session was conducted to introduce the new PL contact log and the corresponding SharePoint website where contacts are documented. The log was created to provide a more efficient means for documenting PL contacts with families, and to enable seamless editing in response to the changing needs of LA CYSHCN and families. CSHS expanded CC with transition services in regions 3 and 6.

Population

CSHS continued to lead the effort to increase state MH capacity. The Statewide CC Supervisor provided technical assistance to 6 established MHs: screening for CYSHCN, assessing needs, making resource information easily accessible to staff with wall-mounted brochure racks and region-specific CBR binders, and assisting with complex referrals. Clinic CCs led quarterly MH staff meetings for quality improvement. Updated Regional Resource Guides were mailed to all CC contract sites and 2010 Needs Assessment Physician Survey respondents. This laminated front-and-back guide facilitates linkages by serving as a quick-reference of CBRs. Additionally, CSHS did a mass-mailing of CBR information to a roster of 659 addresses including Federally Qualified Health Centers, School-Based Health Centers, NCQA-certified physician practices, and Neurology and Orthopedic adult and pediatric physician practices. LBDMN completed the second edition of its Family Resource Guide (FRG). The FRG is designed to provide families with infants who were recently diagnosed with birth defects the information necessary to obtain needed CBRs now and in the future. The FRG is advertised in all birthing hospitals and can be downloaded from the LBDMN website. CSHS community outreach included 2,457 contacts by PLs in family information fairs and educational workshops for families on CBRs. CSHS posted the quarterly newsletter, Family Matters, to its website, with featured articles on transition activities, summer camps for CYSHCN, and self-advocacy skills. The HSV PLs continued to follow-up with families of infants that failed newborn hearing screening. One PL is fluent in Spanish, English, and American Sign; the other in English and American Sign.

Infrastructure

CSHS was awarded the MCHB State Implementation Grant (SIG) for CYSHCN. The grant

improves access to a quality, comprehensive, coordinated community-based system of services for CYSHCN and their families that is family-centered and culturally competent. Receipt of these funds enabled expansion of the FRC, implementation of regional Resource Information Workshops (RIWs), expansion of the MH initiative to additional practices and the extension of existing CC contracts to include transition activities, and the creation of a program to provide transportation assistance to CYSHCN and families to medical appointments and related services. CSHS continued to employ PCs to facilitate support and training programs for PLs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Employ Parent Liaisons in all CSHS offices	X	X		
2. Provide workshops and educational programs through PLs to families with CYSHCN		X	X	
3. Fund a statewide transportation assistance program to medical appointments and services for CSHS and Genetics-eligible patients and families	X	X	X	
4. Provide community-based resource information to providers statewide			X	
5. Provide care coordination services through the CSHS Family Resource Center at Children's Hospital in New Orleans	X	X	X	
6. Expand Care Coordination in CSHS clinics	X	X	X	
7. Continue to update and enhance CSHS program website			X	
8. Fund resource information workshops for CSHS stakeholder front-line staff		X	X	X
9.				
10.				

b. Current Activities

Direct and Enabling

CSHS has expanded its care coordination project to regions 2, 7, 8, and 9. Youth ages >14 years receive targeted transition activities in preparation for adult health care, work and independence. PLs help families identify needed CBRs and document encounters on a daily contact log.

To date, 450 front-line state agency staff and community stakeholders have attended RIWs to learn about services offered to CYSHCN and families by other state agency programs. The FRC provides CBR information to CYSHCN and families attending outpatient clinics at Children's Hospital. In FFY 2011, 653 referrals were made during 456 family encounters. By April 2012, 10 families had received stipends/transportation to a medical appointment through CSHS' contract with Region 6 FHF for transportation assistance.

Population

In addition to CC, the CSHS MH initiative in private practices includes transition activities. The four new MHs received a \$20,000 stipend to designate an in-house care coordinator and incorporate MH principles within the practice as described above.

Title V CYSHCN staff maintain updated mailing rosters of all providers and hospitals who receive resource information. Staff regularly update all resource information materials.

Infrastructure

The CSHS Statewide Parent Training Coordinator retired after 20 years of service. The Region 6 PL now serves in this position. The PCs continue to provide trainings for PLs.

c. Plan for the Coming Year

Objective: 90% of families of CYSHCN age 0 to 18 will report that community-based service systems are organized so they can use them easily.(CSHCN Survey)

Direct and Enabling

The FRC will continue its expansion by providing additional support services with the addition of a youth and PL. FRC staff will work to ensure that Vietnamese and Spanish translations of resource materials are maintained as ease of use is lowest among these groups (Non-Hispanic White 68%, Non-Hispanic Black 64%, Non-Hispanic Other 57%, Hispanic 55%). Translation services via phone will continue to be available through the FRC. CSHS will contract with a computer programmer to develop and maintain a FRC database to capture all activities.

CSHS will work to address ease of use among low income families with the following activities: CSHS will expand its transportation service statewide. Region 6 FHF will develop a Memorandum of Understanding with other interested FHF centers to provide these services. Funds will be disseminated from Region 6 and will be based on anticipated demand in each region. CSHS will continue its contracts with FHF's to coordinate and facilitate 3 regional RIWs per center per year to increase referrals between state agencies. PLs will continue to provide direct consultation to all families/patients on community-based resources and document each encounter on a daily contact log.

Only 67% of transition-age youth report that they can easily access community-based services. CSHS will address this issue with completion of its statewide expansion of CC focusing on transition in CSHS regions 4 and 5. Only 54% of those without a MH report they can easily access community-based services. CSHS staff will continue to assess MH status during clinic visits and to link youth with MHs.

Population

Only 38% of transition age youth report receipt of services within a MH. CSHS will train three private academic physician practices on MH principles and transition activities. Resource information on cultural competence will be included in trainings as Non-Hispanic Other and Hispanics are among the lowest to report receipt of care within a MH (Non-Hispanic White 49%, Non-Hispanic Black 29%, Non-Hispanic Other 47%, Hispanic 33%). The Statewide CC Supervisor will provide presentations to each practice and expert technical assistance to the practices' designated CC. Each practice will be closely monitored during implementation.

Infrastructure

CSHS will reconvene its stakeholders to review RIW evaluation results and discuss any necessary changes to protocol. CSHS PCs will work with FHF Directors to update RIW regional manuals in preparation for SIG grant year 2 activities.

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	2007	2008	2009	2010	2011
Annual Performance Objective	10	44	44	44	44
Annual Indicator	40.9	40.9	40.9	40.9	32.8
Numerator					

Denominator					
Data Source		National Survey of CSHCN			
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
	2012	2013	2014	2015	2016
Annual Performance Objective	44	34	35	36	37

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.

Notes - 2009

The data reported in 2008 are pre-populated with the data from 2007 for this performance measure.

a. Last Year's Accomplishments

The 2009/2010 NS-CSHCN indicates that only 32.8% of LA's YSHCN received the services necessary to make transition to all aspects of adult life, an 18% decrease from the 2005/2006 NS-CSHCN survey results. This is disappointing, given that CSHS has focused on transition with many new initiatives in response to the 2005 NS-CSHCN Survey, when transition and screening were the only LA NPMs below the national average. LA remains below the US average (40.0%) for this NPM. One possible reason for this decrease is the gradual return to LA of many complex CYSHCN after Katrina. The 2005/2006 NS-CYSHCN was completed immediately after Katrina, when more complex CYSHCN had left the state because they did not have the resources they needed. The 2010 data indicate that the % CYSHCN in LA increased from 14.8% to 18.6% of children, and this increase was mostly in the 12-17 year age group (40.9% of CYSHCN vs 19.4% for 0-5 years). Data also indicate that there was a shift to more complex CYSHCN in the state (2006: 10.5% had 4+ criteria; 2010 14.8% had 4+ criteria).

Direct and Enabling

CSHS staff screened YSHCN in all CSHS clinics for transition needs and provided services to 1,909 transition aged youth. Expanded CC focusing on transition was continued in Regions 3 and 6. Region specific physician transition checklists were created for CSHS Care Coordination (CC) contracted practices, enabling physicians to assess needs by checklist and timeline as a care plan tool for continuing transition services. Additionally, region specific family/youth transition checklists were created and provided to all CC contracted practices and CSHS regional staff. CC contracted practices served 1,569 YSHCN, specifically targeting health care transition related to MH CC domains. About 10% (1,079) of PL outreach services focused on transition information. Regions 1, 2, 8, and 9 reported the highest rate of transition resources requested. This reflects disparate transition needs according to state geographic location. The FRC PL and the Statewide CC Supervisor provided transition information during 4 health fairs/community events.

Population

CC was expanded to 4 additional private practices, totaling 6 practices or 485 physicians/staff that received MH CC Transition (CC/T) Technical Assistance (TA), specifically addressing the healthcare transition MH domains. The CSHS website was updated with a transition section, for both providers and YSHCN/families. Regional Resource Guides (RRG) that list services/resources specifically for La CYSHCN were updated, and posted on the website. A CSHS transition fact sheet and an insurance fact sheet were developed specifically for LA's YSHCN. Transition articles continued to be published in the quarterly CSHS Family Matters Newsletter. CSHS continued partnerships with regional Medicaid staff to facilitate applications to other appropriate Medicaid programs for YSHCN, especially targeting those nearly age 19, the age at which LaCHIP eligibility ends. Staff continued to inform families about the Medicaid Purchase Plan and had success in assisting young adults to access these benefits while maintaining employment. The State PL Consultant and Parent Training Coordinator (PCs) continued to review transition concerns with regional PLs during quarterly meetings. CSHS mailed RRGs and FHF/CSHS brochures to a combined total of 756 FQHCs, SBHCs, NCQA certified MHs, MD Needs Assessment survey respondents, and orthopedic and neurologic subspecialists; 265 school nurses; 14 CCs; and, 18 School Linkage Committee (SLC) members. 39 pediatric residents from LSU and Tulane completing developmental rotations (directed by the CSHS Director), and 40 Delgado Community College allied health students were oriented on MH and CC and provided RRGs.

Infrastructure

CSHS participated in multi-agency assessment and collaboration among agencies in the Department of Health and Hospitals (DHH), the Department of Child and Family Services (DCFS), and Families Helping Families (FHF) as a component of the 2010 Title V Needs Assessment. One of the anticipated goals was to strengthen collaboration between the agencies that serve YSHCN during transition. The CSHS Statewide CC Supervisor participated in NCQA training. Two articles were published in the MCH Journal on CC and a third was accepted on characteristics of YSHCN in the MH who receive transition services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screen YSHCN in CSHS clinics for transition needs and provide information as requested.	X	X		
2. Provide transition care coordination in CSHS clinics in 6 regions of the state.	X	X		
3. Provide transition CC in 9 private primary care practices.	X	X	X	
4. Update transition section on CSHS website.		X	X	
5. Update CSHS transition fact sheet and transition check list		X	X	

6. Update CSHS insurance fact sheet		X	X	
7. Disseminate CSHS brochures and regional resource guides to FQHCs, School-Based Health Centers, and statewide orthopedic/neurologists and NCQA certified MH, health fairs, and community education programs.			X	
8. Provide quarterly transition training to CSHS PL staff.		X	X	
9. Develop 2 articles on community-based resources and transition for submission to AAP and LAFP.				X
10. Contract with FHF to coordinate and facilitate Resource Information Workshops.			X	X

b. Current Activities

Direct and Enabling

Staff screened 153 YSHCN in CSHS clinics on transition needs by April. The CSHS CC transition program expanded to Regions 2,7,8 and 9, thus 75% of clinic staff are trained in CC and transition services. CC contract MHs have screened 147 youth with 60 YSHCN identified. Transition materials including chart checklists were given to CC practices.

Population

The transition section on the CSHS website was updated. Nine CC contracts are in place. To date, 311 physician/residents received MH CC transition training. The Health Care Transition Index (HCTI) is used to assess practice transition capacity over time. All 9 practices completed the tool. In FFY 2012, two CC contract practices completed contracts; 2 have closed due to the loss of state funding. CSHS mailed RRGs, FHF and CSHS brochures, and insurance information to a combined total of 659 FQHCs, SBHCs, NCQA certified MHs, MD survey respondents, orthopedic and neurologic physicians, 250 school nurses, 10 CC, and 15 SLC members.

Infrastructure

CSHS contracted with FHF to coordinate and facilitate 27 regional Resource Information Workshops for front-line DHH/DCFS staff to learn about state resources available to CYSHCN and families. Articles on transition were included in the CSHS newsletter. MH CC transition training and RRGs have been provided by the CSHS Statewide CC Supervisor to 17 pediatric residents at Tulane and LSU in New Orleans and 20 allied health students to date

c. Plan for the Coming Year

Objective: To increase the proportion of Louisiana YSHCN who report they receive services necessary to make transitions to all aspects of life, including adult health care, work, and independence to 34% by FFY 2013.

Direct and Enabling YSHCN will continue to be screened for transition needs in all CSHS clinics and CC contract practices. CC in CSHS clinics will be expanded to the final 2 regions. Transition checklists will continue to be given to pediatric residents to use during continuity clinics. The Family/Youth checklist will be disseminated to the target group during clinics to further familiarize families/YSHCN with the transitioning process.

Population

The roster of pediatric/adult orthopedic/neurologists will be updated. Updated RRGs and transition and insurance factsheets will be sent to these practices. RRGs and transition and insurance factsheets will also be sent to FQHCs, SBHCs, NCQA certified MHs, pediatricians, and family practice physicians. The transition section of the CSHS website will be updated accordingly. School nurses will continue to receive RRGs and Family/Youth Transition checklists thereby reaching more YSHCN. CSHS staff will focus on YSHCN who may be aging out of their current insurance coverage to obtain appropriate health insurance with such programs as the Medicaid Purchase Plan, and SSI Disability Insurance Benefits. Three new CC contract practices will be added to receive MH CC transition training. Region-specific CC binders and wall-mounted

information will also be provided. HCTIs will be conducted with all CC contract practices. The CCs in CC contract practices will continue to orient physicians, residents, families, and staff on MH CC and transition.

Infrastructure

Articles on community-based resources and transition will be submitted for publication to both the AAP and LA FP newsletters. Articles on transition will continue to be included in the quarterly CSHS Family Matters newsletter. Lectures will continue to be presented to all pediatric residents at Tulane and LSU in New Orleans on MH CC and transition. Regional Information Workshops will be held to inform/update and increase knowledge among DHH/DCFS staff serving CYSHCN on services specific to YSHCN population, thereby facilitating more appropriate and frequent referrals between programs.

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	2007	2008	2009	2010	2011
Annual Performance Objective	84	82	82	85	85
Annual Indicator	77	81.9	74.9	75	71
Numerator					
Denominator					
Data Source		The National Immunization Survey (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	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	75	75	80	80	80

Notes - 2011

2011 data is provisional and based upon calendar year July 2010 – June 2011 data. NOTE: As of 2011, the seven-vaccine series (i.e., 4:3:1:4:3:1:4) will be reported by NIS as 4:3:1:0:3:1:4 and state coverage estimates included in this report were based on the series that excludes Hib due to the shortage.

Notes - 2010

2010 data is final and based upon calendar year July 2009 – June 2011 data. NOTE: As of 2010, the seven-vaccine series (i.e., 4:3:1:4:3:1:4) will be reported by NIS as 4:3:1:0:3:1:4 and state coverage estimates included in this report were based on the series that excludes Hib due to the shortage.

Notes - 2009

2009 data is final.

The National Immunization Survey (NIS) is sponsored by the National Immunization Program (NIP) and conducted jointly by NIP and the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention. The survey is a list-assisted random-digit-dialing telephone survey followed by a mailed survey to children's immunization providers. Estimates of vaccine coverage are produced for the nation and for each of 78 Immunization Action Plan (IAP) areas, consisting of the 50 states, the District of Columbia, and 27 large urban areas. Final 2009 data from the NIS survey for Louisiana indicates 74.9 + 6.5% of children within the ages of 19-35 months are at the appropriate immunization level for age for the vaccine series 4:3:1:3:3:1 which now includes 1 dose of Varicella vaccine in the series. NOTE: Because of changes in measurement of the Hib vaccine and the vaccine shortage that occurred from December 2007 to September 2009, state coverage estimates included in this report were based on the series that excludes Hib. Using this modified seven-vaccine series (minus Hib), coverage remained stable in 2009.

a. Last Year's Accomplishments

Direct

The block grant supported immunization services in OPH Parish Health Unit (PHU) clinics statewide. Approximately 184,045 vaccine doses were administered to over 98,100 eligible clients served at the local parish health units, a decrease of nearly 50% from the previous year. Local PHUs provide ongoing immunization services for children without a health care provider or insurance despite reduction in clinics and staff resources.

Population

The Immunization Program continued to raise public awareness through the Shots For Tots campaign to encourage parents to get their children two years old and younger vaccinated on an age-appropriate schedule. Louisiana ranked among the top 20 states nationally for immunization coverage rate among children 19-35 months according to the annual CDC National Immunization Survey.

The 19th annual Shots for Tots (SFT) was held in October 2011 to offer up-to-date information to all stakeholders with an interest in immunizations in the delivery of comprehensive immunization services, explore innovative strategies for improving immunization coverage, and provide the latest scientific information on policy changes and newly developed vaccines. Through this conference, health care professionals will keep abreast of changes in immunization recommendations for infants, children and adults.

Infrastructure

Collaboration between the Medicaid Program and LA-OPH Immunization Program continues with increasing progress for the incentive pay-for-performance (P4P) immunization initiative that involves participation by Vaccine For Children (VFC) providers and enrollment/utilization of the LINKS registry as means to achieve high immunization coverage rates within VFC practices. The P4P initiative will continue as funding permits.

Perinatal Hepatitis B active case finding using electronic lab data has shown significant improvement in detecting HBsAg positive pregnant females in addition to improvement in data quality. Accuracy and completeness of perinatal HBV infection reporting helps ensure and measure progress toward elimination of HBV transmission.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supply vaccines to enrolled providers through the Vaccines for Children (VFC) program.			X	
2. Expand VFC provider enrollment.			X	X
3. Expand on-site VFC/AFIX (Assessment Feedback Information Exchange) active provider sites.				X
4. Expand the Louisiana Immunization Network for Kids Statewide (LINKS) by interfacing with electronic health data systems.				X
5. Enhance efforts to provide immunizations in public health units monitored by CASA state surveillance reviews.	X		X	X
6. Continue with Medicaid Program with pay-for-performance incentives to improve immunization practices.		X		X
7. Annual Statewide Shots for Tots Conference.				X
8. Conduct immunization reminder/recall notifications quarterly.		X		
9. Annual National Infant Immunization Week campaign.		X		
10. Perinatal HBV hospital survey and evaluate HBV protocols.				X

b. Current Activities

Direct

As a result of layoffs in 2011-12, OPH reduced staff and available PHU clinic sites around the state, however collaboration with FQHCs and Rural Health Centers (RHCs) are being implemented to assure the safety net of under-insured and non-VFC eligible clients.

Population

The Immunization Program has continual focus on improving activities associated with the perinatal Hepatitis B Virus (HBV). The Perinatal Hepatitis B Prevention Program (PHBPP) plans to evaluate policies and procedures of all birthing hospitals statewide by surveying practices regarding HBV prophylaxis management, maternal hepatitis B status documentation and infant universal HBV birth dose vaccination. Results of this survey will be validated by abstraction of maternal medical records by random sampling of hospitals.

National Infant Immunization Week (NIIW) is an annual campaign to promote vaccines for children 2 years and younger. The Louisiana Shots for Tots Coalition distributed packets to all child care centers and Head Starts in LA as an effort to improve compliance and raise immunization rates among infants and children. In addition, the LA SFT Coalition is hosting the 2012 National Conference on Immunization and Health Coalitions.

Infrastructure

The Louisiana Immunization-Medicaid P4P initiative will end as of June 30, 2012 due to funding cessation. This initiative demonstrated a cost effective impact to increase immunization rates using cash incentives.

c. Plan for the Coming Year

Objective: To improve the current statewide vaccination coverage rate by 5% among children 19--35 months of age for year 2012-13 with completion of the 4:3:1:3:3:1:4 series to achieve the 90% Healthy People Performance Objective.

Direct

The Title V Block Grant will continue to support immunization services in PHU clinics statewide. Quarterly reminder notifications will continue to be mailed to PHU clients to ensure that children are up-to-date on their vaccinations and to monitor and improve immunization coverage levels. To vaccinate at least 80% of children 19--35 months of age will require maintaining partnerships between the Immunization Program, Shots for Tots (SFT) Coalition, community coalitions and health care providers.

Population

Perinatal Hepatitis B data collection from hospital surveys and random medical record review will be completed and analyzed to determine outcomes related to the ACIP-recommended case management of maternal HBV-infected women to prevent mother-to-child HBV transmission.

Educational focus campaigns will be implemented to promote and administer the Tdap vaccine to expectant mothers and close contacts of newborns, train providers on vaccine accountability, increase IPV vaccine among children <24 months of age and increase and enhance measles surveillance activities as a result of recent measles outbreaks. Planning is underway for the 20th SFT Conference scheduled for October 2012 in New Orleans.

Infrastructure

The Immunization Program will continue to work with regional and local health departments to raise immunization rates by providing feedback data via the Clinical Assessment Software Application (CASA) files sent annually. CASA data provides feedback regarding immunization coverage throughout the state and allows the opportunity to assess areas in need of improvement by providing vaccination education, resources for clinicians who provide vaccines and guidance for parents. The child-care module via LINKS to capture child-care aggregate data for up-to-date and age-appropriate vaccination coverage is still pending due to funding.

The pilot study with METRON, the same system used by physicians for billing purposes, is still uploading data to LINKS as the assessment phase. Potential feedback from this pilot study will provide immunization coverage rates among private providers. Other pilot programs underway include interfacing LA Health Information Exchange data to LINKS that captures specific immunization data as well as meaningful use efforts to interface with Electronic Health Records/Electronic Medical Records systems to LINKS.

The VFC staff conduct ongoing private provider site visits striving to communicate effectively about vaccine safety, ensure providers have effective tools for educating parents, promoting collaboration, maintain trust in vaccines and improving standards of practice. Staff evaluates proper management of vaccines to reduce loss and minimize waste.

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	2007	2008	2009	2010	2011
Annual Performance Objective	25	25	24.5	24	23
Annual Indicator	30.9	28.8	28.4	23.8	23.8
Numerator	2892	2721	2651	2297	2297

Denominator	93471	94353	93482	96619	96619
Data Source		Louisiana Vital Records and Statistics			
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?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	23	22	22	22	22

Notes - 2011

2011 data is provisional and based upon the 2010 data.

Notes - 2010

2010 data is provisional and based upon the 2010 data.

Notes - 2009

2009 data is final.

a. Last Year's Accomplishments

In 2010, the total number of live births for female teenagers aged 15 through 17 was 2,297 and the total number of women all ages was 58,619. The 2010 rate of birth (per 1,000) for female teenagers aged 15 through 17 years was 23.8 versus 28.4 in 2009 and 28.8 in 2008. In 2010, Louisiana ranked 18th for the rate of teen pregnancies and 13th for teen birth rates in the nation.

Direct

The primary direct service related to preventing pregnancy is the statewide network of OPH Family Planning (FP) services. The OPH FP program provided comprehensive reproductive healthcare services to 45,707 women in 64 parishes in Louisiana through OPH Parish Health Units (PHU) in 2011. Services included: physical examination, preventive health screenings, pap smears, education, counseling, and contraceptives including long acting reversible contraceptive methods (LARCs). In the same year, 3,071 female teenagers aged 15 through 17 utilized family planning services, which is a decrease from previous years. Adolescent clients continue to be a high priority in Family Planning (FP) clinics throughout the state of Louisiana. In addition to traditional health care services, age appropriate education and counseling was provided and parental involvement was encouraged.

The FP Program adolescent contract site provided young males in the New Orleans Metropolitan area with health information, education and clinical services. Education was focused on contraceptive methods, preconception counseling, fatherhood counseling, and STD/HIV prevention and treatment. Services were provided during traditional and non-traditional hours. This location has traditionally attracted youth at high risk for reproductive health problems,

including the homeless. The FP Program also worked with the School Based Health Centers (SBHCs) to ensure referral to FP clinics for services that are not provided in the SBHCs.

Enabling

The OPH FP Program continued to conduct outreach activities in all Louisiana parishes to ensure increased awareness of services. Outreach activities were conducted in community based settings including schools, faith-based institutions, and healthcare settings.

The FP Program increased its reach through a grant from the Office of Adolescent Health to implement an evidence-based teen pregnancy prevention program, Teen Outreach Program (TOP). The FP Program piloted the selected program providing adolescents with Life Skills training.

The OPH MCH Nurse-Family Partnership (NFP) Program continued to provide services statewide. As a program working with first-time mothers, family planning including healthy pregnancy spacing and pregnancy intention is addressed as a part of the curriculum.

Population

The MCH Program's Partners for Healthy Babies (PHB) website and helpline both promote information about pregnancy and resources. In May 2011, MCH Program staff, together with the program's contracted marketing firm and some key external partners, met to discuss the possible development of a pre-/ interconception social marketing campaign. The priority area identified was around the concept of promoting a "life plan" which would include pregnancy intention and pregnancy spacing. Due to budget reductions in the fall of 2011, the development of the campaign has not been actively pursued, but is anticipated. FP started using the new texting program to find family planning services.

Infrastructure

MCH epidemiology staff analyzed Vital Records and PRAMS data to identify areas of the state with high teen birth rates and capture information about health behaviors prior to, during, and after pregnancy.

To identify barriers to FP services for adolescent clients, Mystery Caller Assessments were conducted in all service sites in 2011. The results of the assessment lead to trainings to improve adolescent service.

In June 2011, the FP Program hosted a Summit for the employees and stakeholders. The agenda included a session on effective outreach strategies for all populations, including adolescents.

Adolescents continue to be recruited as FPP State Advisory Board members.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide comprehensive reproductive health care services to adolescents.	X			
2. Present and distribute education materials to teens and professionals.		X	X	
3. Provide technical assistance on teen pregnancy prevention mass media campaigns.			X	X
4. Provide training manual to clinic nurses for education on adolescent reproductive health issues.				X
5. Conduct Mystery Caller Study and Needs assessments to				X

assess adolescent need				
6. Promote clinical trainings to create a teen-friendly environment and increase teen utilization.				X
7. Collaborate with CBOs to implement teen pregnancy prevention programs	X	X		
8. Develop Adolescent Resource Directory		X		
9. Participating in the Teen Pregnancy Prevention Coalition and organizing teen pregnancy prevention activities			X	
10.				

b. Current Activities

Direct

OPH continues to offer or ensure comprehensive reproductive health care services, including preventive health screenings are provided to FP clients.

Enabling

The FP Program has continued to conduct outreach activities in all Louisiana parishes to ensure increased awareness of services.

The FP Program is continuing implementation of Teen Outreach Program (TOP).

NFP Program continues to provide services statewide.

Population

The MCH Program's PHB website and info line both promote information about pregnancy intention. The FP Program promoted a text message service to locate FP services.

Infrastructure

Vital Records and PRAMS data collection and analysis continue. A dedicated women's health epidemiologist is planned to support the merged MCH and FP programs.

The FP program staff have provided trainings on various topics, including "Reaching Adolescents in Family Planning" and "Human Trafficking."

To better serve the adolescent community an Adolescent Resource Directory was created and will be published by the end of the year.

The OPH MCH and FP Programs are in the midst of developing a merged administrative program model, likely to be named "Bureau of Family Health." With MCH and FP sharing so many key indicators, outcome goals, and strategies, combining the programs will strengthen the state's overall ability to address prevention, pregnancy spacing, pregnancy intention, and interconception health.

c. Plan for the Coming Year

Direct

Direct FP services through OPH will be implemented as newly-transformed comprehensive personal health services through merging STD and FP clinical services.

Enabling

The OPH FP Program will continue to conduct outreach activities in all Louisiana parishes to ensure increased awareness of services.

The FP Program will continue implementation of Teen Outreach Program (TOP) in 7 different parishes.

NFP Program will continue to provide services statewide.

Population

The MCH Program's PHB website and info line both will continue to promote information about pregnancy spacing and pregnancy intention. The FP Program will continue to promote a text message service to locate FP services.

Infrastructure

The OPH MCH and FP Programs merged as "Bureau of Family Health" will work to operationalize the new program structure with defined program targets and regional action plans around teen pregnancy.

Trainings will continue to be provided to clinicians and staff on how to effectively provide services to adolescents. Needs assessments and Mystery Caller assessments will be conducted to identify areas for improvement.

Adolescents will continue to be recruited as FPP State Advisory Board members.

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	2007	2008	2009	2010	2011
Annual Performance Objective	20	23	40	40	40
Annual Indicator	18.0	33.2	33.2	33.2	33.2
Numerator	157	16223	16223	16223	16223
Denominator	871	48894	48894	48894	48894
Data Source		2008 Basic Screening 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
	2012	2013	2014	2015	2016
Annual Performance Objective	40	40	40	40	40

Notes - 2011

The Oral health Program has completed the Basic Screening Survey and the final results are available to share. According to the survey, 41.9% of third grade children had untreated dental

caries, 65.7% had dental caries experience, only 33.2% had dental sealants on at least one of the permanent molar teeth, and 42.7% had to be referred to dentists for treatment. The total number of children screened were 2642(Denominator) and out of that only 899 (Numerator) had dental sealants. To calculate the percent of 3rd graders with dental sealants, the weighted numbers have been used for the numerator and the denominator which represent the 3rd grade population in the state. The value of the weighted numerator is 16,223 and the value of the denominator is 48,894.

Notes - 2010

According to the Basic Screening Survey conducted by the Oral Health Program, only 33.2% of children had dental sealants on at least one of the permanent molar teeth. The total number of children screened were 2642(Denominator) and out of that only 899 (Numerator) had dental sealants. To calculate the percent of 3rd graders with dental sealants, the weighted numbers have been used for the numerator and the denominator which represent the 3rd grade population in the state. The value of the weighted numerator is 16,223 and the value of the denominator is 48,894. The program is planning to conduct another survey in the next couple of years to assess change in the percentage of children with protective dental sealants. The Oral Health Program delivers the sealants as a direct service and also partners with other organizations.

Notes - 2009

The Oral health Program has completed the Basic Screening Survey and the final results are available to share. According to the survey, 41.9% of third grade children had untreated dental caries, 65.7% had dental caries experience, only 33.2% had dental sealants on at least one of the permanent molar teeth, and 42.7% had to be referred to dentists for treatment. The total number of children screened were 2642(Denominator) and out of that only 899 (Numerator) had dental sealants. To calculate the percent of 3rd graders with dental sealants, the weighted numbers have been used for the numerator and the denominator which represent the 3rd grade population in the state. The value of the weighted numerator is 16,223 and the value of the denominator is 48,894.

a. Last Year's Accomplishments

Direct

In preparation for the 2011-12 school year, the Oral Health Program (OHP) school-based dental sealant program's Oral Sealant Coordinator worked to establish contracts for services and train staff in schools where 50% or more of the children were on free or reduced lunch. Contracts were established with the Health Enrichment Network (THEN) clinicians serving Allen and Avoyelles parishes, Health Centers in School (HCS) serving East Baton Rouge parish, and the University of Louisiana-Monroe (ULM) serving two parishes in northeast Louisiana. In addition the OHP entered into a Memorandum of Agreement with the Louisiana State University Health Sciences Center School of Dentistry (LSUSD) for dental residents and hygiene students to provide clinical services for the school-based dental sealant program in four parishes, Orleans, Jefferson, Plaquemines, and St Martin. By September 2011, the Oral Health Program (OHP) and its program contractors had conducted 5 sealant clinics, screening 253 children, placing 478 sealants on 145 children's teeth.

Enabling

All children who participated in sealant program received oral hygiene education, oral hygiene products, and if needed, referrals to safety net providers in their local community. Parents were informed of the oral health status of their children and needed follow up treatment. This information was also provided to the school's nurse so that he/she could follow up with the parents to ensure that the prescribed care is sought. Of the 253 children screened in 5 SBHCs conducted in September of 2011, 29% had untreated cavities and 20% were referred for treatment. Parental consent forms in Spanish were developed.

Population

The Fluoridation Program continued to address efforts to increase the proportion of the

population with fluoridated drinking water (CWF); however the program lost the Preventive Health and Health Services Block Grant funding. The OHP Fluoridation Engineer finalized the contracts with the cities of Shreveport and Gonzales, LA for equipment upgrades. Due to increased anti-fluoridation advocacy efforts, the OHP program met with the cities of Crowley and Lake Charles, LA to ensure continuation of CWF. OPH also met with the city of Natchitoches to discuss re-initiating CWF. Even though the OHP was unable to provide funds, the Natchitoches decided to self-fund the project. OHP continues to work with the community of Walker to finalize the installation of equipment for initiation.

Infrastructure

Funding from the CDC Infrastructure and Capacity Building Cooperative Agreement increased the OHP staff to five 1.0 FTE positions. The additional staffing allowed the program to increase program capacity and strengthen infrastructure resulting in the programs ability to expand both direct and population based services. The OHP Fluoridation program began annual water system inspections and distributed the new Fluoridation Program Manual which outlined a system's reporting responsibilities and procedures for safe operation of fluoridating systems. OHP also developed a policy brief on the adoption of a public health designation for dental hygienists. This designation would increase the OHP program and other provider's ability to deliver preventive services in schools, public health centers, etc. and would have an impact on the infrastructure for delivery of service models. The Fluoridation Engineer conducted training for water operators on community water fluoridation and on health the benefits of optimally fluoridated water and the Dental Sealant Coordinator conducted training on data collection for the sealant program using the CDC SEALS data base.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Secured funding from HRSA for redesigned program delivery model for school-based dental sealant program for statewide application in Louisiana.				X
2. Established collaboration with LSUHSC School of Dentistry and ULL Dental Hygiene Schools to expand dental sealant program through utilizing program as a rotation.	X			X
3. Conduct school-based dental sealant clinics	X		X	
4. Sealant program participants receive oral hygiene instruction and oral health products to promote improvement of oral health		X		
5. Contract with The Health Enrichment Network for a school-based dental sealant program in the delta parishes of Louisiana	X			X
6. Contract with Health Centers in Schools for a school-based dental sealant program in East Baton Rouge Parish	X		X	X
7. Contract with ULM for a school-based dental sealant program in northeast Louisiana				X
8. Hired a Dental Sealant Coordinator				X
9.				
10.				

b. Current Activities

Direct

This school year OHP program partners and contractors conducted 28 sealant clinics in eight parishes, screened 1,453 children, and placed 3,470 sealants. Of the children screened, the percent with untreated decay ranged from 75% to 28%. Eleven dental residents and 24 hygiene students worked in 6 clinics under the LSUSD MOA. OHP participated in "Give Kids a Smile Day" in East Baton Rouge Parish and served 451 children.

Enabling

Children in the sealant program receive oral hygiene products, oral hygiene and nutrition lessons, and are screened for oral health status and sealant placement. Parents and school nurses receive a status report and list of safety net clinics. Children identified as needing immediate treatment were referred to the school nurse for assistance with scheduling follow-up. OHP assisted women via Medicaid waiver, Expanded Dental Services for Women (EDSPW), with finding providers, conducted a fluoride varnish workshop for the Maternal Infant Early Childhood Home Visiting (MIECHV) supervisors, and is working to develop a "tool kit" for FQHCs to establish school-based dental services.

Population

Walker, Louisiana initiated CWF in May 2012 which will provide an estimated 20,000 citizens with optimally fluoridated water.

Infrastructure

OHP staff conducted two water operator trainings and two CDC SEALS trainings. The Oral Health Coalition met four times and the Fluoridation Advisory Board met once.

c. Plan for the Coming Year

Objective: Increase to 40% the share of third grade children who have received protective sealants on at least one permanent molar tooth.

Direct

OHP will expand collaborative efforts with FQHCs and school-based health centers and maintain existing contractors (funding permitted) to increase sustainability and expand service areas for the 2012-13 school-based dental sealant program. OHP will renew the LSUSD MOA which provides dental clinicians for at least five schools in the dental sealant program. Through direct service and program partners/contractors school-based sealant initiatives will serve 25 schools in 10 parishes to achieve NP 9. Funding permitted; OHP will also conduct a pilot fluoride varnish program.

Enabling

OHP will use Oral Health Coalition resources to initiate activities and strategies that will increase access and the number of dental providers accepting Medicaid eligible children and pregnant women. Students in the school-based dental sealant program will receive oral hygiene and nutrition instruction. OHP will continue to seek ways to educate on public health dentistry to dental students, dental and medical providers, and the general public through professional association meetings and annual state conferences. OHP staff will attend Louisiana Dental Association and Louisiana Dental Board meetings to present on the status of public health dentistry.

Population

OHP will continue to seek funding to initiate CWF, partner with the Fluoridation Advisory Board to increase community education efforts through local, grass-roots efforts in communities affected by the fluoridation mandate, and monitor and provide technical assistance to fluoridating water systems to ensure the safe delivery of optimally fluoridated water.

Infrastructure

OHP will enter into the fifth and final year of the CDC Cooperative Agreement and anticipates applying for the grant for 2013-2018. OHP will focus efforts to increase utilization of the fluoride varnish program that allows for Medicaid reimbursement for the application of fluoride varnish in medical settings by partnering with WIC and NFP to promote the use of fluoride varnish by their client base and with Louisiana AAP to increase pediatrician participating in the fluoride varnish program. OHP has requested HRSA Workforce Grant funding to maintain and expand the dental sealant program, conduct a demonstrations fluoride varnish program and fund CWF initiation

projects. OHP and the Policy group of the Oral Health Coalition will work to bring about policy and/or systems changes that will result in increased access to dental services for the MCH population. OHP will continue efforts to change the dental practice act to include a public health designation for dental hygienist. This would increase provider's ability to deliver preventive services in schools, public health centers, etc. and would have an impact on the infrastructure for delivery of service models.

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	2007	2008	2009	2010	2011
Annual Performance Objective	4	4	4	4	4
Annual Indicator	5.7	5.1	4.5	4.0	4.0
Numerator	51	47	42	37	37
Denominator	888587	914724	931876	927458	927458
Data Source		Louisiana Vital Records and Statistics			
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?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	4	4	4	4	4

Notes - 2011

2011 data is provisional and based upon the 2010 data.

Notes - 2010

2010 data is provisional and based upon 2010 data.

Notes - 2009

2009 data is final.

a. Last Year's Accomplishments

In 2009, 42 children aged 0 to 14 died as a result of motor vehicle crashes at a final rate of 4.5 deaths per 100,000 children. Preliminary data for 2010 also show a rate of 3.99 deaths per 100,000 children, with 37 children aged 0 to 14 killed in motor vehicle crashes. The final rate for

2009 and preliminary rate for 2010 demonstrate a consistent decrease from previous year indicators (with 5.7 deaths per 100,000 children in 2007 and 5.1 deaths per 100,000 children in 2008), and reaching the annual performance objective of 4 deaths per 100,000 children aged 14 years and younger. Since 2007, the annual indicator has remained below the Healthy People 2010's goal of 9.0 deaths per 100,000 population and Healthy People 2020 goal of 12.4 per deaths per 100,000 population. 2011 data is not available for reporting.

Population

Prior to 2011 the state funded nine Regional MCH Child Safety Coordinators, who were certified National Child Passenger Safety Technicians (CPST's) and participated in car seat/child restraint check-up events, in collaboration with the Louisiana Passenger Safety Task Force, Louisiana Highway Safety Commission, first responders (EMT's, firefighters and law enforcement), and other CPST's. In 2010, to work toward reducing child motor vehicle, the MCH Child Safety Coordinators participated in more than 763 child passenger check-up events/appointments, which trained more than 1,355 caregivers on how to properly install his/her child restraint seat, resulting in 1,041 seats/child restraints being checked. Due to funding restraints, in 2011 the MCH Program reorganized the regional positions to create MCH Regional Coordinators. The MCH regional coordinators have absorbed some of the MCH Child Safety Coordinators duties but focus mainly on mortality surveillance and case review.

Infrastructure

The MCH Child Safety coordinators offered education, awareness, and technical assistance in child safety/injury prevention, including child passenger safety and pedestrian safety, to healthcare providers, educators, childcare providers, faith-based and community leaders, and the general public through workshops, health fairs, the media (radio and television), printed materials (brochures, newsletters, pamphlets), and presentations. In 2010, more than 14,780 children and adults were reached with culturally appropriate child safety/injury prevention educational information pertaining to motor vehicle crashes. The safety coordinators participated in the annual Emergency Medical Services for Children (EMS-C) Advisory Council and assisted in providing injury prevention activities for over 1,500 Head Start children.

The current MCH Regional Coordinators have a strong emphasis on managing the Louisiana Child Death Review (CDR), comprised of state and local panels that review unexpected, unintentional deaths of children 14 years old and younger. The purpose of such reviews, including motor vehicle crashes, is to develop a greater understanding of the causes of child deaths and develop preventive methods to reduce the incidence of injury deaths to infants and children. In 2010, the State and Local CDR Panels reviewed at least 81 unexpected infant and child deaths, which is a compilation of initial and follow-up reviews for reporting purposes. The MCH Child Safety Coordinators continued to serve as the local CDRP Coordinators while aligning themselves with prevention recommendations of the American Academy of Pediatrics, Children's Safety Network, and the National Center for Child Death Review. Recommended prevention strategies from the CDRP emphasize media campaigns and increased education for parents, communities and schools as well as promoting the creation and enforcement of laws and policies.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH to provide technical assistance and collaborate with the EMS-C on childhood injury and motor vehicle occupant injury prevention program planning/activities and policy development.				X
2. Support the outreach efforts of the nine MCH Regional Coordinators to provide safety/injury prevention education and resources.				X
3. MCH Regional Coordinators will collaborate with epidemiology				X

colleagues to report injury data to implement effective child motor vehicle occupant and other injury prevention interventions.				
4. Child Death Review Panels will review all unexpected deaths of children under the age of 15 years resulting from motor vehicle crashes and other causes.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure

The MCH program conducted a statewide Child Safety needs assessment, using State and Local Child Death Review Panel (CDRP) members and partners, resulting in the development of 5 priority areas related to child safety, one being motor vehicle crashes. Action plans and prevention strategies are being developed to address these priority areas. MCH Regional Coordinators continue to provide injury prevention education outreach statewide via presentations and distribution of materials.

The State and Local CDRPs have continued to review unexpected deaths of children 14 years and under, including motor vehicle-related deaths. Using case review findings and Louisiana Vital Records, the MCH program created a six-year cumulative case review report from 2002-2007 and is currently working on the 2008-2010 Child Death Review Report for distribution to the Louisiana Legislature, CDRP members, policy makers, program planners, DHH and the general public.

c. Plan for the Coming Year

Objective: To decrease from 4 per 100,000 children the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes.

Population

The MCH Regional Coordinators will continue to abstract and review child motor vehicle deaths in their regions. They will identify risk factors and create action steps for the community to prevent further similar deaths.

Louisiana Child Death Review will provide trainings on effective, culturally sensitive child death investigations to CDRP members, coroners, medical examiners, and death scene investigators. Through improved investigative case reporting and in-depth reports from trained CDRP members, a more in depth Child Death Review Report will be created and submitted to the Louisiana Legislature, CDRP members, policy makers, program planners, DHH, MCH staff /partners, and the general public annually. Child deaths 14 years and younger resulting from motor vehicle crashes and other injury-related causes will continue to be reviewed to implement and promote effective injury prevention interventions at the state and local levels in collaboration with the Injury Research and Prevention Program and Emergency Medical Services for Children.

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	2007	2008	2009	2010	2011
Annual Performance Objective	15.6	15.8	25	26	21
Annual Indicator	21.9	21.9	21.0	20.0	18.2
Numerator	66	101	97	59	40
Denominator	302	461	463	295	220
Data Source		2005 National Immunization Survey (NIS)	2006 National Immunization Survey (NIS)	2007 National Immunization Survey (NIS)	2008 National Immunization Survey (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
	2012	2013	2014	2015	2016
Annual Performance Objective	21.5	22	22.5	23	23.5

Notes - 2011

The data reported in 2011 is provisional and based upon 2008 National Immunization Survey (NIS). The NIS has been used to estimate the rate (%) of breastfeeding at 6 months since reporting year 2006, when Louisiana Pregnancy Risk Assessment and Monitoring Survey (LaPRAMS) was no longer used. Because only women whose infants between 2 and 6 months were selected at the time of the survey, estimate of breastfeeding at six months using LaPRAMS is considered biased.

Notes - 2010

The data reported in 2010 is final and based upon 2007 National Immunization Survey (NIS). The NIS has been used to estimate the rate (%) of breastfeeding at 6 months since reporting year 2006, when Louisiana Pregnancy Risk Assessment and Monitoring Survey (LaPRAMS) was no longer used. Because only women whose infants between 2 and 6 months were selected at the time of the survey, estimate of breastfeeding at six months using LaPRAMS is considered biased..

Notes - 2009

This year's data is final and based upon 2006 National Immunization Survey (NIS) data. LaPRAMS 2006 data indicated that 17.02% of mothers breastfed their infants at 6 months of age, however, LaPRAMS has not reached 70% response rate since Hurricane Katrina in 2005 and

therefore data is unreliable. Furthermore, infants are between 2 and 6 months at the time of the survey, which may lend bias to the question of breastfeeding at six months.

a. Last Year's Accomplishments

In 2007, 20.2% of children in Louisiana were breastfeeding at 6 months of age according to National Immunization Survey (NIS). NIS provisional data for 2008 indicates a slight decrease, with 18.2% of the state's children breastfeeding at 6 months of age.

Enabling

The OPH WIC Program continued to ensure that WIC clinics endorsed breastfeeding as the preferred method of infant feeding. The WIC Program reviewed educational materials such as videos, handouts, and posters and adopted updated, culturally appropriate materials. In 2011, the WIC Program began two additional peer counseling programs providing coverage in all regions of the state to support and increase breastfeeding initiation and duration rates. WIC continued to provide manual, hospital grade and personal electric breast pumps to participants as needed.

Population

Breastfeeding awareness information and support continued at the community level, including hospitals, faith-based organizations, physicians' offices and other health care providers, as well as community events. In collaboration with state and local coalitions, the WIC Loving Support campaign assisted local businesses in establishing workplace lactation accommodations for employees. Other components of the Loving Support campaign included radio PSAs promoting the benefits of breastfeeding, including obesity prevention, and the state's improvement in rates of breastfeeding.

The OPH MCH Program continued to support Louisiana's hospital-based breastfeeding initiative, The Gift, in its seventh year of implementation. The Gift's goals are to increase breastfeeding rates and the implementation of evidence based practices in Louisiana hospitals. Hospitals that meet The Gift's "Ten Steps to a Healthy, Breastfed Baby" are recognized by the OPH MCH Program and receive designation as a "Gift Certified" facility. Gift Certification must be re-applied for every 2 years. There are 58 maternity hospitals and 1 birthing center in Louisiana. From October 1, 2010 to September 30, 2011, three birthing facilities achieved Gift Certification for the first time and ten birthing facilities were re-certified.

The Louisiana Breastfeeding Coalition (LBC) maintained its website and online statewide breastfeeding resource directory, ZipMilk LA.

Collection of data on breastfeeding initiation and exclusivity on the state's Newborn Screening forms began in June 2011.

Infrastructure

The Gift Statewide Coordinator conducted meetings with hospital administrators and staff to solicit participation in the program. Presentations were given at community and stakeholder meetings to increase knowledge of breastfeeding and The Gift. Routine follow-up, including a mid-certification survey, was conducted with Certified facilities. The Gift and the LBC were exhibited at statewide conferences.

The MCH Program continued to support a 6-hour nursing CEU breastfeeding training program for hospital staff. The training curriculum includes evidence-based breastfeeding support as it relates to The Gift. A total of 124 people were trained during 6 trainings sessions in regions 3, 4, 6, 7 and 8. Pre- and Post- tests, to assess change in knowledge, were given to all participants. The Pre- and Post-test score averages were 54.78% and 95.8% respectively.

The Gift Statewide Coordinator continued to provide infrastructure support for the LBC. The LBC

is guided by a twelve-member steering committee with the mission of making breastfeeding the norm for all babies in the state. The LBC continued to build its membership, conduct regular meetings and implement its strategic plan. The LBC continued its collaboration with local breastfeeding coalitions located in the Central, Greater New Orleans, North East and Acadiana areas of the state.

To improve support for breastfeeding in LA child care centers, the LBC partnered with a local pediatrician, Our Lady of the Lake Children's Hospital and local Breastfeeding Coalitions (BFCs) to develop an educational intervention (toolkit) to educate child care providers on best practices for supporting breastfeeding. The LBC also collaborated with local BFCs, WIC and universities to increase the number of employers in compliance with the federal workplace breastfeeding law. Over 50 employers statewide are recognized on the LBC's website.

A World Breastfeeding Week (WBW) press release was developed and disseminated in collaboration with LA Department of Health and Hospitals.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provision of manual, hospital grade and portable electric breast pumps.		X		
2. Collection and analysis of WIC breastfeeding initiation and duration at 6 months of age rates.				X
3. Monitoring of breastfeeding policies and procedures including on-line breastfeeding training for all clinic staff and monitoring of positive clinic environment that endorses breastfeeding.				X
4. Provision of prenatal breastfeeding education bags to support breastfeeding initiation and duration rates.		X		
5. Provision of trainings to promote new WIC foods for breastfeeding dyads to clinic staff and community partners.		X	X	X
6. Delivery of breastfeeding trainings with continuing education units for hospital staff and community breastfeeding health care workers statewide by The Gift program.				X
7. Provision of breastfeeding classes and breastfeeding peer counselors for prenatal, postpartum and breastfeeding participants to encourage and support breastfeeding initiation and duration.		X		X
8. Maintenance of an on-line breastfeeding resource directory.			X	
9. Provision of support and assistance to birthing hospital administrators and staff to enroll their hospital in The Gift program.				X
10. Establishment of breastfeeding worksite promotion and support along with provision of statewide outreach activities.				X

b. Current Activities

Enabling

Two new WIC breastfeeding peer counseling programs provide coverage in the central and northern regions of the state. WIC clinics continue to provide breastfeeding education and support as a result of their competency based USDA training; participants are provided prenatal breastfeeding education bags, new and enhanced WIC foods and breast pump assistance.

Population

Since October 2011, three hospitals earned Gift Certification and seven hospitals were re-

certified. Out of 58 eligible facilities, 24 are certified and 2 have applications in process. 2009 LaPRAMS data found that breastfeeding initiation was 71.0% among women giving birth at a GIFT facility compared to 60.9% at non-GIFT facilities

LBC website and ZipMilk LA maintenance continue.

Infrastructure

Seven 6-contact hour trainings were conducted in six regions of the state, training a total of 250 people. Pre-and Post-test scores were 68.74% and 97.29% respectively.

Train-the trainer-sessions were conducted in New Orleans and Baton Rouge with lactation professionals and state child care health consultants on how to use the Supporting Breastfeeding in Child Care Centers toolkit.

MCH applied for a Blue Cross Blue Shield (BCBS) Foundation of LA grant to expand The Gift, facilitate hospital participation in the national Best Fed Beginnings (BFB) learning collaborative, provide training, and pilot an effort to strengthen breastfeeding education and support in New Orleans.

c. Plan for the Coming Year

Objective: Increase the proportion of children who are breastfeed at 6 months of age to 22.0% by 2013.

Enabling

WIC will continue expansion of the breastfeeding peer counselor program statewide to provide encouragement and support to participants prenatally as well as to breastfeeding moms in an effort to increase breastfeeding initiation and 6 month duration rates. Clinics will provide breastfeeding education and support through classes, distribution of prenatal breastfeeding education bags, implementation of the New WIC Foods and breast pumps.

Population

The MCH Program will continue to support the implementation and expansion of The Gift. The Gift Statewide Coordinator will conduct meetings and trainings with hospital staff, and collect data from certified facilities specific to breastfeeding rates, lactation support, staff education and training, and hospital policies. The Gift Statewide Coordinator will provide additional technical assistance to LA hospitals that are accepted into the national breastfeeding learning collaborative, Best Fed Beginnings.

The state agency will continue to provide a statewide breastfeeding outreach campaign on the benefits of breastfeeding utilizing the Loving Support makes breastfeeding work campaign.

The Gift Statewide Coordinator will continue to maintain the LBC website and ZipMilk LA.

Collection of data on breastfeeding initiation and exclusivity on the state's Newborn Screening forms will continue.

Infrastructure

WIC will continue to provide support to worksites to increase support for WIC breastfeeding moms and staff will receive updated Loving Support training. WIC will continue to work with community partners on new breastfeeding policies, WIC food packages that encourage breastfeeding, and breastfeeding education materials. The peer counseling programs will increase resources in their mom to mom support groups, develop a partnership with birthing hospitals, and maintain statewide coverage. The program will implement a web based documenting and tracking system that can be used to capture vital information and monitor

program success.

The Gift will continue to offer breastfeeding training that provides continuing education credits, but will explore providing the training in a web-based format. The Gift will also work through a re-branding process to improve its marketability and its alignment with the Baby-Friendly Hospital Initiative. If granted the award from Blue Cross Blue Shield, implementation of the proposed activities will begin in September 2012 and continue for three years.

The LBC will continue to implement its strategic plan, hold regular meetings, and participate in USBC/CDC and Regional Breastfeeding Coalition Bi-Monthly Tele-conferences as well as the Fourth National Conference of State/Tribal Breastfeeding Coalitions.

Grants will be sought to continue training child care providers to support and promote breastfeeding.

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	2007	2008	2009	2010	2011
Annual Performance Objective	98	98	98	98	98
Annual Indicator	97.4	97.1	96.9	95.8	97.4
Numerator	63223	62916	61916	31211	57825
Denominator	64878	64773	63922	32570	59395
Data Source		Early Hearing Detection and Intervention Database			
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
	2012	2013	2014	2015	2016
Annual Performance Objective	99	99	99	99	99

Notes - 2011

Data is based upon a calendar year.

Notes - 2010

Data is based upon a calendar year.

Notes - 2009

Data is based upon the entire year.

a. Last Year's Accomplishments

The goal of Hearing Speech & Vision (HSV) program is to meet American Academy of Pediatrics' 1-3-6 guidelines for screening, identification and intervention that state a newborn should receive hearing screening by 1 month of age, diagnosis by 3 months and initiation of intervention services by 6 months of age. HSV works to reduce morbidity and educational delays associated with hearing loss. Hospital staff screened 97.4% of live births born in LA for hearing loss. This rate has been stable over the past few years. Among the 5.2% who failed, the rate for Loss to Follow-Up (LTFU) is 30%, a 14% decrease from last year and better than the national rate of 45%.

Accuracy of newborn hearing screening statistics and follow-up rates is primarily dependent on the technological infrastructure for information exchange. Work by the LA Early Hearing Detection and Intervention (LA EHDI) team is addressing this with a comprehensive and sustained approach. Slight errors in estimates do occur and are continuing to be addressed.

Direct

Direct services were performed by HSV audiologists who provided services for children that lack insurance or access to care. They provided 1,111 hearing and speech screening services for 279 infants and toddlers and 63 hearing aids for CSHS patients.

Through the HSV Cubsight Vision program that trains and coordinates vision screening, 26,535 preschool children had their vision screened.

Enabling

Parent Coordinators (PC) held 7 family events across LA in different regions with the target population of families of children who are deaf or hard of hearing. During events, 75 families reported interest in communicating with other families, increasing the family-family support network. The Spanish speaking bilingual PC worked to reduce the LTFU rate by contacting 372 families by phone. As language may be a barrier for acquisition of services, this PC had a pivotal role in reducing cultural disparities for these children as well as mitigating the long-term impact of language delay as a result of late identification of hearing loss.

Population

The newborn hearing screening rate was 97.4%. LA EHDI supported hospital efforts by providing parent education and outreach materials in English and Spanish to all birthing hospitals. English-Spanish translation was provided for hospitals and audiologists as requested. LTFU rate was 30%, a 14% decrease due to many factors. One factor was work by two outreach specialists, a program coordinator, and a tracking specialist working with 12 birthing hospitals with hearing screening failure rates either less than 1% or greater than 10%. Additionally, LTFU rate decreased as a result of increased reporting by audiologists and physicians rescreening in the Medical Home (MH). It is estimated that 60 MHs have equipment in their offices that can be used for rescreening. The increase in MH reporting followed in-service on screening and reporting to 7 of the 60 practices.

Infrastructure

Through the HSV Cubsight Vision program that trains and coordinates vision screening for preschoolers, 26,535 children had vision screened. The 2 HSV vision consultants trained 811 volunteers to do vision screening for preschool children using photo screenings, and school age children using standard vision screening techniques.

COMTEC was awarded the contract for phase I of LA EHDl Information System (LA EHDl-IS). This phase developed and completed the foundation for the web-based data system, integrating hearing screening and follow-up surveillance data with the new vital records program or LEERS (LA Electronic Event Registration System). LA EHDl piloted collaboration with two early childhood programs: Early Head Start (EHS) and Early Steps (ES), LA's Part C program. EHS had 5 sites that shared hearing screening data with LA EHDl. 5 children who were originally LTFU were identified and referred for services, deeming the pilot a success. Future efforts at data sharing fall under enabling services since information exchange facilitates timely follow-up. A pilot for data sharing with ES was initiated with future plans for data exchange between LA EHDl and ES being developed.

The LA EHDl team participated in the National Initiative for Children's Healthcare Quality (NICHQ) Improving Hearing Screening & Intervention Systems (IHSIS) Learning Collaborative and began utilizing a Plan-Do-Study-Act (PDSA) cycle to address LTFU and quality improvement.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide audiology follow-up for LA EHDl where there is no access to community services.	X			
2. Provide hearing aids for identified children who have no access to community services.	X			
3. Provide community outreach to families with hard of hearing or deaf children by Parent Coordinators, including support and family-centered activities.		X		
4. Review Early Head Start program screening records for lost to follow-up (LTF) children, and enable acquisition of needed audiology services.		X		
5. Contact families whose children failed, and reported LTF, to enable acquisition of needed audiology services.		X		
6. Screen all live born infants born in LA for hearing screening prior to discharge, and monitor audiology follow-up status among those that failed.			X	
7. Provide TA for birthing hospitals, and specialized TA for those with high LTF.			X	
8. Provide education on screening and reporting in the Medical Home to physician offices, and in conferences.			X	
9. Develop protocol and procedures for data sharing with Louisiana Early Steps Program.				X
10. Continue to enhance and modernize the LA EHDl surveillance system.				X

b. Current Activities

Direct

503 audiology services have been provided to 146 infants and toddlers, and 29 hearing aids have been dispensed to CSHS patients to date. Two vision consultants have coordinated vision screenings for 17,248 preschoolers.

Enabling

PCs have held 6 community outreach events in 4 regions and 4 family-centered activities. EHS screening data will be relayed to LA EHDl by last quarter of FFY 2012. Our bilingual PC has phoned 195 LTFU families. The follow-up coordinator sent 216 letters addressing LTFU to MHs and audiologists to offer TA.

Population

98.50% of newborns have been screened. All birthing hospitals received TA. LTFU is 31%. Of hospitals with >40% LTFU, 33 have received TA to decrease LTFU, including tips on talking with parents, improving screening procedures, troubleshooting equipment and documenting information. Of 60 MHs that screen hearing, on-site assistance was given to 6. Hearing screening protocols were presented to MH physicians at a pediatric staff meeting at Woman's Hospital, the largest birthing center in LA.

Infrastructure

A contract is being finalized to implement phases II and III of LA EHDI-IS which include data gathering, analysis and surveillance of diagnostic and early intervention information, and report generating. The protocol for data sharing with ES is being developed. LA EHDI staff presented hearing screening education for MHs at the National EHDI conference in March 2012 in St. Louis.

c. Plan for the Coming Year

Objective: Maintain proportion of newborns screened for hearing loss before hospital discharge at 99%.

Goal for number of infants screened will remain 99% until LEERS and our data system can be modified to report infant transfers and deaths. Data acquisition on transfers to hospitals with Neonatal Intensive Care Units (NICU) as well as death data is critical considering increased risk of hearing loss associated with NICU care. Efforts will continue to encourage hearing screening report submission by hospitals receiving transferred infants.

Direct

To circumvent barriers to accessing audiology services, CSHS will continue to provide services in 2 regions of the state in public health unit audiology clinics, and to dispense hearing aids in areas with a lack of private providers.

Enabling

PCs will continue to engage families of children who are hard of hearing or deaf in outreach events and family-centered activities. These services will be available in targeted regions of state to expand the family to family information and support network. PCs will continue to contact families of children who are LTFU. The importance of early identification of hearing status and acquisition of needed services will be reiterated by phone and mail contact.

Population

Birthing hospitals in LA will continue to screen all live born infants prior to hospital discharge. Screening status will continue to be documented in LEERS. Data surveillance involves LTFU tracking and reveals locales where LTFU rates are high. Staff will provide TA to hospitals with either <1% or >10% failure rates and hospitals identified with a 40% or higher LTFU rate. This TA will address delivering results to parents, training nursery supervisors on procedures and documentation and troubleshooting equipment problems. Audiologists will receive TA to increase reporting. To circumvent cultural disparities in early identification and acquisition of services, English-Spanish translation services will remain available to hospitals upon request. Among MHs that screen, TA will continue to be provided to improve screening procedures and reporting rates. Lastly, the latter will be addressed during conferences.

Infrastructure

The goal is to have LA EHDI-IS finalized by the end of the FFY. The system is designed to produce comprehensive data reports for all birthing hospitals thereby assuring accuracy and efficiency of newborn hearing screening: implementation, results, follow-up, and relevant descriptive data to enhance program planning, policy, and intervention. Early intervention

program collaboration specifically to decrease LTFU and decrease the age of initiating early intervention will continue to be explored.

Vision consultants will have contracts amended to accommodate the growing demand for vision screening training and assistance in coordinating and planning service provision within the private sector.

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	2007	2008	2009	2010	2011
Annual Performance Objective	9	9	8	8	8
Annual Indicator	12.3	11.7	11.7	11.7	3.5
Numerator	143425	137156	137156	137156	42011
Denominator	1167153	1174079	1174079	1174079	1188283
Data Source		AAP Child Health Insurance Report	AAP Child Health Insurance Report	AAP Child Health Insurance Report	Louisiana Health Insurance 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
	2012	2013	2014	2015	2016
Annual Performance Objective	3.5	3.5	3.5	3.5	3.5

Notes - 2011

Data pulled from "Louisiana's Uninsured Population - A Report from the 2011 Louisiana Health Insurance Survey"

Numerator: Uninsured Children

Denominator: Parish population totals from the 2010 census and then used the most recent demographic estimates to get the age distribution, which were 2009 demographic estimates

Notes - 2010

Data is provisional and based upon the 2008 data.

Notes - 2009

Data is provisional and based upon the 2008 data.

a. Last Year's Accomplishments

Enabling

Pregnant women, infants, and children accessing OPH Public Health Units (PHU) and School Based Health Centers (SBHCs) were screened for income eligibility for state-sponsored health insurance. Income-eligible uninsured patients were given referral information and a joint application for Louisiana Medicaid/CHIP with print and online enrollment information available in English, Spanish, and Vietnamese.

Population

MCH continued to work with Louisiana Covering Kids and Families Coalition Project and supported the efforts of the new Robert Wood Johnson Foundation's Maximizing Enrollment grant, MaxEnroll, to enroll 98% of eligible children in Medicaid or LaCHIP by year 2013.

The MCH Partners for Healthy Babies (PHB) website and toll-free information line provide information about LaCHIP/Medicaid and the LaCHIP Affordable Plan for families.

Infrastructure

MCH continued to work with State Medicaid and LaCHIP staff to provide updated information regarding its services to clients in OPH PHUs statewide and to provide technical assistance, particularly in the area of access to services and enrollment. MCH continued to be represented on the Louisiana Covering Kids and Families Coalition's Advisory Committee and LA Medicaid continued representation on the BrightStart/Early Childhood Advisory Council (Louisiana's MCHB ECCS Grant Initiative).

In 2009, BrightStart was designated by the Governor as the state's Early Childhood Advisory Council (ECAC). Medicaid has continued to have representation on the Council.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Eligibility screening for Medicaid/LaCHIP/LaMOM for all infants, children, & pregnant women seen in OPH.		X		
2. Provide Medicaid eligible clients with information on Medicaid/LaCHIP and LaMOMS and how to apply.		X		
3. Support the outreach and enrollment efforts of Medicaid's MaxEnroll Initiative and of the SBHCs.			X	
4. Technical assistance to the LaCHIP, LaMOM, and Medicaid Programs for enrollment eligibility and access to services.				X
5. Maintain MCH representation on the Louisiana Covering Kids and Families Coalition's Advisory Committee.				X
6. Medicaid representation on BrightStart's Advisory Council.				X
7.				
8.				
9.				
10.				

b. Current Activities

Enabling

OPH PHUs continue to screen patients for eligibility for state-sponsored health insurance programs and provide applications. Clients enrolled in NFP continue to receive assistance in enrolling in appropriate health insurance programs.

Population

The PHB website and toll-free information line provide information about LaCHIP/Medicaid and

the LaCHIP Affordable Plan for families.

Infrastructure

Between February 1 and June 1, 2012, all regions of the state transitioned to the Medicaid coordinated care network (CCN) system, BAYOU Health. Of the state's 1.2 million recipients, nearly 900,000 now access care through one of five BAYOU health carriers. Children comprise the majority of enrollees; the system also covers approximately 70% of deliveries each year. The BAYOU Health plans are required to ensure access to needed care and provide support with care coordination, follow up and transportation. The health plans are accountable to over 47 healthcare quality outcome measures; the MCH CDC epidemiologist has been empanelled as one of the members of the BAYOU Health Quality Committee. In 2011, the Louisiana Health Insurance Survey showed that a record low 3.5% of children are uninsured. ExpressLane eligibility, increased awareness of LaCHIP, and expanded access through the LaCHIP affordable plan have been credited with this achievement. MCH has been working with OPH on the definition of services to be offered through the CCNs.

c. Plan for the Coming Year

Enabling

OPH PHUs will continue to screen infants, children and adolescents for eligibility for LaCHIP/Medicaid and LaMOMS/Medicaid and facilitate enrollment. Clients enrolled in NFP will continue to receive assistance in enrolling in the appropriate state-sponsored health insurance programs.

Population

The PHB website and information line will be updated to reflect any changes in enrollment processes that may be necessary as a result of Medicaid CCN implementation.

Infrastructure

MCH will continue to work with OPH on the transition of Medicaid to a CCN system. MCH will continue to coordinate with Medicaid through the BrightStart ECAC.

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 Data	2007	2008	2009	2010	2011
Annual Performance Objective	12	11.5	11	10.5	10.5
Annual Indicator	13.8		12.4	12.5	27.8
Numerator					
Denominator					
Data Source		CDC PedNSS	CDC PedNSS	CDC PedNSS	CDC PedNSS
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
	2012	2013	2014	2015	2016
Annual Performance Objective	27.5	27	26.5	26	25.5

Notes - 2011

Data is based on the 2011 PedNSS data and is defined as the percentage of children >= 85th percentile rather than the percentage of children >= 95th percentile that has been used in past years.

Notes - 2010

Data is based on the 2010 PedNSS data and is defined as the percentage of children >= 95th percentile.

Notes - 2009

Data is final.

a. Last Year's Accomplishments

Enabling

WIC provided services in 116 locations for counseling and education sessions to families statewide on healthy eating and physical activity. Referrals were made to WIC for specialized nutrition counseling.

For the 4th year, WIC organized the Louisiana WIC Farmer's Market Nutrition Program (FMNP). 365 families received a one-time issuance of a 6 coupon booklet for \$4 each with a total value of \$24 to use at farmer's markets in 14 Louisiana parishes. 2190 coupons were issued and 43% were redeemed.

The MCH Registered Dietitian (RD) worked with Louisiana State University School of Public Health on a childhood obesity initiative utilizing the Nutrition and Physical Activity Self-Assessment for Child Care (NAPSACC) program. The pilot program was implemented in 3 child care centers in New Orleans. Evaluation results are pending.

Population

Through the FMNP, Louisiana WIC collaborated with New Orleans Healthy Start for a Father's Day event at the Crescent City Magazine Street Farmers market in June 2011. The event included a food demonstration and outreach to the fathers of the WIC families who participated.

LA WIC developed a cookbook featuring helpful cooking tips/recipes to be distributed to WIC families and to the WIC FMNP participants. 50,000 cookbooks were distributed to current WIC families and WIC FMNP participants. In addition WIC distributed 50,000 new the Adventures of Zobey-Jungle Jive DVDs to children aged 2-5 years and to the children participating in the NAP SACC initiative.

WIC education materials developed by MCH and WIC were promoted in WIC clinics and disseminated to the Nurse-Family Partnership program.

Infrastructure

The MCH RD actively participated in the Louisiana Obesity Council. The MCH RD and Obesity Council coordinator served on the state team leading the CDC funded Schools Putting Prevention to Work Project (SPPW), led by the LA DHH Tobacco Control Program. The project funded 27 school districts with \$17,000 awards and assisted them with developing model School Health Advisory Councils. They also participated in the Obesity Council policy workgroup which during the 2011 legislative session was instrumental in passing a House Resolution to promote physical activity and limited screen time in Louisiana child care centers.

The MCH RD continued to serve as the co-chair of Louisiana Action for Healthy Kids (LA AFHK). In September 2011 LA AFHK held its annual state meeting in conjunction with the 2011 Childhood Obesity public health conference. The public health conference brings together local, national and international experts on the topic of developing public health strategies that can be employed to tackle the growing problem of childhood obesity. The annual report card, presented at the conference, is an evidence-based document that serves as an advocacy tool to increase awareness of health concerns associated with childhood obesity. LA AFHK and the Obesity Council sponsored the conference which drew in 500 health professionals from around the state.

The MCH RD provided training to 100 Child Care Health Consultants (CCHC) at the annual conference, covering food allergies, healthy eating and physical activity for children in the child care setting.

The WIC state breastfeeding coordinator and the WIC state nutrition education (NE) coordinator provided a nutrition education and breastfeeding training to Southern University Ag Center staff. The purpose of the training was to discuss initiatives in WIC and how to coordinate BF messages among participants in WIC, SNAP-Ed and EFNEP.

The MCH RD worked with the NFP home-visiting program to assess the link between nutrition risk and depression. Pregnant women were given a nutrition risk survey, along with a 24-hour recall to assess food intake, and the Edinburgh Postpartum Depression Scale to assess depression risk. Results from this pilot program were published in the International Journal of Disability and Human Development.

The Obesity Council coordinator also coordinated the Fruits and Veggies More Matters and the Let's Move Cities and Towns Initiative, and provided healthy eating and active living promotions and free health screenings at local farmers markets, DHH worksites and community events.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Counseling and education sessions to families on healthy eating and physical activity.		X		
2. Referrals to WIC Services for specialized one-on-one nutrition counseling.		X		
3. Utilization of educational materials on healthy weight & physical activity for infants and children.			X	
4. Training of health professionals to enhance their abilities to promote healthy lifestyles with patients.				X
5. Participation in the Louisiana Obesity Council and other committees.				X
6. Assess the link between nutrition risk and depression.				X
7. Utilizing the Nutrition and Physical Activity Self-Assessment for Child Care program in three child care centers in New Orleans.		X		
8. Outreach activities to encourage families to increase consumption of fruits and vegetables.			X	
9.				
10.				

b. Current Activities

Enabling

WIC continues to provide services in OPH for counseling/education sessions to families on

healthy eating.

The MCH RD continues to partner with LSU to expand NAP SACC to a Randomized Control Trial with 13 child care centers across the state with 13 centers acting as a control.

Population

The Louisiana WIC FMNP will continue in participating parishes and 475 booklets will be distributed.

The WIC NE Coordinator, MCH RD, and the Obesity Council coordinator are participating with the City of New Orleans Health Department's "Fit NOLA" project.

WIC purchased 50,000 MyPlate materials in both English and Spanish for pregnant women, 100,000 MyPlate Preschool handouts and 120 MyPlate posters for distribution in WIC clinics statewide.

The WIC NE coordinator will begin a revision of the WIC educational materials including the new dietary guidelines and MyPlate recommendations.

Infrastructure

The MCH RD coordinated the CCHC Conference and trained 100 professionals on nutrition in the child care setting. In addition the MCH RD trained local childcare staff on the topic of nutrition.

The MCH RD coordinated the annual AFHK in March 2012. The focus was on Fuel Up to Play 60 and a school grant opportunity for the 2012-2013 school year. The MCH RD and obesity council coordinator recruited schools and reviewed 40 applications for this grant. Approximately thirty schools will be awarded funding ranging from \$1000-\$5000.

c. Plan for the Coming Year

Objective: Reduce the percent of children (2-5 years old) receiving WIC with a BMI at or above the 85th percentile to 10.5 %.

Enabling

WIC will continue to provide services in OPH for counseling and education sessions to families statewide on healthy eating and physical activity.

The MCH RD applied for a grant through Blue Cross Blue Shield of Louisiana to expand the NAP SACC program to 350 child care centers across the state.

Population

120 Picky Eater DVDs will be purchased for all WIC clinics. The WIC NE coordinator will develop a lesson plan to accompany the DVD.

The WIC NE coordinator will continue with revision of the WIC educational materials series of 54 cards. The revision will include new dietary guidelines and MyPlate recommendations. The NE coordinator will also work on developing several short video clips for online posting related to infant formula prep/storage, breastmilk storage, and starting solid foods.

The WIC NE coordinator will begin work with Delgado Dietetic Technician Program to develop a series of kid-friendly recipes utilizing WIC foods. The recipes will be developed by the Delgado students and taste-tested on the children in the child care center on campus. The recipes will be targeted for publication on the WIC website and featured in recipe cards for clinic distribution.

The Louisiana WIC FMNP will continue to be promoted in the participating parishes and will be

further expanded dependant on funding.

The WIC NE Coordinator, MCH RD, and the Obesity Council coordinator will continue participating with the City of New Orleans Health Department's "Fit NOLA" project.

Infrastructure

MCH and WIC will continue to actively participate in the Louisiana Obesity Council, AFHK, the Southwest Regional USDA committee, and the State Nutrition Action Plan committee.

The Obesity Council coordinator will assist in the planning for the Childhood Obesity Conference and the Louisiana Report Card at PBRC. The MCH RD will plan the annual AFHK state team meeting and will work with the 30 schools awarded through AFHK for the 2012-2013 school year. Funded schools will work on projects related to nutrition education, competitive foods, and promotion of school breakfast.

The MCH RD and Obesity Council coordinator will continue participating in the Obesity Council policy workgroup to promote legislation around physical activity and limited screen time in Louisiana child care centers.

The Obesity Council coordinator will work with local Baton Rouge restaurant owners on a Healthy Kids Menu project. She will also continue to coordinate the Fruits and Veggies More Matters and the Let's Move Cities and Towns Initiative.

The MCH RD will act as the coordinator for the CCHC program, which will include monitoring of the CCHC monthly activity reports and planning the annual training and will also serve as a CCHC and will train staff of at least 4 childcare centers on the topic of healthy nutrition.

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	2007	2008	2009	2010	2011
Annual Performance Objective	13.5	13.5	12.5	13.5	13.5
Annual Indicator	12.5	14.9	14.1	14.1	14.1
Numerator	7787	9171	8548	8548	8548
Denominator	62059	61680	60514	60514	60514
Data Source		LA Pregnancy Risk Assessment Monitoring System			
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?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	13.5	13.5	12	12	11

Notes - 2011

Numerator and denominator are weighted. Data is provisional and based upon final 2009 data.

Notes - 2010

Numerator and denominator are weighted. Data is provisional and based upon final 2009 data.

Notes - 2009

Numerator and denominator are weighted. Data is final.

a. Last Year's Accomplishments

Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS) data for 2009 indicated that 14.1% of pregnant women reported smoking during the last three months of their pregnancy, which represents a small decline (5%) compared to 14.9% in 2008.

Direct and Enabling

The OPH MCH SBIRT program, a collaboration with Louisiana Section of the American College of Obstetricians and Gynecologists and the DHH Office of Behavioral Health (OBH), contracted regional SBIRT Coordinators to work with provider offices to implement the Chasnoff 4P's Plus intervention during the 2010-2011 fiscal cycle. However, support for the regional coordinators was phased out in the Fall of 2010 and state licensure for the SBIRT 4P's Plus Chasnoff tool was discontinued in July 2011. Structural program changes were made to achieve a far wider of uptake of perinatal tobacco screening and cessation activity among pregnant women receiving services in private sector settings. The new approach focused on securing Medicaid reimbursement for private providers, and integrating 5P's screening in OPH services such as WIC and the limited prenatal care settings. Women who screened positive for Tobacco use on the SBIRT form received onsite structured brief intervention for tobacco cessation and were given referrals to the Louisiana Tobacco Quitline. This program transition was necessitated due to funding limitations and the discontinuation of publically supported outpatient/inpatient obstetric services in state administered hospital systems over the past 18 months.

The Nurse-Family Partnership (NFP) nurse home visitors provided health education on smoking cessation, referrals, education, guidance and support to first time, low income mothers.

Population

MCH continued support for Partners for Healthy Babies (PHB), a comprehensive helpline and web site for client information on healthy pregnancy, including focus on smoking cessation in pregnancy. Callers to the PHB helpline are directly referred to the Louisiana Tobacco Quitline (1-800-QUIT-NOW).

Infrastructure

SBIRT collaborations continued with state Tobacco Control Program (TCP), March of Dimes, LPHI, OBH and Medicaid to promote smoking cessation among pregnant women. Regional SBIRT coordinators in nine state public health regions provided treatment, technical support to

clinical providers, education resources and assisted with coordinating referrals until the separately funded regional SBIRT coordinators were discontinued in January 2011. Regional FIMRs identified tobacco use as a risk factor in poor pregnancy outcomes and recommended strategies for community based interventions.

MCH worked successfully with the Louisiana Public Health Institute (LPHI), Louisiana DHH Birth Outcomes Initiative (BOI), TCP and Louisiana Medicaid to develop provider pay for performance measures for SBIRT screening statewide. DHH rule making authorized reimbursement for an initial provider SBIRT screen, at entry into prenatal care. An estimated 70% of Louisiana births are funded by Medicaid indicating the potential impact of enhanced SBIRT screening on state birth outcomes.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support Partners for Healthy Babies health messaging campaigns and resources for prenatal care providers and pregnant women / reproductive age women.			X	
2. Provide Pregnancy Risk Assessment Monitoring System (PRAMS) surveillance system.				X
3. Collaborate with Medicaid to promote and implement reimbursement structures for statewide risk screening and intervention.			X	X
4. Collaborate with LPHI, DHH-Tobacco Control Program, ACOG, private and public providers and Medicaid to promote systems based interventions to reduce tobacco use in pregnant women.				X
5. Continue to collaborate with Louisiana Bureau of Minority Affairs to increase awareness of tobacco use, poor birth outcomes and SIDS.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct and Enabling

The OPH/OBH/LPHI SBIRT program formally transitioned into a statewide Medicaid reimbursed pay for performance model in 2011. In the summer of 2011, the MCH Medical Director trained the OPH regional staff on implementation of the 5P's tool. Screening has been integrated into the routine protocols for OPH services. Collaboration with Medicaid has resulted in clinical provider reimbursement and pay for performance for screening and brief intervention services. FAX-TO-QUIT cessation counseling assistance for smoking cessation continues. The Louisiana Tobacco Quitline developed a pregnancy specific protocol which includes postpartum counseling support, and has prioritized pregnant women for service. NFP continues to provide health education on smoking cessation, cessation services referrals, and support.

Population

The PHB campaign continues to direct women to the information line and website; both the website and live phone resources staff proactively include information about cessation. Media expansion has been underway through collaboration with the TCP grant for pregnant women on cessation activities.

Infrastructure

The MCH Program has been assisting the BOI team with the development of a web-based behavioral health screening tool, Louisiana Health Assessment and Referral Tool (LaHART). This tool, intended initially for prenatal settings, will become the required Medicaid reimbursement mechanism.

c. Plan for the Coming Year

Objective: Reduce the percent of women who smoke during the third trimester to 12.0%

Direct and Enabling

OPH regional health units providing WIC, family planning and other services will continue to provide screening, brief intervention and referral for cessation services into routine clinical protocols; MCH will provide training and technical assistance as requested to support this protocol. The NFP program will continue to directly address tobacco use during pregnancy in its curriculum, and provide education, counseling and referrals for women in need of cessation services. MCH will explore how to integrate smoking cessation approaches in any of the other Maternal, Infant, Early Childhood Home Visiting (MIECHV) models the program may implement.

Population

The PHB infoline and website public information campaign will continue to support health messages and proactive referrals for smoking cessation. If PHB has sufficient resources to pursue developing interconception health messages, tobacco cessation/substance use will be considered as a potential area for emphasis.

Infrastructure

MCH will continue to collaborate with BOI and Medicaid to facilitate provider education and technical support for SBIRT activities and program implementation/maintenance as the LaHART tool is formally implemented. The Title V director will ensure that the Louisiana state team maintains active participation on the Tobacco Cessation COIN workgroup.

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	2007	2008	2009	2010	2011
Annual Performance Objective	8.8	8.8	8.8	7.7	7
Annual Indicator	7.7	5.2	6.8	7.0	7.0
Numerator	25	17	22	23	23
Denominator	323073	328634	324812	326779	326779
Data Source		Louisiana Vital Records and Statistics			
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?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	6.5	6.5	6.5	6.5	6.5

Notes - 2011

Data is provisional and based upon 2010 data.

Notes - 2010

Data is provisional.

Notes - 2009

Data is provisional.

a. Last Year's Accomplishments

Direct

Louisiana Office of Public Health Adolescent School Health Program (OPH ASHP) continued to provide Louisiana's youth with risk assessments and direct behavioral health counseling and referral. OPH-ASHP had 66 state funded SBHCs, with an additional 5 privately funded sites, for a total of 71 SBHCs statewide providing access to over 60,000 students. Behavioral health concerns remained among the top two most common reasons for visits to SBHCs in both urban and rural areas of Louisiana.

The Louisiana Public Health Institute (LPHI) received a General Electric Foundation grant that supported continued behavioral health, especially psychiatric services, in a few of the New Orleans SBHCs. LA SBHCs continued to be ineligible to bill Medicaid for behavioral health services rendered, despite OPH ASHP efforts to obtain the LA Medicaid office's approval for SBHC billing.

Enabling

All Nurse-Family Partnership (NFP) clients, including those 15-19 years old, were screened for depression, including a question concerning self-harm. Any positive screens were referred immediately for services or seen by the NFP mental health consultant in the areas where they are available.

OPH implemented screening for alcohol, tobacco, substance use, depression and domestic violence in all of the prenatal and WIC clinics. Women with depression or suicidal ideations were referred to appropriate services.

Infrastructure

The MCH Program Director remained an active member of the Louisiana Behavioral Health Planning Council (LBHPC), a cross-department, multi-disciplinary advisory council that is required for the state to receive the federal Mental Health Block Grant. MCH coordinated with the Louisiana Partnership for Youth Suicide Prevention through the Adolescent Health Program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. OPH ASHP to provide mental health counseling and referrals through School-Based Health Centers.	X			
2. OPH programs to screen clinic patients and NFP clients for depression; refer as indicated.		X		
3. OPH ASHP assist all SBHCs in the state's behavioral health managed care program, called Magellan, so the SBHCs can receive Medicaid reimbursement for services to enhance SBHC sustainability.		X		X
4. OPH MCH to participate in Behavioral Health Planning Council				X
5. OPH MCH to review maternal mortality cases for suicide prevention opportunities				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct

Behavioral health services, in particular for youth, have undergone major transformation in Louisiana in 2012. The Louisiana Behavioral Partnership (LBHP) is the new behavioral health program managed by DHH - Office of Behavioral Health (OBH). The LBHP is designed to serve the needs of children with extensive behavioral health needs either in or at-risk of out-of-home placement; Medicaid-eligible children with medically necessary behavioral health needs who need coordinated care; adults with severe mental illness and/or addictive disorders who are Medicaid eligible; and, non-Medicaid children and adults who have severe mental illness and/or addictive disorders.

Enabling

All NFP clients, including those 15-19 years old, continue to be screened for depression, including one question concerning self-harm. Any positive answers result in the client being referred immediately for services or seen by the NFP mental health consultant in the areas where they are available.

Infrastructure

MCH continues to participate in the LBHPC. The Pregnancy Associated Mortality Review (PAMR) program is now being supported in part by a dedicated mortality surveillance epidemiologist, but case reviews at the state level are not yet routine. MCH is currently redeveloping the protocols for Child Death Review and Pregnancy Mortality Review to ensure case investigations and reviews are complete and timely.

c. Plan for the Coming Year

Objective: Decrease the rate of suicide deaths among youths 15-19 to 7.0 (per 100,000).

Direct

Full implementation of the LBHP service is expected to improve coordination of behavioral health services for 50,000 youth and about 100,000 adults with serious mental illness and/or addictive disorders who are uninsured or served through Medicaid, and to better leverage state general fund dollars to enhance and expand services for those in need. Approximately 2,500 youth will be served by the Coordinated System of Care (CSoc) model that is for children at highest risk for out of home placement or institutionalization.

ASHP expects a decrease in the number of SBHCs in the coming year. One center will definitely close and another 2 may close if negotiations with a potential new sponsor are not successful. Additionally, state funding for all SBHCs remains uncertain dependent on legislative decisions about the 12-13 state budget and anticipated revenue shortfalls. SBHCs may be able to sustain state funding cuts through increased third party reimbursement, especially with the possibility of Medicaid reimbursement for behavioral health services which were previously non-billable. The SBHCs that remain in existence will continue to perform risk assessments and provide behavioral health counseling and referral. The number of students with access to these services may decrease slightly given the decrease in the number of operating SBHCs.

Enabling

All NFP clients, including those 15-19 years old, will continue to be screened for depression and are referred to services as appropriate. Screening will continue in OPH settings.

Infrastructure

MCH will remain engaged with the LBHPC. As the LBHPC service delivery system matures, MCH will determine the appropriate level of engagement with the state's planning and monitoring infrastructure. PAMR cases will be reviewed to identify suicide prevention opportunities.

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	2007	2008	2009	2010	2011
Annual Performance Objective	90	90	90	90	90
Annual Indicator	87.7	90.5	88.8	88.4	88.4
Numerator	1246	1242	1152	1101	1101
Denominator	1420	1372	1297	1245	1245
Data Source		Louisiana Vital Records and Statistics			
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?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	90	90	90	90	90

Notes - 2011

Data is provisional and based upon the 2010 data.

Notes - 2010

Data is provisional and based upon the 2009 data.

Notes - 2009

Data is provisional.

a. Last Year's Accomplishments

Very low birth weight (VLBW, <1500grams) contributes greatly to both infant morbidity and mortality. VLBW deliveries accounted for 2.0% of live births (N=1,326) in 2009 and 2.1% (N=1,280) in 2010. The Healthy People 2020 goal is to have at least 83.7% of all VLBW births born in facilities with newborn nursery services at Level III or higher designation, as these facilities have the range of advance technology and subspecialty clinical expertise to optimize neonatal outcomes for infants with the greatest medical risk and acuity. The Healthy People goal was established based on the expectation of a 10% improvement over the 2008 national baseline measure of 76.1%. In Louisiana, the percent of VLBW births delivered at high-risk facilities (III or III Regional) indicated a steady increase from 81.6% in 2001 to 90.5% in 2008. Final 2009 data indicated 88.8% while provisional 2010 data indicated 88.4% VLBW births occurred in Level III/IIIR facilities.

Infrastructure

The Louisiana Perinatal Commission has successfully facilitated the development and implementation of the State Perinatal Plan, which adopted hospital licensing standards for maternal and neonatal care, requiring a concordance in level between obstetrical and neonatal services, i.e. for a neonatal Level III facility, obstetrical services should be of Level III as well. Additional guidelines emphasized requirements for professional clinical personnel resources at high level facilities and the establishment of formal transfer agreements between lower and higher level perinatal facilities. The Louisiana Office of Public Health (OPH) continued to provide epidemiological surveillance data and analysis, and MCH provided clinical updates through presentations at Louisiana Perinatal Commission and regional Fetal and infant Mortality Review (FIMR) meetings. The MCH EPI unit maintained updated information on VLBW deliveries by level of delivery hospital.

FIMR groups have maintained structured evaluations of clinical and health systems contributors to fetal and infant deaths. Their work continues to focus heavily on the high numbers of preterm births and VLBW infants delivered in our state. Regional FIMR Community Action Teams (CATs) have been instrumental in developing recommendations for regional community and health systems responses to risk factors which contribute to LBW, prematurity and infant mortality.

The Perinatal Periods of Risk (PPOR) methodology, an analysis of infant mortality according to birth weight and age at death, was an important component of the analyses provided to Regional FIMR teams. Data have indicated that VLBW births account for nearly half of the total fetal-infant mortality rate, indicating that VLBW births and prematurity are important factors for Louisiana, which is consistent with national clinical analyses. In addition to PPOR, the MCH Epi group updated an in-depth analysis of VLBW deliveries at lower level facilities and distributed the report to the Perinatal Commission for follow-up.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Study distribution of VLBW infants born at all levels in the state, by region & parish.				X

2. Analyze VLBW in lower level facilities by race, Medicaid status, and delivery hospital. Share results with stakeholders.				X
3. Update MCH Data Profiles with the most current data on percent of VLBW in Level III or higher.				X
4. Support MCH grants for the perinatal mortality reduction initiative.				X
5. Support and promote regional Fetal-Infant Mortality Reviews (FIMRs).				X
6. Disseminate analysis findings to all regional FIMRs and Perinatal Commission				X
7. Continue collaboration with March of Dimes and other community based groups through FIMRs				X
8.				
9.				
10.				

b. Current Activities

Infrastructure

The State Perinatal Plan continues to guide levels of maternal and neonatal care, with MCH monitoring VLBW births. Data from 2008 indicated the 90.5% of VLBW births, including 90.2% of white and 90.7% of black VLBW infants were delivered in Level III or higher facilities. As rates declined slightly in 2009 and 2010, a small but inconsistent racial disparity has emerged. Specifically, 88.2% of white while 89.7% of black VLBW occurred in Level III/IIIR facilities whereas 89.8% of white but only 87.7% of black 2010 deliveries occurred in Level III/IIIR facilities. Healthy People (HP) revised the goal for this measure from 90% in 2010 to 83.7% for 2020. While Louisiana currently exceeds the HP2020 goal, the state is working to achieve at least 90% again. An updated data report continues to indicate that reducing VLBW deliveries in only a few lower-level facilities will enable Louisiana to exceed 90%.

MCH continues to support FIMR activities in all nine public health regions to review cases, conduct home interviews, and coordinate Case Review Teams (CRTs) and CATs, and support initiatives to decrease the number of VLBW births and increase Level III/IIIR VLBW deliveries. Louisiana also actively participates in the Region IV and VI Infant Mortality Collaborative. Perinatal regionalization and VLBW deliveries in Level III or IIIR facilities was identified as one major strategy at the collaborative meeting in January 2012.

c. Plan for the Coming Year

Objective: To increase the proportion of VLBW infants delivered at facilities for high-risk deliveries and neonates to at least 90% overall and for all race groups. Preliminary data from 2010 indicates another very slight decrease to 88.4% (2009=88.8%) of Louisiana women who delivered VLBW infants in Level III or higher facilities. An analysis using 2009 data by state public health region demonstrates that four of nine regions achieved >95% of VLBW births in appropriate level facilities. Three regions reported < 80% of VLBW deliveries in Level III or IIIR, consistent with the location of the Level II hospitals delivering the most VLBW births in the state. One of these Level II hospitals stopped labor and delivery services in 2011 while a second of these Level II facilities recently upgraded to Level III services. As a result, updated analyses of 2011 data are expected to show improvement in this measure.

Infrastructure

Updates to the regional FIMR groups on risk factors associated with VLBW births at lower level facilities will occur and additional vital statistics analyses will continue to be performed. Regional FIMR groups will continue to monitor factors associated with VLBW deaths through case reviews. Opportunity for community action where appropriate will be carried out through FIMR CATs. The

MCH Medical Director is working with staff to design and implement an evaluation plan. Follow-up contact is expected to be made with the identified hospitals based on the data analysis report. It is expected that specific hospitals will be contacted to help facilitate solutions to further improve the percent of VLBW born in level III or higher facilities. Strategic planning for effective statewide and regional health systems responses will engage key partners and stakeholders such as the DHH Birth Outcomes Initiative, March of Dimes, Louisiana ACOG, the MCH Coalition and the State Perinatal Commission.

One new approach to help facilities better monitor their performance includes a dashboard managed on the DHH website. The VLBW in Level III measure will report the overall state percent of VLBW in Level III/IIIR facilities as well as show the percent of VLBW deliveries by facility for Level I or II facilities. As the Region IV and VI Infant Mortality Collaborative continues to develop, Louisiana will remain an active participant in the perinatal regionalization Collaborative Innovation Network (COIN). Moving forward, the Title V Director, Birth Outcomes Director, Medicaid Medical Director, MCH Medical Director, and State MCH Epidemiologist will work together to implement a plan to reduce VLBW deliveries in lower level facilities. This plan will likely include working with the state Hospital Licensing Standards office as well as key lower level hospitals delivering VLBW births.

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	2007	2008	2009	2010	2011
Annual Performance Objective	87	88	89	90	91
Annual Indicator	86.9	86.8	86.8	88.0	88.0
Numerator	57097	56193	56503	54576	54576
Denominator	65731	64752	65109	62043	62043
Data Source		Louisiana Vital Records and Statistics			
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?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	91	91	91	91	91

Notes - 2011

Data is provisional and based upon the 2010 data.

Notes - 2010

Data is provisional and based upon the 2010 data.

Notes - 2009

Data is final.

a. Last Year's Accomplishments

Increases in early entry into prenatal care observed over the past decade have remained stable. The percentage of women entering 1st trimester prenatal care was 86.8% in 2009 and the preliminary rate for 2010 is 88.0%. Louisiana continues to rank favorably among all the state and exceeds the Healthy People 2020 target of 77.9%.

Direct

For FFY 2011, MCH provided limited direct funding for comprehensive prenatal care services in the OPH statewide network of parish health units (PHUs). Over 12,326 pregnancy tests were performed. WIC services remained in place and WIC related benefits and health education were provided to pregnant, post-partum, and breastfeeding women through PHU programs. In medically underserved areas, contractors provided prenatal services to 1,071 low-income women, with approximately 4,188 visits.

Enabling

The Nurse-Family Partnership (NFP) Program continued to provide services statewide. Early and adequate prenatal care is a focus of the program.

MCH provided support for Healthy Start Programs in 4 northern Louisiana Parishes, which were responsible for outreach/case management services for at risk pregnant women until October 2011 when budget reductions prompted discontinuation of these activities. Similarly, support to the Baton Rouge Healthy Start program was discontinued in July 2011.

Population

MCH continued support for Partners for Healthy Babies (PHB), a comprehensive helpline and web site that provides information related to pregnancy, child development, parenting, and resources.

MCH continued to promote the national Text4Baby service; Louisiana was one of the first states in the nation to sign on as a partner. Text4Baby is promoted via the PHB website, to helpline callers when appropriate, on social media messaging, to all NFP clients, and through promotional cards statewide.

Infrastructure

Vital Records and PRAMS data collection and analysis continued. Regional Fetal Infant Mortality Review (FIMR) and HIV/FIMR case review and action teams reviewed cases to assess and address prenatal care entry and adequacy.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provision of prenatal services via network of parish health units in Targeted Public Health region.	X			
2. Provide targeted case management programs, such as Nurse Family Partnership.		X		

3. Link women to prenatal care via the Partners for Healthy Babies social marketing project Helpline and promote preconception health.			X	
4. Collect and analyze PRAMS data to provide program direction.				X
5. Support Regional Infant Mortality Reduction infrastructure, at each regional level, using Coordinators.				X
6. Work with Medicaid to ensure access to early and comprehensive prenatal care services.				X
7.				
8.				
9.				
10.				

b. Current Activities

Direct

Pregnancy tests continue in the OPH PHUs, but as of September 2011, MCH discontinued support of prenatal care services, with the exception of limited services offered through OPH PHUs, primarily in the Northeast Delta Region.

Enabling

NFP teams continue to provide active program services in all regions of the state and are expanding with the support of Affordable Care Act (ACA) Maternal, Infant, and Early Childhood Home Visitation (MIECHV) funding. NFP program model encourages early access to quality prenatal care.

Population

The PHB campaign promoting the Title V helpline and website was redeveloped in May 2012. While the new materials will be available statewide, the print materials and radio spots will be focused in certain areas of the state with late entry and poorer outcomes. MCH is continuing to develop strategies to promote Text4Baby services.

Infrastructure

Vital Records and PRAMS data collection and analysis continue. Regional FIMR and HIV/FIMR case review and action teams are ongoing.

In 2012, the Louisiana Medicaid program transitioned from a traditional fee-for-service model to a managed care delivery structure. Louisiana Medicaid remains the principal source of health care funding for an estimated 70% of births. MCH epidemiology staff will monitor changes in prenatal care entry timing and adequacy.

c. Plan for the Coming Year

Direct

Pregnancy tests will continue to be available in OPH PHUs. MCH will work to ensure active, timely linkage to care for pregnant patients.

Enabling

NFP teams will continue to provide active program services in all regions of the state.

Population

PHB will continue to foster targeted outreach to high-risk populations of the state, with a particular emphasis on disparities. MCH will continue to promote Text4Baby services.

Infrastructure

MCH Epi will continue to provide critical analysis of major correlates associated with limitations in effective access to prenatal care through analysis of PRAMS, Vital Records, and Medicaid data. Regional FIMR and HIV/FIMR case review and action teams will also continue.

MCH, together with BOI will work with BAYOU Health plans to support the outreach components and achieve further improvements in access to care for pregnant women.

D. State Performance Measures

State Performance Measure 1: *Percent of all children and adolescents enrolled in public schools in Louisiana that have access to school-based health center services.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	7.3	7.5	7.7	8	8.4
Annual Indicator	7.3	8.1	8.1	8.4	9.9
Numerator	49454	56192	54904	58748	68651
Denominator	681753	690340	681038	696558	696558
Data Source		Adolescent School Health Initiative Annual Report			
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	9.5	9	9	9	9

Notes - 2011

One school based health center (SBHC) will definitely be closed at the end of 2012. With the possibility of decreased state funding to support SBHCs in coming years, projections of annual performance objective percentages have been decreased to 9%.

a. Last Year's Accomplishments

Direct

The number of students with access to Office of Public Health (OPH) Adolescent School Health Program (ASHP) school-based health centers (SBHCs) was 68,651 or 9.9% of the approximate 696,558 students enrolled in public schools. OPH-ASHP exceeded its goal of providing 8.4% of all students access. There were 57 full-time and 9 part-time, OPH-funded SBHCs, for a total of 66 ASHP sites. Additionally, there were 5 non-OPH funded SBHCs.

ASHP applied for and received another grant from Blue Cross/Blue Shield of Louisiana (BC/BSLA). Building on the success of the 2010-11 Hypertension grant and some of the data collected in that project, ASHP proposed to correlate BMI data with Chronic Disease prevalence

in the SBHC population.

Infrastructure

ASHP certified 1 non-OPH funded SBHC as eligible to bill Medicaid as a SBHC provider type.

ASHP continued to provide technical assistance to SBHCs in adopting EMRs by encouraging them to connect with Regional Extension Centers for technical assistance. LPHI presented information at a biannual provider network meeting on some of the financial incentives for EMR adoption.

Because most SBHCs are SCHIP/Medicaid application centers, SBHC staff was able to maintain a low percentage of uninsured students enrolled in SBHCs at about 8%.

Fourteen SBHC sponsors underwent a Continuous Quality Improvement (CQI) review, focusing on core sentinel conditions, including comprehensive physical exams, immunization rates, asthma management, data management, academic achievement, and health insurance enrollment. Random chart audits showed up-to-date immunization increased from 73% at the beginning of the school year to 88% by year end. There were 9,643 comprehensive exams performed. Random chart audits showed that for students receiving a comprehensive exam, 100% of charts reviewed showed tobacco screening had occurred and, if necessary, counseling to address tobacco use took place. There were 8,989 visits for preventive counseling/health education, which included 3,552 HIV/STD counseling visits. Asthma related visits numbered 1,965 and there were 23,325 visits where a height, weight, BMI and blood pressure was recorded in the data management system. There were 1,053 diabetes screenings and 5,116 HIV/STD screenings.

ASHP continued to assist the LA Obesity Council in its efforts to reduce obesity in Louisiana's young people by providing the Council with data on the prevalence of overweight students seen in SBHCs as well as by educating students on healthy nutrition and increasing activity. ASHP's data system provided BMI percentages for almost 24,000 students.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. SBHCs provide comprehensive preventive and primary physical and mental health services.	X	X		
2. Set policies and standards for SBHC operation and assist SBHCs in adopting Electronic Medical Records.				X
3. Provide technical assistance, monitoring, continuous quality improvement in SBHCs.				X
4. Work to raise level of funding to support SBHC operation, through providing technical assistance on enrolling SBHCs in Louisiana's Medicaid Managed Care Organizations, namely Bayou Health and Magellan.	X	X	X	X
5. Publish Louisiana School-Based Health Centers Annual Services Report and generate statistical reports on service delivery in Louisiana SBHCs.				X
6. Collaborate with various entities to promote coordinated school health model.				X
7. Provide resources to policy makers, educators, service providers, etc. on school health issues.				X
8. Engage in appropriate research activities that advance knowledge in the field of pediatric/adolescent medicine				X
9. Implement statewide protocol for diagnosis and treatment of	X			

hypertension.				
10. Implement grant to Correlate BMI with Chronic Disease.	X			X

b. Current Activities

Direct

Presently the number of state funded SBHCs is 65 and there are 5 non-OPH funded sites. Midyear FY10-11 budget cuts amounted to a 6.56% reduction in funding, but a projected additional cut of 23.67% in FY11-12 did not occur. Initially, all sites were able to continue operation without reducing services by increasing in-kind contributions. However, subsequent cuts to the LSU hospital system resulted in 3 SBHCs closing in March 2012. One of these sites will remain permanently closed. The other two are actively recruiting a new sponsor and hope to reopen in FY12-13. Implementation of the hypertension best practice is ongoing. ASHP is conducting the BMI-Chronic Disease project funded by Blue Cross/Blue Shield of Louisiana Foundation.

Infrastructure

Nine (9) SBHC sponsors who operate 14 SBHCs underwent on-site Continuous Quality Improvement (CQI) reviews. ASHP provided 3 technical assistance workshops on coding and billing, provider credentialing, and EMR adoption to assist SBHCs with sustainability planning. In 2011-12, 20 out of 26 sponsors will have adopted EMRs and be progressing toward meaningful use.

c. Plan for the Coming Year

Objective: Maintain the percent of all children and adolescents enrolled in public schools that have access to school-based health centers at a 9% level. With no additional funds allocated to open new centers in the coming year, it is not possible to increase this level.

Direct

In 2012-13, ASHP will maintain the 2011-12 level of funding. The number of SBHCs in 2012-13 will be 64, down by just 1 site from the 2011-12 number. ASHP expects the number of students with access to decrease slightly, but aspires to keep numbers of student visits/services provided consistent with last year.

Infrastructure

ASHP continues to work with SBHC sponsors to increase 3rd party reimbursement to mitigate state budget reductions. With Louisiana's transition to managed care health services (BAYOU Health) and managed care behavioral health services (Magellan) for the first time, SBHCs may be able to bill for and be reimbursed for behavioral health services. Both Magellan and Bayou Health offer the possibility of SBHCs becoming more sustainable through increased reimbursement.

ASHP will continue to certify non-state funded SBHCs that meet standards of care for Medicaid reimbursement as a SBHC provider type. As Louisiana rolls out its Medicaid managed care systems, ASHP will work closely with SBHCs to help them transition to these new systems.

ASHP will release the findings of the BMI and Chronic Disease study funded by BCBS of LA and conducted in 2011-12.

In 2012-13, ASHP plans to conduct CQI visits with at least 10 SBHC sponsors who operate 21 SBHCs.

2012-13 will bring anticipated changes to ASHP's method of collecting and analyzing data. The current data collection system, Clinical Fusion, will be phased out as SBHCs begin/continue using EMRs. ASHP is working with SBHCs to coordinate data reporting in formats that allow data

aggregation and analysis. DHH's development of the Louisiana Health Information Exchange (LaHIE) will allow multiple data systems to send data to a central location for processing and dissemination to programs.

State Performance Measure 2: *Percent of unintended pregnancies among women who had a live birth.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					54
Annual Indicator		55.8	55.4	55.4	55.4
Numerator		33737	34730	34730	34730
Denominator		60507	62743	62743	62743
Data Source		LA Pregnancy Risk Assessment Monitoring System			
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	53.5	53	52.5	52.5	52.5

Notes - 2011

Numerator and denominator are weighted. Data is final 2009.

Notes - 2010

Numerator and denominator are weighted. Data is final 2009.

Notes - 2009

Numerator and denominator are weighted. Data is final 2009.

a. Last Year's Accomplishments

According to CDC-funded LA Pregnancy Risk Assessment Monitoring System (PRAMS) data, 55.4% of Louisiana women ages 19-64 who had a live birth report that their pregnancy was unintended. Louisiana ranks 18th for the rate of teen pregnancies and 13th for teen birth rates in the nation.

Direct

The primary direct service related to improving pregnancy spacing is the statewide network of Family Planning (FP) services. The OPH FP program provided comprehensive reproductive healthcare services to 45,707 women in 64 parishes in Louisiana through OPH Parish Health Units (PHU) in 2011. Services included: physical examination, preventive health screenings, pap smears, education, counseling, and contraceptives including long acting reversible contraceptive methods (LARCs). Post-partum women were prioritized for appointments. Services also included

education and counseling regarding preconception and interconception care. The FP Program continued providing free female and male sterilization waivers to interested clients.

Enabling

The FP Program continued to conduct outreach activities in all Louisiana parishes to ensure increased awareness of services. Outreach activities were conducted in community based settings including schools, faith-based institutions, and healthcare settings. With a decrease in resources and staff, the FP Program relied more on OPH field staff to provide community outreach including outreach for the family planning waiver program, Take Charge, that pays for family planning services for women up to 200% of the federal poverty level.

The FP Program increased its reach through a grant from the Office of Adolescent Health to implement an evidence-based teen pregnancy prevention program, Teen Outreach Program (TOP). The FP Program piloted the selected program providing adolescents with Life Skills training.

The Nurse-Family Partnership (NFP) Program continued to provide services statewide. As a program working with first-time mothers, family planning including healthy pregnancy spacing and pregnancy intention is addressed as a part of the curriculum.

Population

The Partners for Healthy Babies (PHB) website and info line both promote information about pregnancy spacing and pregnancy intention. In May 2011, MCH staff, along with the program's contracted marketing firm and some key external partners, met to discuss the possible development of an interconception social marketing campaign. The priority area identified was the concept of promoting a "life plan" which would include pregnancy intention and pregnancy spacing. Due to budget reductions in the fall of 2011, the development of the campaign has not been actively pursued, but is anticipated. FP started using a new texting program to find family planning services.

Infrastructure

A FP Needs Assessment was conducted in an effort to address the needs of Louisiana citizens and to identify gaps services. The FP Program also conducted the annual statewide needs assessment with providers to identify training needs. FP coordinated trainings for providers through the National Family Planning Program's training center, Cardea; FP coordinated over 2,000 hours of training in in 2010. FP also organized a summit for state stakeholders. Sessions topics included "Outreach Strategies" and "Long Acting Reversible Contraceptives."

The FP Program continued to collaborate with the Greater New Orleans Community Health Connection (GNOCHC), a Medicaid demonstration project in the New Orleans area for low-income individuals who otherwise do not qualify for Medicaid, to ensure the availability of reproductive health services as a part of the initiative's comprehensive primary care, reproductive and behavioral health services.

MCH and FP worked with the DHH Birth Outcomes Initiative (BOI) in the development of an interconception care coordination program through GNOCHC for women with a prior poor birth outcome; birth spacing is a major goal. FP and the BOI also worked to strengthen the Take Charge waiver program.

MCH and FP continued to collaborate via standing program meetings such as the MCH health communications committee and the FP Advisory Council.

Vital Records and PRAMS data collection and analysis continued.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide family planning services throughout the state in over 71 sites.	X	X		
2. Enhancement of educational materials.	X			X
3. Community outreach and education to women in need of family planning services.			X	
4. Training of family planning service providers on topics that enhance family planning services.				X
5. Collaboration with the Greater New Orleans Community Health Connection (GNOCHC).			X	
6. Partnering with Federally Qualified Health Centers.			X	X
7. Merge of services and departments to better reach the community.	X	X	X	X
8. Increasing awareness of Long Acting Reversible Contraceptives.	X			
9.				
10.				

b. Current Activities

Direct

OPH continues to offer comprehensive reproductive health services, including preventive health screenings. FP is working to increase the knowledge and use of Long Acting Reversible Contraceptives.

Enabling

FP continues to conduct outreach in all parishes. TOP continues to be implemented statewide.

Population

The PHB website and info line promote information about pregnancy spacing and pregnancy intention.

Infrastructure

FP continues to conduct provider trainings and work to develop an annual training schedule.

The FP and Sexually Transmitted Disease (STD) programs have been working to develop a comprehensive approach to FP and STD services offered in OPH clinics. The shift to comprehensive personal health services represents fundamental changes to clinic flow and services provided.

MCH will help develop protocols for GNOCHC as needed and will work to ensure coordinated referral paths.

MCH has been working with the BOI staff to provide input on pre and interconception care plans for the state. MCH is participating in the HRSA Region IV/VI Interconception Care COIN.

MCH and FP are developing a merged administrative program model. This will strengthen the state's overall ability to address pregnancy spacing, pregnancy intention, and interconception health.

c. Plan for the Coming Year

Direct

Direct FP services through OPH will be implemented as newly-transformed comprehensive personal health services, as described in the "current year" infrastructure section. The merging of STD and FP clinical services across the state will offer more opportunity for providers to educate and counsel clients. The consolidated clinic model will also offer the staff more chances to increase enrollment in the Take Charge FP Medicaid waiver program.

The FP Program plans to increase the number of doctors partnering with FP and accepting the sterilization waivers, which will make sterilization a more attainable option for many throughout the state. FP will introduce a new Interconception Care tool to the providers to be used with clients for mapping their interconception and preconception goals.

Enabling

The FP Program will continue to conduct outreach activities in all Louisiana parishes to ensure increased awareness of services.

FP will continue implementation of Teen Outreach Program (TOP).

The NFP Program will continue to provide services statewide.

Population

FP will continue to conduct outreach activities in all Louisiana parishes to ensure increased awareness of services; the MCH Program's health education and communications expertise will be tapped to support these efforts.

The PHB website and info line will continue to promote information about pregnancy spacing and pregnancy intention. The FP Program will promote a text message service to locate FP services. Health Ed/Communications will continue to participate in the development of CDC's interconception social marketing campaign.

Infrastructure

The MCH and FP Programs merged as "Bureau of Family Health" will work to operationalize the new program structure with defined program targets and regional action plans around pregnancy spacing.

MCH will continue to support BOI's development of the interconception care coordination program through GNOCHC for women with a prior poor birth outcome.

MCH will continue to work closely with the BOI staff to provide input on pre and interconception care plans for the state, including work with the new BAYOU Health plans to develop comprehensive post partum discharge plans.

MCH will ensure active representation and participation in the HRSA Region IV/VI Interconception Care COIN.

Vital Records and PRAMS data collection and analysis will continue. A dedicated women's health epidemiologist is planned to support the merged MCH and FP programs.

State Performance Measure 3: *Rate of children (per 1,000) under 18 who have been abused or neglected.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	9	9	8.3	8.8	7.5
Annual Indicator	9.6	8.4	9.0	7.6	8.8
Numerator	10360	9276	9968	8541	9828
Denominator	1079560	1107973	1107973	1123386	1118015
Data Source		LA Department of Social Services	LA Department of Social Services	LA Department of Children and Family Services	LA Department of Children and Family Services
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	7.4	7.3	7.2	7.1	8.3

Notes - 2011

Numerator : From LA Department of Social Services for CY 2011 (final). The methodology used by DSS is reportedly somewhat different from that utilized previously (not specified).
Denominator: Number of Children < 18 years of age in Louisiana households from U.S. Census Bureau (AE Casey Kids Count Data, 2011)

Notes - 2009

Numerator : From LA Department of Social Services for CY 2009 (final). The methodology used by DSS is reportedly somewhat different from that utilized previously (not specified).
Denominator: Number of Children < 18 years of age in Louisiana households from 2008 American Community Survey administered by U.S. Census Bureau;

a. Last Year's Accomplishments

During CY 2011, there were 20,122 validated allegations of abuse and neglect in children under age 18. The unduplicated count of 9,828 victims yields a rate of 8.8 victims per 1,000 children.

Enabling

Nurse-Family Partnership (NFP) Program continued to provide services statewide. Prevention of abuse and neglect is among the demonstrated results of NFP.

MCH-funded mental health services were provided to 87 women through Healthy Start New Orleans, and to 178 women through the Lake Charles Best Start Program. MCH contracted with Project LAST of the Children's Bureau of New Orleans to provide clinical grief/trauma assessments, home, school-based, family and group therapy, and crisis intervention services. Project LAST served 222 families (317 adults, 261 children) impacted by violence (abuse, homicide, other), non-criminal deaths, traumas, SIDS, and other sudden unexpected infant deaths. Crisis intervention services were provided to 1,167 students and adults at schools which experienced loss of life and/or violence

Population

MCH continued support for Partners for Healthy Babies (PHB), a comprehensive helpline and web site that provides information related to pregnancy, child development, parenting, and resources.

The MCH Program has developed Happy and Healthy Kids, a parenting newsletter that is distributed with every birth certificate. Approximately 72,000 Happy and Healthy Kids parenting newsletters were distributed to current subscribers, and distributors via parish health units, provider offices, health fairs, and vital records complimentary birth certificates.

Infrastructure

The MCH Program maintained a state and regional infrastructure for Child Death Review (CDR) to review unexpected deaths of children under the age of 15 years, including SIDS. MCH Child Safety Coordinators continued to serve as the local CDR coordinators. In September 2011, budget constraints prompted the MCH Program to restructure the CDR Program and consolidate regional positions into a single Regional MCH Coordinator in each region to implement CDR, Fetal and Infant Mortality Review (FIMR), and Pregnancy Associated Mortality Review (PAMR) surveillance and action processes. The new consolidated position was transitioned to a nurse role which resulted in the turnover of all existing CDR staff.

MCH continued to offer a 36-hour infant mental health training to NFP personnel, NFP infant mental health consultants, and to personnel from the state's Part C (Early Steps) Program, and from the Department of Children and Family Services (DCFS)-50 individuals were trained.

NFP Infant Mental Health consultants were trained in the evidence-based Circle of Security parenting intervention. A series of trainings to 11 Orleans Parish Healthy Start staff included "Overview and assessment of perinatal depression", IMH, "Establishing Rapport with Clients", and the "Impact of Childhood Sexual Abuse". Three Metropolitan Human Services clinicians were trained in "Recognition of problems in the mother child relationship due to mental illness." MCH reached 80 clinicians in southwest Louisiana with presentations on infant mental health theory, approaches to working with infants and caregivers, and on perinatal depression and Interpersonal Therapy theory. All trainings provided CE credit. In addition, 15 attendees participated in the OPH Grand Rounds presentation, "New treatment and research findings in perinatal depression."

The Oral Health Program monitored the number of abuse and neglect cases reported by dental professionals to DCFS. Nineteen cases of potential abuse/neglect were reported in calendar year 2011; ten cases were validated, nine were not validated.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Child Health Record psychosocial assessment for children 0-6 in health units.	X			
2. Home visitation services for low-income families.		X		
3. Infant mental health services to low-income families through Best Start and NFP programs.		X		
4. Statewide training in infant mental health, perinatal depression, and related issues to public health nurses and other early childhood professionals.				X
5. Collection, analysis, and assessment of unexpected child deaths by the Child Death Review Panel.				X
6. Monitoring of child abuse and neglect referrals by dental professionals.				X
7. Public education through new parent's newsletter, Happy and Healthy Kids.				X
8. Targeted psycho-educational services for at-risk mothers.			X	
9. Targeted psycho-educational and support services for at-risk		X		

children and their families.				
10.				

b. Current Activities

Enabling

NFP services continue to be offered statewide.

Population

MCH continues to support the PHB comprehensive helpline and web site. In May 2012, MCH redeveloped the PHB social marketing campaign materials.

MCH continues to distribute the Happy and Healthy Kids newsletter.

Infrastructure

MCH continues to maintain a state and regional infrastructure for CDR. In December 2011, MCH hired a dedicated mortality surveillance epidemiologist to focus on increasing the Program's capacity to provide timely, actionable data to support regional and state-level CDR activities and action processes. MCH program staff have been working with the Department of Children and Family Services (DCFS) to harmonize case identification, investigation, and review processes. In July, all of the Regional MCH Coordinators will be coming together with the MCH Program Director, the Medical Director, and the mortality epidemiologist to continue to redevelop the foundation of the CDR program.

MCH is in the process of finalizing the State Child Death Review Report, a six-year cumulative case review report from 2002-2007.

MCH continues to the 36-hour infant mental health training--28 professionals have been reached so far this year.

c. Plan for the Coming Year

Enabling

NFP services will continue to be offered statewide. As Louisiana looks to pilot other Maternal, Infant, Early Childhood Home Visiting (MIECHV) models, Louisiana may opt to pilot models that can support efforts to prevent abuse/neglect and/or can target families that have been referred for DCFS services.

Population

MCH will continue to support the PHB comprehensive helpline and web site and distribute the Happy and Healthy Kids newsletter. The content of the newsletter will be reviewed and updated to reinforce the state's realignment around child development and school readiness.

Infrastructure

MCH will maintain and strengthen the state and regional infrastructure for CDR. CDR protocols will specify how MCH and DCFS will harmonize case identification, investigation, and review processes.

The program expects to produce an annual CDR report.

The MCH Program will continue to the 36-hour infant mental health training. The approach and content of the training will be reviewed and harmonized with other efforts of professional development opportunities for Louisiana's early childhood workforce.

State Performance Measure 4: *The difference in the percent of publically insured and percent of privately insured CYSHCN in Louisiana who need more care coordination services.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					8
Annual Indicator				11	20
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	6	19	18	16	15

Notes - 2011

Indicator data came from the 2009-2010 NS-CSHCN conducted by HRSA and CDC. The same survey questions used in the 2005-2005 NS-CSHCN were used in the latest version. Thus, parameter estimates are comparable.

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

Notes - 2010

This is a new performance measure therefore there is no annual performance objective for 2010. Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments

Care Coordination (CC) capacity differs substantially according to primary health insurance coverage. CYSHCN currently receiving CC services report disparate needs for more CC by insurance type: public (30.2%) vs. private (10.3%). This disparity has increased from 11% to almost 20%, which corresponds to an 81% change in the disparity rates between NS-CSHCN survey years (05/06 vs. 09/10). Quality, comprehensive CC is a significant component of the AAP definition of the Medical Home (MH). CC has been shown to reduce health care system inefficiencies related to duplication of services, time, money, and burden on the family. CC increases the likelihood of receiving needed services in a timely manner, enables the family to more easily navigate the service system, and helps to ensure that health condition management is comprehensive and continuous. Such services reduce the risk for sequelae and/or disability-adjusted life years. This measure was added for FFY 2011 to emphasize CSHS activities that address the significant disparity between privately and publically insured CYSHCN who are in need of extra CC services. The disparity signifies a deficit in the quality of comprehensive services available for publically insured CYSHCN who have significantly higher rates of complex conditions, and subsequently poorer health outcomes. Efforts at improving both the quality and comprehensive nature of CC services will minimize the risk for poorer health outcomes for all of Louisiana's CYSHCN population.

Direct and Enabling

CSHS subspecialty clinics have both income and medical eligibility criteria. Last FFY, 4,077 CYSHCN received care during a CSHS subspecialty clinic visit, including care coordination and family support. CSHS clinics include a multi-disciplinary team of a nurse, social worker, parent liaison, contract physician, and in some cases a nutritionist, audiologist, or speech pathologist. 91.4% of CSHS patients have Medicaid and 4.4% are uninsured. PLs discussed community-based resource information 4,843 times with families in CSHS clinics and 2,457 times within

community settings. CSHS staff provided transition services to 290 YSHCN. Clinic transcripts were sent to 3,945 patients' Medical Homes (MH). PLs provided 1,079 families with transition information at health fairs.

Population

CSHS contracted with 6 academic practices to increase CC capacity continued, adding transition services to the contracts. The CC software database was expanded to two pediatric clinics. CSHS contracted with 3 new academic practices and provided MH CC orientation and technical assistance to staff. The MHs received a \$20,000 stipend to designate an in-house care coordinator and incorporate MH principles within the practice. In CSHS contracted practices, 20,558 children/youth received CC services. One page, quick reference, Regional Resource Guides (RRGs) listing services specific to CYSHCN were updated, as well as region-specific comprehensive resource binders for use by CCs in academic practices. CSHS mailed 756 RRGs and FHF/CSHS brochures to FQHCs, SBHCs, NCQA-certified MHs, MD Needs Assessment survey respondents, and orthopedic and neurologic subspecialists, 265 school nurses, 14 CCs, and 18 School Linkage Committee (SLC) members. Thirty-Nine Tulane and LSU residents completing developmental rotations (directed by the CYSHCN director) were trained in MH. Forty Delgado Community College-Allied Health students were oriented on MH, and provided RRGs. The CSHS website was updated.

Infrastructure

The Title V CYSHCN Director and Statewide CC Supervisor served on the state's Advisory Board for the Louisiana Healthcare Quality Forum (LHCQF) MH Committee. The Statewide CC Supervisor participated on the Health Advisory Committee for the New Orleans Recovery School District, Early Head Start Program. CSHS worked with Medicaid to incorporate CC into healthcare reform. Two papers were published in MCH Journal on CC and a third was accepted on characteristics of YSHCN in the MH who receive transition services. Two articles on CSHS services and transition were prepared for submission to the LA AAP newsletter. The Statewide CC Supervisor participated in NCQA training where trainers requested copies of RRGs for use as examples in other states.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assess transition needs and provide specified transition services to YSHCN in the CSHS subspecialty clinics as well as YSHCN in the community.	X	X		
2. Provide community resource information to CYSHCN and their families by CSHS PLs in CSHS subspecialty clinics and within the community.	X	X		
3. Assess MH status, and link CYSHCN and their families to a MH accordingly.	X	X		
4. Update the CSHS website to reflect current events, community, regional, state, and national resources, and current regional resource guides.	X	X	X	
5. Update roster and mail RRGs, insurance and transition fact sheets and both FHF and CSHS Brochures to primary care providers, FQHCs, SBHCs, subspecialists, school nurses, CCs, pediatric residents, allied health students, and SLC members.		X	X	
6. Contract with three academic pediatric practices to provide MH CC training for staff and pediatric and family medicine residents, emphasizing the disparities in receipt of CC. Expand the CC database as contracts allow.			X	X

7. Serve as a stakeholder advisor on the LHCQF MH Committee and the MH Technical Assistance Sub-committee, and the Early Head Start Program Health Advisory Committee			X	X
8. Work/Collaborate with Medicaid to incorporate CC into healthcare reform.				X
9. Publish analytic articles addressing disparities in receipt of CC services in peer review journals.				X
10. Compose and submit for publication to the LA AAP one articles on the CSHS Program, and transition.				X

b. Current Activities

Direct and Enabling

CSHS clinics continue to provide safety net services. To date, 2,925 patients have been served in CSHS clinics; 93% had Medicaid and 4% were uninsured. PLs discussed community-based resource information 1,264 times with CSHS families and 697 times at community events. CSHS staff provided transition services to 153 YSHCN. PLs provided 441 families with transition information at health fairs. CSHS staff assess MH status and assist families in linking to a MH. The CC transition program in CSHS clinics expanded to 4 regions.

Population

CSHS contracted practices had provided CC services to 5,540 children/youth by April. Mailing rosters for all providers were updated. CSHS mailed 659 updated RRGs, insurance and transition fact sheets, and FHF/CSHS brochures to FQHCs, SBHCs, NCQA-certified MHs, MD Needs Assessment survey respondents, and orthopedic and neurologic subspecialists. 250 school nurses, 10 CCs, and 15 SLC members received updated RRGs. Pediatric and family medicine residents and Allied Health Students were oriented on MH. CSHS posted RRGs on the website.

Infrastructure

The CC database was expanded to one CC contracted practice. The Statewide CC Supervisor participates on the LHCQF MH Committee and the MH Technical Assistance Sub-Committee. The Statewide CC Supervisor continues to work with the Early Head Start Program, Delgado Community College-Allied Health, and the SLC.

c. Plan for the Coming Year

Direct and Enabling

Only 40% of LA CYSHCN report receiving comprehensive care within a medical home, compared with 43.0% of US CYSHCN in 2010 and 49.6% in LA in 2005/2006. CSHS nurses will continue to assess patients' MH status and social work staff will assist with linkage to a MH when needed. Clinic transcripts will continue to be mailed to patients' MH. PL contact logs will be updated as needed. PL and social workers will continue to provide direct consultation to families/patients on community based resources. YSHCN will be assessed for transition needs and provided services accordingly. The CC transition program in CSHS clinics will be expanded to the final two regions in the state.

Population

Based upon the disparity for needing more CC by insurance type, the CSHS CC program will continue technical assistance with the 5 current private practices and expand services to 3 new private academic practices to increase MH CC capacity. This intervention addresses the fact that the MH decreases the need for more CC regardless of insurance type; whereas among CYSHCN without a MH, there is a >100% disparity for needed CC between the two insured groups (need more CC: public w/o MH: 44.6% vs. private w/o MH: 21.7, p<0.05). The Statewide CC Supervisor will continue to provide MH orientation to pediatric residents and allied-health students. Mailing rosters for FQHCs, SBHCs, and physicians will be updated and resources mailed accordingly. CSHS will continue to update RRGs and post them on the CSHS website.

Infrastructure

CSHS will continue to engage in meetings with DHH and Medicaid to increase reimbursement for CC, thereby enabling physicians to provide more comprehensive CC services. The Statewide CC Supervisor will continue to work with the Early Head Start Program, Delgado Community College-Allied Health, and the SLC. The CC database will be expanded to other CC contracted practices across the state, as the database contract allows. CSHS will compose and submit articles on community based resources and transition to the LA AAP and LA Association for Family Physicians newsletters. The Title V CYSHCN Director and the Statewide CC Supervisor will continue to serve on the state's Advisory Board for the Healthcare Quality Forum (LHCQF) MH Committee.

State Performance Measure 5: *Percent of singleton live births delivered at 34-36 weeks gestation.*

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					7.4
Annual Indicator		7.6	7.7	7.5	7.5
Numerator		4754	4811	4474	4474
Denominator		62884	62745	60052	60052
Data Source		Louisiana Vital Records and Statistics			
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	7.3	7.2	7.1	7	6.9

Notes - 2011

Data is provisional and based upon the 2010 data.

Notes - 2010

Data is provisional.

Notes - 2009

Data is final.

a. Last Year's Accomplishments

Late PTB is defined as live births occurring from 34 weeks through 36 completed weeks of gestation. Health People 2020 objectives for addressing later prematurity as a key health indicator targets a 10% reduction from 9% (in 2007) to 8.1%. Surveillance in Louisiana in 2009 identified 7.7% singleton live births at 34-36 weeks gestation. This represents an estimated 9.4% reduction from 8.5% late preterm births in 2005 with further reduction to 7.5% observed for 2010 provisional surveillance.

Enabling

The MCH Nurse-Family Partnership (NFP) Program continued to provide services statewide. The NFP curriculum provides targeted assessment and education for risk factors associated with prematurity such as poor maternal nutrition/weight gain, prevention of sexually transmitted infections and substance use. Women enrolled in NFP receive targeted education on the signs and symptoms of preterm labor, in addition to inter-conception education regarding risk factors which may impact the risk for prematurity such as birth spacing. In the past year, NFP enrolled 1,471 women and educated all of them on PTB risk prevention.

MCH also funded part-time infant mental health clinicians to support the NFP teams and clients at Healthy Start - New Orleans, serving 15 pregnant women with depression or other mental health problems and providing perinatal depression workshops and referrals for Healthy Start clients. Until July 2011, MCH also provided funding to the Baton Rouge Healthy Start, which provides case management services, prenatal care visits as well as health education to the community through educational classes and one-on one sessions. This is important in terms of treatment of perinatal depression to prevent future poor birth outcomes.

Infrastructure

MCH supported Fetal and Infant Mortality Review (FIMR) teams statewide. In 2010-2011, MCH employed a revised surveillance model focusing on monitoring fetal-infant mortality associated with PTB-case review and action processes focused on certain fetal deaths, and infant deaths between 24-36 weeks gestation in order to understand the individual, community and system factors around which to focus prevention efforts.

Vital Records and PRAMS data collection and analysis continued.

MCH worked with the DHH Birth Outcomes Initiative (BOI) in the development of an interconception care coordination program through the Greater New Orleans Community Health Connection (GNOCHC) for women with a prior poor birth outcome.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. FIMR program review targeting fetal and infant deaths associated with premature births.			X	X
2. Collaboration with the DHH Birth Outcomes Initiative's activities to decrease the number of late preterm births, including efforts to enhance clinical provider and high risk patient education and access to proven prevention measures.			X	X
3. Targeted NFP education curriculum development and administration for preterm birth prevention especially for at risk mothers.	X		X	
4. Work with Medicaid to enhance access to 17-P for providers and patients to prevent repeat preterm births.		X	X	X
5. Work thru PHB to provide health messaging and social marketing which promotes preconception and interconception health measures which help reduce preterm births.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Enabling

NFP continues to provide services statewide. As Louisiana looks to pilot other Maternal, Infant, Early Childhood Home Visiting (MIECHV) models, at least one pilot is expected to include a focus on prematurity prevention.

MCH is funding infant mental health clinicians to support the NFP teams and to serve clients in the Healthy Start New Orleans program.

Infrastructure

MCH supports FIMR teams statewide. MCH is working to strengthen the foundation of the program to ensure that the processes are robust and action-focused. In addition, MCH will be exploring sustainability and/or expansion of the program in partnership with the new Medicaid BAYOU Health providers who are required to conduct FIMR and maternal mortality case reviews. In December 2011, MCH hired a mortality surveillance epidemiologist to focus on increasing the Program's capacity to provide timely, actionable data to support regional and state-level mortality activities and prevention efforts.

Vital Records and PRAMS data collection and analysis continues. Examination of FIMR Bassinet data allows for the analysis of clinical and major demographic correlates of prematurity and infant mortality at the population level.

MCH is working with BOI to monitor and enhance the implementation of expanded access to 17-OH Progesterone (17-P). 17-P is an evidence-based intervention for prevention of PTB among women who have experienced a spontaneous prior preterm birth.

c. Plan for the Coming Year

Objective: To reduce the percent of singleton live births delivered at 34-36 weeks gestation to 7.3%. This is in keeping with the state's strategic goal of overall PTB reduction by 8% over the next two years.

Enabling

Prevention of PTB will continue to be part of NFP educational curriculum. MCH will continue to fund infant mental health clinicians to support NFP teams and to serve clients at Healthy Start New Orleans. This service will be evaluated as part of the MIECHV activities. MCH will be working with the DHH Behavioral Health Partnership program to explore sustainability of these services through Medicaid.

Population

PHB, the state's MCH resource line and website, will continue to reach out to high-risk populations to raise awareness and address issues related to PTB, including multimedia preconception and interconception health messaging, public relations and other health communications/education activities.

MCH will collaborate with Louisiana Medicaid managed care to ensure access and utilization of 17-P in specific high risk populations through coordination of patient and provider education related to treatment access, and the partnership with BOI for the implementation of clinical risk identification tools.

Infrastructure

MCH will undertake a comprehensive analysis of regional domains which contribute to late PTB on a region by region basis. This will allow for individualized system/community based interventions specific to regional variables that influence late PTB events. The program will continue to develop and expand its capacity for targeted surveillance and analysis of PTB risk

correlates at a regional/population level through coordination with Louisiana Vital Records.

In 2012 Louisiana Medicaid transitioned from a traditional fee for service model to Medicaid managed care structure. Louisiana Medicaid remains the principal source of health care funding for an estimated 70% of births, and close to 80% of pregnancies affected by LBW (surrogate for PTB). The Medicaid managed care model for MCH related services seeks to emphasize care coordination and risk reduction services. As this transition in health care delivery undergoes transformation, MCH will provide coordination with the managed care vendors to create monitoring capacity for the systems based assessment of clinical care coordination and practices which are intended to foster the prevention and reductions in PTB.

MCH will develop an integrated program structure with Family Planning to support effective birth spacing improvement strategies which can influence reduced rates of PTB and LBW. The regional FIMR teams will continue targeted monitoring of fetal-infant mortality associated with PTB for the purpose of structuring health systems interventions which support the prevention of future preterm births and associated perinatal loss.

State Performance Measure 7: *Percent of women who use alcohol during pregnancy.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	5	5	6.7	5	5
Annual Indicator	5.5	8.4	7.2	7.2	7.2
Numerator	3384	5127	4435	4435	4435
Denominator	61592	61324	61704	61704	61704
Data Source		LA Pregnancy Risk Assessment Monitoring System			
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	5	5	5	5	5

Notes - 2011

Numerator and denominator are weighted. Data is final 2009.

Notes - 2010

Numerator and denominator are weighted. Data is final 2009.

Notes - 2009

Numerator and denominator are weighted. Data is final 2009.

a. Last Year's Accomplishments

Last Year's Accomplishments

2009 Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS) data indicate that 7.2% of pregnant women reported drinking during pregnancy (as reported in the last 3 months of pregnancy). This represents a 14% decrease from a rate of 8.4% of respondents in 2008 (contrasts with a prior increase from 5.5% noted in 2007).

Direct and Enabling

The MCH SBIRT program, a collaboration with Louisiana Section of the American College of Obstetricians and Gynecologists and the Office of Behavioral Health (OBH), contracted regional SBIRT Coordinators to work with provider offices to implement the Chasnoff 4P's Plus intervention during the 2010-2011 fiscal cycle. However, support for the regional coordinators was phased out in the Fall of 2010 and state licensure for the SBIRT 4P's Plus Chasnoff tool was discontinued in July 2011. Structural program changes were made to achieve a far wider of uptake of perinatal screening among pregnant women receiving services in private sector settings. The new approach focused on securing Medicaid reimbursement for private providers, and integrating 5P's screening in OPH services such as WIC and the limited prenatal care settings. This program transition was necessitated due to funding limitations and the discontinuation of publically supported outpatient/inpatient obstetric services in state administered hospital systems over the past 18 months.

Nurse-Family Partnership (NFP) nurse home visitors provided health education on substance use, referrals, education, guidance and support to first time, low income mothers.

Population

MCH continued support for PHB, a comprehensive helpline and web site for client information on healthy pregnancy. Callers to the PHB helpline are referred to treatment resources.

Infrastructure

Regional SBIRT coordinators in 9 state public health regions provided treatment, technical support to clinical providers, education resources and assisted with coordinating referrals until the separately funded regional SBIRT coordinators were discontinued in January 2011. Regional FIMRs identified substance use as a risk factor in poor pregnancy outcomes and recommended strategies for community based interventions.

MCH successfully collaborated with BOI and Louisiana Medicaid to develop provider pay for performance measures for smoking and substance use screening statewide. An estimated 70% of Louisiana births are covered by Medicaid indicating the potential impact of enhanced screening on state birth outcomes.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support NFP prenatal education curriculum provision for low-income mothers and infants.	X	X		
2. Support the Partners for Healthy Babies health messaging resources for perinatal alcohol use prevention.			X	
3. Expand screening for alcohol use in pregnancy in prenatal care settings in all state regions in collaboration with Medicaid and Birth Outcomes.	X	X		
4. Support regional Fetal-Infant Mortality Review (FIMR) programs development of targeted community based strategies to reduce perinatal alcohol abuse.				X
5. Collaborate with LPHI to support alcohol prevention messages and activities.				X

6.				
7.				
8.				
9.				
10.				

b. Current Activities

Enabling

The SBIRT program formally transitioned into a statewide Medicaid reimbursed pay for performance model in 2011. In the summer of 2011, the MCH Medical Director trained the OPH regional staff on implementation of the 5P's tool. Screening has been integrated into the routine protocols for OPH services. Collaboration with Medicaid has resulted in clinical provider reimbursement and pay for performance for screening and brief intervention services. Screening is part of routine protocols for OPH services. NFP continues to provide health education on substance use, service referrals, and support.

Population

The PHB campaign continues to direct women to the information line and website.

Infrastructure

FIMR program continues to document and evaluate the association of perinatal alcohol exposure as a risk factor for increased infant mortality and prematurity rates. Pregnancy Associated Mortality Review (PAMR) surveillance identified alcohol and substance use as a significant contribution to regional maternal mortality.

MCH has assisted the BOI team with the development of a web-based behavioral health screening tool, Louisiana Health Assessment and Referral Tool (LaHART). This tool was intended for prenatal settings, will become the required mechanism to reimburse Medicaid prenatal providers for the reimbursable screen during pregnancy.

c. Plan for the Coming Year

Direct and Enabling

OPH regional health units providing WIC, family planning and other services will continue to provide screening, brief intervention and referral into routine clinical protocols; MCH will provide training and technical assistance as requested to support this protocol. NFP will directly address substance use during pregnancy in its curriculum, and provide education, counseling and referrals for women in need of treatment resources.

Population

The PHB infoline and website will support health messages and proactive referrals. If PHB has sufficient resources to pursue developing interconception health messages, tobacco cessation/substance use will be considered as a potential area for emphasis.

Infrastructure

MCH Epidemiology will analyze major environmental and clinical correlates associated with perinatal alcohol exposure. Such analyses will form the basis for public health intervention and policy development. Linkages with OPH Fetal Alcohol Syndrome (FAS) programs will be developed to strengthen disease surveillance capacity. MCH will explore OPH capacity to develop linkages with the state Birth Defects Registry and to identify children with manifestations of the fetal alcohol syndrome (FAS) disorders spectrum for further development of prevention efforts.

The FIMR program will continue to document and evaluate the association of perinatal alcohol exposure as a risk factor for increased infant mortality and prematurity rates. PAMR surveillance identified alcohol and substance use as a significant contribution to regional maternal mortality.

MCH Epidemiology will collaborate with BOI and Medicaid to develop evaluable performance measures to monitor the effectiveness of screening perinatal alcohol use along with associated referrals.

Structures for clinical care coordination and treatment referrals will be developed for integration with the newly implemented DHH Magellan program and DHH BAYOU Health Medicaid program. These clinical service vendors are expected to have responsibility for a broad range of targeted clinical care coordination activities for all Medicaid recipients. MCH will collaborate with BOI to facilitate structured interventions with clinical providers, public health and managed care vendors.

MCH will continue to collaborate with BOI and Medicaid to facilitate provider education and technical support for SBIRT activities and program implementation/maintenance as the LaHART tool is formally implemented.

State Performance Measure 8: *Percent of African American women who most often lay their baby on his or her back to sleep.*

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					45
Annual Indicator				46.6	46.6
Numerator				10122	10122
Denominator				21724	21724
Data Source				LA Pregnancy Risk Assessment Monitoring System	LA Pregnancy Risk Assessment Monitoring System
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	45	46	47	47	49

Notes - 2011

Numerator and denominator are weighted. Data is final 2009.

Notes - 2010

Numerator and denominator are weighted. Data is final 2009.

Notes - 2009

Numerator and denominator are weighted. Data is provisional and based upon final 2008 data.

a. Last Year's Accomplishments

The percent of African American women who most often lay their baby on their back to sleep increased from 47% in 2008 to 54% in 2009. The Sudden Infant Death Syndrome (SIDS) death rates amongst African Americans continue to be disproportionately high when compared to other races in Louisiana, with a rate of 1.4 deaths per 1,000 live births in 2009. Overall the racial disparity for 2009 was 1.2.

Direct and Enabling

MCH continued to support counseling for families that experience SIDS or Other Unexpected Infant Deaths (OID). In New Orleans, the Children's Bureau served 6 families with counseling and support for SIDS/OID and continued its network of parent peer contacts and community health educators to provide additional counseling and resources for SIDS/OID families. However, due to regional level OPH restructuring, bereavement outreach to families by OPH was limited. MCH continued to provide bereavement resources to families affected by SIDS/OID through the distribution of print material.

Population

MCH continued to implement a "safe sleep" social marketing public information campaign in targeted areas of the state with a focus on creating a safe sleep environment with emphasis on sleep position and surface. Campaign efforts targeted racial disparities through the use of community and professional outreach. SIDS information was distributed statewide to birthing hospitals, healthcare providers, and daycare providers. The MCH SIDS initiative continued collaboration with community-based agencies to provide educational sessions to daycare providers, public health nurses, social workers and the general public.

Infrastructure

The MCH Program maintained a state and regional infrastructure for Child Death Review (CDR). A CDR Medical Director reviewed autopsy and death scene investigations and the state CDR Panel continued to review unexpected deaths in children under age 15, including SIDS deaths. There were a total of 97 sudden unexplained infant deaths that were reviewed by the Louisiana CDRP. The MCH SIDS Program continued to collaborate with the OPH Region 5 in their annual "SIDS Awareness and Safe Sleep" summit to focus on unsafe sleep practices while providing stakeholders with the tools to assist with educating the public.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Review Autopsy and death scene investigations.				X
2. Present SIDS and safe sleep education programs to health professionals, law enforcement and the public.			X	X
3. Distribute educational materials to hospitals, health providers, and daycare centers.				X
4. Collaborate with community-based organizations to disseminate SIDS risk reduction message.			X	
5. Disseminate new American Academy of Pediatrics Safe Sleep Guidelines to healthcare professionals.				X
6. Administer social marketing campaign about safe sleep environment promotion within high-risk areas.			X	
7. Promote regulatory guidelines for safe sleep environment in day care and family day home centers.		X		
8.				
9.				
10.				

b. Current Activities

Direct and Enabling

MCH has continued to coordinate with Children's Bureau to provide grief counseling for families of SIDS/OID victims in the New Orleans area. Bereavement outreach to families by OPH continues to be limited in the remainder of the state due to reductions in field staff.

Population

The social marketing campaign promoting safe sleep environments continues to focus on accidental suffocation and sleep position within high-risk target population areas through media, community outreach, and medical profession outreach. Communication and marketing research aided in the ongoing development of culturally competent educational materials and paid media. The 2012 social marketing plan was completed with a strong focus on community mobilization.

Infrastructure

The CDRP continues reviewing unexpected deaths in children under the age of 15, including SIDS deaths. In December 2011, MCH hired a dedicated mortality surveillance epidemiologist to focus on increasing the program's capacity to provide timely, actionable data to support regional and state-level CDR activities and action processes. In addition, MCH has applied for a competitive grant through CDC to strengthen the infrastructure for SUID investigations.

MCH's Child Care Health Consultant training program continues to emphasize safe sleep environments.

MCH ensures active participation in the HRSA Region IV/VI "Safe Sleep" COIN.

c. Plan for the Coming Year

Objective: Increase to 45% the percentage of African American women who place their healthy, full-term infants to sleep on their backs all of the time.

Direct and Enabling

In the greater New Orleans area, the Children's Bureau will continue to provide counseling and resources for families who are victims of SIDS/OID. MCH will work with OPH regional staff to reinstate direct bereavement outreach to families who have experienced SIDS in the remainder of the state.

Population

The MCH safe sleep social marketing public information campaign will be implemented within high-risk target population areas of the state through media and increased emphasis on community mobilization and outreach. Qualitative research and evaluation results based on current media material and messaging will continue to be utilized to develop culturally competent educational materials. Market research will continue to be used to develop new campaign strategies to effectively target hard to reach populations. MCH will work with the Regional MCH Coordinators in regional risk reduction activities such as safe sleep summits.

Infrastructure

Autopsy and death scene investigations will continue to be reviewed by MCH staff. Infant Death Scene Investigation trainings will be revised and continued at the regional level to ensure that coroners, death scene investigators, first responders, and stakeholders possess the necessary skills to respond in a supportive, culturally competent manner to families who have experienced a sudden unexpected death and ensure protocol is followed. The CDRP will continue reviewing SIDS deaths and collaborate with other multi-disciplinary review teams throughout Louisiana.

The MCH Program will begin to collaborate with Louisiana Department of Children and Family Services (DCFS) on the review of SIDS/OID deaths, development of data sharing policies across agencies, and collaboration of paid media initiatives, in addition to ongoing interagency collaboration with existing community-based agencies and organizations in promotion of safe sleep environment messages. The SIDS Program will continue to provide technical assistance for development of policy and/or regulatory standards related to safe sleep environments in licensed childcare facilities. The SIDS Program plans to continue provision of training for licensed childcare and family day home providers related to safe sleep environments.

MCH will ensure active representation and participation in the HRSA Region IV/VI "Safe Sleep"

COIN.

State Performance Measure 9: *Percent of women having a live birth who reported being told prior to pregnancy that they had Type 1 or Type 2 diabetes*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					4
Annual Indicator				4.4	2.7
Numerator				2684	1627
Denominator				61187	60352
Data Source				LA PRAMS	LA PRAMS
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	4	4	4	4	4

Notes - 2011

Numerator and denominator are weighted. Data is final 2009.

Notes - 2010

Numerator and denominator are weighted. Data is final 2008. This is a new Performance measure therefore there is no annual performance objective for 2010.

a. Last Year's Accomplishments

Direct

Women who were identified to have Type 1, Type 2, or gestational diabetes received the appropriate nutrition counseling in WIC.

Population

WIC education materials related to diabetes education (Children with Diabetes; Women with Diabetes; and Gestational Diabetes) developed by MCH and WIC were made available in February 2011 and were promoted in all WIC clinics and were disseminated to the Nurse Family Partnership (NFP) home visiting program.

Preconception health, including nutrition and diabetes management, was promoted through the MCH Partners for Healthy Babies The Stork Reality campaign.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Counseling and education sessions to women in WIC with diabetes.	X			
2. Referrals to WIC Services for specialized one-on-one nutrition counseling.		X		
3. Counseling and education to women with diabetes in NFP.		X		
4. Utilization of educational materials on diabetes.		X		
5. Promotion of preconception health via Partners for Healthy Babies.			X	
6. Outreach related to the link between poor maternal health and				X

poor birth/maternal outcomes.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct

Women who are identified to have Type 1, Type 2, or gestational diabetes receive the appropriate nutrition counseling in WIC.

Enabling

Women enrolled in WIC identified to have diabetes are referred to the high risk nutritionist for nutrition counseling. Women in the NFP program who have diabetes are monitored to ensure appropriate care. Nurses assess the client's ability to monitor her blood sugars according to the regimen recommended for her which may include performing own sticks, having the right equipment and supplies and keeping an accurate blood sugar log to provide to her physician. NFP also helps ensure that such clients are linked to a primary care facility to continue care after exiting NFP.

Population

Preconception health, including nutrition and diabetes management, is promoted through the PHB.

Infrastructure

The MCH Program's Fetal Infant Mortality Review (FIMR) and Pregnancy Associated Mortality Review (PAMR) assess cases for any link between poor maternal health (including diabetes) and poor birth outcomes. MCH works closely with the Birth Outcomes Initiative (BOI) to develop programs that promote preconception health, in particular for women at risk for poor future pregnancy outcomes, including diabetes. The MCH nutritionist presented at the 2012 Louisiana MCH Coalition meeting with this year's theme "Preventing Obesity Before, During, and After Pregnancy."

c. Plan for the Coming Year

Objective: Reduce the percent of women having a live birth who reported being told prior to pregnancy that they had Type 1 or Type 2 diabetes to 4%

Direct

Women who are identified to have Type 1, Type 2, or gestational diabetes will continue to receive the appropriate nutrition counseling in WIC.

Enabling

Women enrolled in WIC identified to have diabetes will continue to be referred to the high risk nutritionist for nutrition counseling. Women in the NFP program identified to have diabetes will continue to be followed to ensure appropriate medical follow up and self-monitoring skills. Nurses will assess the client's understanding of the diabetes process and what services are available in the community for structured diabetes education especially for a newly diagnosed woman. They will also assess the client's knowledge gaps and refer her to services in the community to address those issues, particularly to the services available for her while she is Medicaid eligible which may be unavailable after her Medicaid eligibility is finished (about 2 months post-partum).

Population

Preconception health, with a particular focus on health education as it pertains to nutrition, physical activity, and chronic disease prevention, will be promoted through PHB. The WIC

education materials developed by MCH and WIC will continue to be promoted and utilized in WIC clinics and the NFP Program.

Infrastructure

MCH will continue to work closely with the BOI in the development of programs promoting preconception health, in particular for women at risk for poor future pregnancy outcomes, including diabetes. In particular BOI is working closely with the Greater New Orleans Community Health Connection (GNOCHC) project. The GNOCHC Section 1115 Research and Demonstration Waiver preserves primary and behavioral health care access to the uninsured. The Interpregnancy Care Program (IPC) is a component of the Special Terms and Conditions under the GNOCHC Demonstration. Any GNOCHC eligible woman who has experienced a preterm, low birth weight, very low birth weight, fetal or infant death will be enrolled into IPC. Case management, including diabetes/chronic disease management, will be conducted in Orleans parish with these high risk women. BOI is also working to disseminate the GNOCHC model throughout the state through other health plans.

Through a Community Transformation Grant, the Louisiana Chronic Disease program will release its coordinated chronic disease state plan, which will include the establishment of a Chronic Disease Prevention Action Alliance, with the focus being Diabetes, Tobacco, Obesity, and Asthma. MCH will collaborate with the Chronic disease program on the establishment and sustainability of this Alliance.

The FIMR and PAMR case review and action processes will continue to assess prevention opportunities for addressing maternal health risks, including diabetes.

State Performance Measure 10: *Percent of women delivering a live birth in less than 24 calendar months of delivering a previous live birth.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					28
Annual Indicator		28.4	27.7	26.4	26.4
Numerator		10804	10414	9559	9559
Denominator		38035	37624	36140	36140
Data Source		Louisiana Vital Record and Statistics			
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	28	27.5	27.5	27.5	26

Notes - 2011

Data is provisional and based upon 2010 data.

Notes - 2010

Data is provisional.

Notes - 2009

Data is final.

a. Last Year's Accomplishments

The primary direct service related to improving pregnancy spacing is the statewide network of OPH Family Planning (FP) services. The FP program provided comprehensive reproductive healthcare services to 45,707 women in 64 parishes in Louisiana through OPH Parish Health Units (PHU) in 2011. Services included: physical examination, preventive health screenings, pap smears, education, counseling, and contraceptives including long acting reversible contraceptive methods (LARCs). Post-partum women were prioritized for appointments. Services also included education and counseling regarding preconception and interconception care. The FP Program continued providing free female and male sterilization waivers to interested clients.

Enabling

The FP Program continued to conduct outreach activities in all Louisiana parishes to ensure increased awareness of services. Outreach activities were conducted in community based settings including schools, faith-based institutions, and healthcare settings. With a decrease in resources and staff, the FP Program relied more on the OPH field staff to provide community outreach including outreach for the family planning waiver program, Take Charge, that pays for family planning services for women up to 200% of the federal poverty level.

The Nurse-Family Partnership (NFP) Program provided services statewide. As a program working with first-time mothers, family planning including healthy pregnancy spacing and pregnancy intention is addressed as a part of the curriculum.

Population

The Partners for Healthy Babies (PHB) website and info line promotes information about pregnancy spacing and pregnancy intention. In May 2011, MCH Program staff, together with the program's contracted marketing firm and some key external partners, met to discuss the possible development of an interconception social marketing campaign. The priority area identified was around the concept of promoting a "life plan" which would include pregnancy intention and pregnancy spacing. Due to budget reductions in the fall of 2011, the development of the campaign has not been actively pursued, but is anticipated. FP started using a new texting program to find family planning services.

Infrastructure

A FP Needs Assessment was conducted in an effort to address the needs of Louisiana citizens and to identify gaps services. The FP Program also conducted the annual statewide needs assessment with providers to identify training needs. FP coordinated trainings for providers through the National Family Planning Program's training center, Cardea; FP coordinated over 2,000 hours of training in 2010. FP also organized a summit for state stakeholders. Sessions topics included "Outreach Strategies" and "Long Acting Reversible Contraceptives."

The FP Program continued to collaborate with the Greater New Orleans Community Health Connection (GNOCHC), a Medicaid demonstration project in the New Orleans area for low-income individuals who otherwise do not qualify for Medicaid, to ensure the availability of reproductive health services as a part of the initiative's comprehensive primary care, reproductive and behavioral health services.

MCH and FP worked with the DHH Birth Outcomes Initiative (BOI) in the development of an interconception care coordination program through GNOCHC for women with a prior poor birth outcome; birth spacing is a major goal. FP and the BOI also worked to strengthen the Take Charge waiver program.

MCH and FP continued to collaborate via standing program meetings such as the MCH health

communications committee and the FP Advisory Council.

Vital Records and PRAMS data collection and analysis continued.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Comprehensive reproductive care (preventive health screenings, pap smears, education, counseling).	X	X		
2. Work with the Greater New Orleans Community Health Connection.			X	
3. Provide training to healthcare providers on interconception care services.				X
4. Conduct outreach activities including a new texting program to assist people in finding FP services.			X	
5. Sterilization waiver program.	X			
6. Long Active Reversible Contraceptive Pilot.	X			
7. Establishing Reproductive Health Clinics.	X	X		
8. Providing educational materials and update information and website.		X		
9. Partnering with Federally Qualified Health Centers.			X	X
10. Strategic Planning Meetings.				X

b. Current Activities

Direct

OPH offers comprehensive reproductive health services, including preventive health screenings. FP is working to increase the knowledge and use of Long Acting Reversible Contraceptives.

Enabling

FP continues to conduct outreach in all parishes. TOP continues to be implemented statewide.

Population

The PHB website and info line promote information about pregnancy spacing and pregnancy intention.

Infrastructure

FP continues to conduct provider trainings and work to develop an annual training schedule.

The FP and Sexually Transmitted Disease (STD) programs have been working to develop a comprehensive approach to FP and STD services offered in OPH clinics. The shift to comprehensive personal health services represents fundamental changes to clinic flow and services provided.

MCH will help to develop the protocols for GNOCHC as needed and will work to ensure coordinated referral paths.

MCH has been working with the BOI staff to provide input on pre and interconception care plans for the state. MCH is participating in the HRSA Region IV/VI Interconception Care COIN.

MCH and FP are developing a merged administrative program model. This will strengthen the state's overall ability to address pregnancy spacing, pregnancy intention, and interconception health.

c. Plan for the Coming Year

Direct

Direct FP services through OPH will be implemented as newly-transformed comprehensive personal health services, as described in the "current year" infrastructure section. The merging of STD and FP clinical services across the state will offer more opportunity for providers to educate and counsel clients. The consolidated clinic model will also offer the staff more chances to increase enrollment in the Take Charge FP Medicaid waiver program.

The FP Program plans to increase the number of doctors partnering with FP and accepting the sterilization waivers, which will make sterilization a more attainable option for many throughout the state. FP will introduce a new Interconception Care tool to the providers to be used with clients for mapping their interconception and preconception goals.

Enabling

FP will continue to conduct outreach activities in all Louisiana parishes to ensure increased awareness of services.

NFP Program will continue to provide services statewide.

Population

The FP Program will conduct outreach activities in all Louisiana parishes to ensure increased awareness of services; the MCH Program's health education and communications expertise will be tapped to support these efforts.

The PHB website and info line will continue to promote information about pregnancy spacing and pregnancy intention. The FP Program will promote a text message service to locate FP services. Health Ed/Communications will continue to participate in the development of CDC's interconception social marketing campaign.

Infrastructure

The MCH and FP Programs merged as "Bureau of Family Health" will work to operationalize the new program structure with defined program targets and regional action plans around pregnancy spacing.

MCH will support BOI's development of the interconception care coordination program through GNOCHC for women with a prior poor birth outcome.

MCH will work closely with BOI staff to provide input on pre and interconception care plans for the state, including work with the new BAYOU Health plans to develop comprehensive post partum discharge plans.

MCH will ensure active representation and participation in the HRSA Region IV/VI Interconception Care COIN.

Vital Records and PRAMS data collection and analysis will continue. Fetal and Infant Mortality review processes, including HIV/FIMR will continue to include discussion and recommendations around pregnancy spacing. A dedicated women's health epidemiologist is planned to support the merged MCH and FP programs.

E. Health Status Indicators

HSI 01A: The percent of live births weighing less than 2,500 grams.

Preliminary 2008 data indicate that 11.2% of LA infants weighed <2,500 grams at delivery. The rate has slowly decreased by 0.1 percentage points each year since 2005, when the rate was 11.5%.//2012/Preliminary 2009 data indicate that 10.7% of LA infants weighed less than 2,500 grams at delivery. The rate of low birth weight (LBW) in LA has slowly decreased by approximately 7% since 2005 when the rate was 11.4%.//2012//**2013/Preliminary 2010 data indicate that 10.8% of LA infants weighed <2,500 grams at delivery. The rate increased by 0.1% between 2009 and 2010.//2013//**

LBW can provide valuable information as a general indicator of the state's maternal health status and prenatal care provision. While a surrogate marker for prematurity, it can also identify infants who have intrauterine growth restriction. By analyzing LBW infants by regions, patient characteristics, and specific population groups such as payer type, it can help direct resources to those areas in most need. By following this figure over time, one can obtain a general measure of risks and results of interventions.//2012/LBW can identify infants at greater risk for infant mortality. Monitoring this figure over time provides a measure of maternal-child health risk status and the effects of targeted interventions.//2012//

Specific interventions include the Infant Mortality Reduction Initiative (IMRI), smoking cessation program, dental services program, substance abuse and depression screening programs.

LA has a family planning waiver, Take Charge, to assist service access for Medicaid eligible women post-delivery. MCH provided enhanced preconception services, especially folic acid use, to the family planning program. The SBIRT program is providing screening/intervention services for substance abuse, depression and domestic violence. The SBIRT program is statewide, in private and public prenatal clinics, and is being expanded to all OPH-WIC clinics statewide. An expanded focus on preconceptional and interconceptional health services is occurring, especially in regard to prevention of adverse pregnancy outcomes. Plans are being developed to identify those women with VLBW and LBW and provide enhanced case management and/or referrals to Healthy Starts (4 in LA), to Family Planning and community care facilities, and to refer Medicaid eligible first time pregnant women to Nurse Family Partnership (NFP), nurse home visiting program that follows the woman through the child's 2nd birthday.//2012/MCH supports enhanced access to services which promote adequate birth spacing and preconception services, especially folic acid use in concert with the Family Planning Program. Pilot programs are being implemented to identify women with a history of LBW and clinical risk markers associated with LBW to provide case management and primary care service access.//2012//

Data sharing agreements are ongoing with key partners of the MCH program. Data linkages of vital records birth, infant death, and fetal death files with LA Medicaid eligibility, WIC eligibility files, Hospital Inpatient Discharge, newborn screening, Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS), Louisiana Birth Defects, and the Caring Communities in Youth Survey data are ongoing to increase data capacity, analyses, and dissemination of program relevant information.

HSI 02A: The percent of live births weighing less than 1,500 grams.

The preliminary data for 2008 indicate that 2.6% of all Louisiana infants were born weighing <1,500 grams, a substantial increase over the 2.2% noted in 2006 and 2007.//2012/The preliminary data for 2009 indicate that 2.0% of all LA infants were born weighing <1,500 grams, a substantial decrease over the 2.6% noted in 2008 (23% reduction).//2012//**2013/2010 Preliminary data indicate 2.1% of infants born in LA weighed <1,500 grams at delivery. This is a slight increase from final 2009 data.//2013//**

VLBW can provide valuable information as a general indicator of the state's maternal health status and prenatal care provision. While a surrogate marker for prematurity, it can also identify

infants who have extreme intrauterine growth restriction. By analyzing VLBW infants by regions, patient characteristics, and specific population groups such as payer type, it can help direct resources to those areas in most need. By following this figure over time, one can obtain a general measure of risks and results of interventions./2012/VLBW serves as a surrogate marker for prematurity, and identifies infants who have the greatest increased risk for serious infant morbidity and infant mortality. VLBW additionally has the potential to serve as a marker for environmental variables which influence the risks of congenital anomalies.//2012//

/2012/Analyses of VLBW infants by state region, patient characteristic, and specific population demographics, facilitate public health resource development and allocation.//2012//

Specific interventions include the Infant Mortality Reduction Initiative, smoking cessation program, dental services program, substance abuse and depression screening programs.

LA's Take Charge family planning waiver has been found to be underutilized due to limitations in scope of coverage. Folic acid is provided in state family planning clinics. An expanded focus on preconceptional and interconceptional health services is occurring, especially in regard to prevention of adverse pregnancy outcomes. The SBIRT program screening and making referrals for substance use, depression and domestic violence in pregnant women is statewide, and in selected WIC clinics./2012/MCH supports enhanced access to services which promote adequate birth spacing, and promotes preconception services, especially folic acid use in concert with the Family Planning Program. In collaboration with the DHH BOI pilot programs are being implemented to identify women with a history of LBW and clinical risk markers associated with LBW to provide enhanced case management and primary care service access.//2012//

HSI 03A: The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

In 2007, the final death rate per 100,000 due to unintentional injuries among children under 15 years was 12.9 per 100,000, which is unchanged from the 2006 rate of 13.0 per 100,000. The death rates have remained stable from 2005 (12.2 per 100,000) to 2006 (13.0 per 100,000) to 2007 (12.9 per 100,000). Final 2008 data is pending.

/2012/In 2008, the final death rate due to unintentional injuries among children age 14 years and younger was 16.5 per 100,000, which is an increase from the 2007 rate of 12.9 per 100,000. Prior to 2008 the death rate from 2006 (13.0 per 100,000) to 2007 (12.9 per 100,000) had remained stable. Final 2009 data is pending. //2012//

/2013/In 2009, the final death rate per 100,000 due to unintentional injuries among children age 14 years and younger was 14.5 per 100,000. Prior to 2008 the death rate from 2006 (13.0 per 100,000) to 2007 (12.9 per 100,000) had remained stable. However, provisional 2010 data suggests a decrease in the death rate to 10.7 per 100,000.//2013//

Unintentional injury fatalities are preventable. Louisiana's data shows that unintentional injuries are the leading causes of mortality among children ages 1 month through 14 years, primarily due to motor vehicle crashes, accidental suffocation, exposure to smoke/fire, and accidental drowning/submersion. Unintentional injury mortality surveillance is a mechanism to measure preventable deaths and identify causes, high risk groups, and risk factors. Surveillance data is necessary for needs assessments, resource allocation, program planning, policy development, legislative action, and for mobilizing communities to implement effective prevention interventions which target behaviors that endanger children.

Unintentional injury fatality data of children under age 15 years serves as a measure to evaluate the effectiveness of MCH-supported child safety/injury prevention efforts of the MCH Regional Coordinators, for child passenger safety, pedestrian safety, fire and water safety, home and outdoor safety; SIDS Risk Reduction and Safe Sleep Program, infant safe sleep environments; Child Care Health Consultant Program and healthy and safe child care environments; School-Based Health Centers and healthy and safe school environments; Parish Health Units and injury

prevention education; and State and Local Child Death Review Panels and case reviews and preventive intervention recommendations.

HSI 04A: The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger. According to LA 2007 data, there were less non-fatal injuries among children aged 14 years and younger at a rate of 158.6 per 100,000 than in 2006 (265.4 per 100,000) and 2005 (219.1 per 100,000). Final 2008 data is pending.

/2012/According to LA 2008 data, there was an increase in non-fatal injuries among children aged 14 years and younger at a rate of 186.0 per 100,000 when compared to 2007 at 158.6 per 100,000 and 2006 at 265.4 per 100,000. Final 2009 data is pending.//2012//

/2013/According to 2009 data, there was an increase in non-fatal injuries among children aged 14 years and younger at a rate of 195.7 per 100,000 vs 187.1 per 100,000 in 2008. Preliminary 2010 data shows a decrease in non-fatal injuries among children aged 14 years and younger at a rate of 169.5 per 100,000.//2013//

LA's injury data surveillance shows that injuries are the leading causes of morbidity and mortality of children aged 14 years and younger. Therefore, injury surveillance can identify behavioral risk factors and high risk groups; serve as a starting point for community assessment of needs; and measure preventable injuries. Community advocates and policy makers can use information from injury surveillance to create a safe community by prioritizing and planning preventive interventions and by informing community and legislative action which targets behaviors that endanger children.

Injury surveillance data of children under age 15 years serves as a measure to evaluate the effectiveness of and resource allocations for MCH-supported child safety/injury prevention efforts of the MCH Regional Coordinators, for falls prevention, child passenger safety, pedestrian safety, fire and water safety, home and outdoor safety; SIDS Risk Reduction and Safe Sleep Program, for infant safe sleep environments; Child Care Health Consultant Program, for healthy and safe child care environments; SBHCs, for healthy and safe school environments; PHUs, for injury prevention education; and State and Local Child Death Review Panels, for case reviews and preventive interventions recommendations.

HSI 05A: The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia. In 2009, the rate per 1,000 women aged 15-19 years with a reported case of chlamydia was 45.04, up from the 2008 rate of 42.71./2012/In 2010, the rate per 1,000 women aged 15-19 years with a reported case of chlamydia was 47.8 up from the 2009 rate.//2012//**/2013/In 2011, the rate per 1,000 women aged 15-19 years with a reported case of Chlamydia was 54.6% up from the 2010 rate.//2013//**

Public health efforts to lower this rate include the continued implementation of sexually transmitted diseases (STD) screening best practices for school-based health centers (SBHCs) throughout the state and incorporation of STD screening as part of the continuous quality improvement initiative of the Adolescent School Health Program (ASHP). In 2009-2010, ASHP required SBHCs to provide onsite STD screening and treatment for students in middle school (5th-8th grades) who are sexually active and/or symptomatic, expanding its previous requirement to screen and treat students in 9th grade and higher./2012/Additionally, ASHP requires risk reduction counseling for any student receiving a comprehensive physical or general risky behavior assessment, whether or not the student admits to being sexually active or shows symptoms of STD. ASHP addresses the issue of STDs within the SBHC program; however, there are only 65 SBHCs in the state. Close to 60,000 students have access to SBHCs, but there are over 696,000 students attending LA's public schools.//2012//

The Family Planning and STD programs routinely screen for Chlamydia in public health clinics. In April of 2008, the OPH Laboratory changed to amplified technology for Chlamydia. This new technology allows for a non-invasive collection method that is more sensitive than the previous

technology.

This Health Status Indicator serves as a monitoring tool and evaluative measure that will help LA focus its resources on continued efforts to bring down the infection rates. By reducing the proportion of adolescents and young adults with Chlamydia Trachomatitis infections, LA can prevent the resulting complications of this infection.

Public health efforts to lower this rate include the routine screening in Family Planning and STD clinics. The STD Program includes Chlamydia screening as a routine part of patient care for all women attending a STD clinic. The Family Planning Program guidelines call for routine screening of women thirty and younger and women over thirty who are symptomatic or at increased risk for infection.

HSI 05B: The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia. In 2009, the rate per 1000 women age 20 through 44 with a reported case of Chlamydia was 17.2, up from the 2008 rate per 1000 of 13.8./2012/In 2010, the rate per 1000 women age 20 through 44 with a reported case of Chlamydia was 16.1, down from the 2009 rate per 1000 of 17.2./2012//**2013/In 2011, the rate per 1000 women age 20 through 44 with a reported case of Chlamydia was 18.0, up from the 2009 rate per 1000 of 17.2./2013//**

The ASHP serves students through age 21 if they are still in school. Through ASHP's SBHC, women age 20 and 21 who are sexually active receive onsite screening and treatment for STD./2012/Additionally, ASHP requires risk reduction counseling for any student receiving a comprehensive physical or general risky behavior assessment, whether or not the student admits to being sexually active or shows symptoms of STD./2012//

Public health efforts to lower this rate include the routine screening in Family Planning and STD clinics. The STD Program includes Chlamydia screening as a routine part of patient care for all women attending a STD clinic. The Family Planning Program guidelines call for routine screening of women thirty and younger and women over thirty who are symptomatic or at increased risk for infection. In April of 2008, the Office of Public Health Laboratory changed to amplified technology for Chlamydia. This new technology allows for a non-invasive collection method that is more sensitive than the previous technology.

This Health Status Indicator serves as a monitoring tool and evaluative measure that will help LA focus its resources on continued efforts to bring down the infection rates. By reducing the proportion of adults with Chlamydia Trachomatitis infections, LA can prevent the resulting complications of this infection.

HSI 08A: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race.

Final data shows that there were fewer deaths for ages 0 through 24 years in 2007 (1,620 deaths) than in 2006 (1,674) and in 2005 (1,807). Though there were slightly more Caucasian deaths (801 or 49.4%) than African American deaths (749 or 49%) in 2007, they each represent about 49% of the total deaths. Also, most deaths were non-Hispanic (1,571 or 97%), and more were infants < age 1 year (594 or 36.7%), followed by young adults 20-24 years (498 or 30.7%), adolescents 15-19 years (299 or 18.4%), and children 1-14 years (229 or 14.1%)./2012/Final 2008 data shows more deaths for ages 0- 24 years in 2008 (1,658) than in 2007. The number of African American deaths increased in 2008 (851) compared to 2007. The number of Caucasian deaths decreased in 2008 (786) compared to 2007. The majority of the deaths were non-Hispanic (1,618) and to infants less than age 1 year (594), followed by young adults 20-24 years (522), adolescents 15-19 years (292) and children 1-14 years (250)./2012//

/2013/Final 2009 data shows fewer deaths for ages 0- 24 years in 2009 (1,519) than in 2008. The number of African American deaths decreased in 2009 (805) compared to 2008. The number of Caucasian deaths decreased in 2009 (694) compared to 2008. The majority of

the deaths were non-Hispanic (1,488) and to infants < age 1 year (570), followed by young adults 20-24 years (435), adolescents 15-19 years (271) and children 1-14 years (243).//2013//

For deaths of infants < age 1 year (355 of 594) and young children ages 1-4 years (52 of 96), more than half, or about 59%, (407 of 690) were African American. However, for deaths of children and young adults in the 5-24 years age groups, more than half, or about 57% (529 of 930), were Caucasian. For Asians, 61.5% (8 of 13) of the deaths were of infants (4) and young children (4), whereas 23% (3 of 13) were of children 15-19 years. Of the 41 Hispanic deaths, 41.4% (17 of 41) were young adults 20-24 years followed by 29.3 % (12 of 41) infants < age 1 year, 17.1% (7 of 41) adolescents 15-19 years, 9.8% (4 of 41) children 1-4 years, and 2.4% (1 of 41) children 5-9 years. There were no Hispanic deaths of children 10-14 years./2012/African Americans consisted of more than half, (57%) of infant deaths less than 1 year and young children ages 1-4 years. More than half (51.8%) of deaths to children and young adults ages 5-24 years were to Caucasians. There were no deaths to Hispanic or Asian children 10-14 years of age./2012//

/2013/African Americans consisted of more than half, (55.9%) of infant deaths <1 year and young children ages 1-4 years. Less than half (48.0%) of deaths to children and young adults ages 5-24 years were to Caucasians. There were no deaths to Hispanic children 10-14 years of age.//2013//

This category of data will assist in directing public health efforts to reduce the number of deaths by identifying behavioral risk factors and the high risk groups based on age, race, and ethnicity and addressing risk factors to change behaviors through targeted, preventive interventions, including education and outreach; appropriate allocation of resources; and legislation for public policy change. The data also serves as a public health call to action at the state and local/regional levels for the 9 regional MCH Child Safety Coordinators, the State and local Child Death Review Panels, community and state leaders as well as with the SIDS Risk Reduction and Safe Sleep Program, Injury Research and Prevention Program, and the Louisiana Youth Suicide Prevention Task Force./2013/***The regional MCH Child Safety Coordinators and the Injury Research and Prevention Program are no longer being funded by the State. The duties of these programs have been folded into other OPH initiatives.//2013//***

Death rates are just one of several measures of our state's health status. Awareness of the leading causes of death can more efficiently and effectively target our efforts and resources toward building a healthier and safer community. As an evaluative measure, by comparing the state's death rates to past rates and to other states' rates, MCH can assess achievement of efforts, appropriateness of efforts, and effectiveness of preventive interventions and allocated resources over time.

HSI #09A & HSI #09B - Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race.
Please refer to data in FORM 21.

This data provides guidance for race and ethnicity specific programs such as SCHIP, Medicaid and WIC. The data informs the MCH program in providing advice to other miscellaneous programs. This data informs and directs health and social marketing campaigns that address disparities in this population.

For children aged 0-19 years of age, Annie Casey Foundation 2009 Report ranks LA 49th with 43% in a household with a single parent. For teenagers between the ages of 16 and 19 who are not enrolled in high school and are not high school graduates, Louisiana ranks 49th in the nation with a drop out rate at 10%. Louisiana's rate of juvenile arrests is 1,564 per 100,000 persons. This is compared to a national rate of 1,398 per 100,000 persons under the age of 18.

/2012/For children aged 0-19 years of age, Annie Casey Foundation 2010 Report ranks LA 49th with 42% in a household with a single parent. For teenagers between the ages of 16 and 19 who are not enrolled in high school and are not high school graduates, Louisiana ranks 49th in the nation with a drop out rate at 8%. Louisiana's rate of juvenile arrests is 2,717 per 100,000 persons.//2012//

/2013/The Annie Casey Foundation 2010 Report ranks LA 49th with 45% in a household with a single parent for children aged 0-19 years of age. For teenagers between the ages of 16 and 19 who are not enrolled in high school and are not high school graduates, Louisiana ranks 49th in the nation with a dropout rate at 10%. In 2009, Louisiana's rate of juvenile arrests is 3,007 per 100,000 persons.//2013//

F. Other Program Activities

Surveillance and Universal Screening

Louisiana's Childhood Lead Poisoning Prevention Program (LACLPPP) receives CDC and MCH funds to maintain a statewide, population-based surveillance system of blood lead levels of children ages 6-72 mos., for case management and environmental inspections of children with elevated blood lead levels, and to support the New Orleans Childhood Lead Poisoning Prevention Program. Mandatory universal blood lead screening of children ages 6- 72 mos. and mandatory reporting of the screening results has been implemented in Louisiana since 2008 and LACLPPP has begun strategic planning to implement CDC's primary prevention initiative, "Healthy Homes", a community-level approach to healthy environments by integrating lead poisoning prevention with injury and asthma.

The Genetic Diseases Program, along with Public Health's Laboratory, operates a statewide Newborn Heal Stick Screening and Follow-up Program, which screens all newborns in the state before hospital discharge for all 28 of the disorders recommended by the American College of Medical Genetics, except for hearing loss. The Louisiana Newborn Screening Rule (LAC48:v.6303.08), effective January 2008, was amended to provide guidance to providers on the timing of collection of newborn screening and on post-transfusion collection of screenings.

The Injury Research and Prevention Program (IRPP), now integrated into MCH, receives CDC funds for Rape Prevention Education and for operating the following Louisiana. surveillance systems: Injury Mortality surveillance, Non-Fatal injury surveillance (Louisiana Hospital Inpatient Discharge Data), Traumatic Brain and Spinal Cord Injury Surveillance (legislatively mandated registry), and Child Death Review surveillance of unexpected deaths of children <15 yrs of age. IRPP also receives Preventive Health Block Grant funding to support primary prevention education for the leading causes of adult injury morbidity and mortality, such as falls (among the elderly) and motor vehicle crashes from distracted driving./2012/IRPP is being integrated into the Louisiana Emergency Response Network. MCH will continue to manage the Child Death Review Program and manage initiatives described in State Priority Need 2. MCH has absorbed the CDC-funded IRPP sexual violence prevention program.//2012//***2013/MCH is the point of contact for injury prevention. MCH is bolstering EPI capacity and capacity to drive actions.//2013//***

CSHS received a \$947,403 CDC grant for the expansion of the Louisiana Birth Defects Monitoring Network, an active surveillance system that is an unfunded legislative mandate currently being supported almost entirely by Title V Block Grant funds. The program currently covers approximately 80% of births in the state, and plans to be statewide by the end of 2011. The new program manager, a physician with disaster surveillance expertise, will work with CDC to select a new software system, work with IT to adapt it to meet Louisiana needs. With all births in the state included in the system, the program will be able to compute statewide statistics for incidence of birth defects identified by the network in order to develop specific prevention/intervention activities. Resource guide distribution to parents of infants identified by

the system should improve with the new grant funding./2012/The LBDMN is now statewide. A software system from CDC is being adapted for use in Louisiana. The LBDMN is working with Environmental Epidemiology to integrate databases and identify associations using GIS mapping. LBDMN partners with community nonprofits in preventive efforts./2012//**2013/The CDC software is not available. LBDMN and Newborn Metabolic Screening will contract to develop an interface with vital records using the Louisiana Electronic Event Registry System (LEERS)./2013//**

CSHS has also received additional funds from MCHB to improve follow-up of infants identified by the newborn hearing screening program by transitioning to a web-based software program and improve data reporting. Coordination with the Parent Pupil Education Program of the School for the Deaf and Early Steps will also improve follow-up of infants identified by the program. CSHS is also participating in a DHH-DSS Data Integration Project to create a master patient database that will be accessible by programs from the two agencies and will be a way to improve care coordination by all programs, and will provide the possibility of "single point of entry" in to all programs for families. CSHS supports the project and requested to pilot it./2012/This project is discontinued./2012//

Coordination/Policy Development

BrightStart is Louisiana's HRSA-MCHB Early Childhood Comprehensive Systems Grant Initiative, a framework of systems integration and public/private partnerships, which functions under the auspices of the Louisiana Governor's Children's Cabinet and the Advisory Board, with the MCH Program providing guidance to the administrative management of the grant initiative. The MCH principal investigator and 2 coordinators oversee all grant activities carried out by Focus Area work groups, representing child safety and the priority areas of the grant: access to health care, early care and education, social-emotional/mental health, family support, and parenting education. BrightStart's Steering Committee was designated by Governor Jindal as Louisiana's Early Childhood Advisory Council in December 2009 and is now called BrightStart Advisory Council. Successes included a completed needs assessment and inventory of current home visiting programs in Louisiana and formed a Home Visiting Advisory Council for input; a website (www.brightstartla.org); an Early Childhood System Integration Budget (2008 Louisiana legislature, Act 774), with the 5 ECCS priority areas as reporting categories; coordination of multi-agency infant mental health training; Quality Start, the childcare rating system managed by DSS, with more than 47% Class-A licensed centers participation; and LA Parent Educators Network, which launched a website (www.lapen.org/registry) and a Parent Educator Registry, hosted its 3rd Annual Summit (March 1, 2010), and developed a Parenting Education Track for the Prevent Child Abuse Louisiana Conference (March 2-3, 2010). /2012/MCH is supporting efforts to pilot the evidence-based Triple-P parenting program. The 4th Annual Louisiana Parenting Education Summit was held on March 24, 2011./2012//**2013/CSHS added resources to its care coordination materials for MHs. Policy development and coordination are emphasized throughout MCH initiatives./2013//**

Toll Free Hotline

MCH funds the statewide Partners for Healthy Babies (PHB) social marketing campaign which uses multimedia approaches to promote healthy behaviors during pregnancy, early entry into prenatal care, reduction of risky behaviors, and in the past year, preconception health. A fundamental component of PHB is the Title V-funded toll-free, 24- hr helpline, 1-800-251-BABY (operated by the American Pregnancy Association, Inc.) and corresponding website, www.1800251BABY.org to link women, and their families, to prenatal care, other health services and to enabling support services in their area (i.e. WIC and Medicaid enrollment information and centers). The hotline received 2,950 calls in 2008 and 4,274 in 2009, and the website had 14,105 hits in 2008 and 10,735 in 2009. The most recent focus area is the preconception health campaign, The Stork Reality which reaches out to women (and men) who are not actively seeking to get pregnant, using traditional media, social media (Facebook/Twitter), and interactive web advertising. Tulane University School of Public Health, Community Health Sciences faculty provide oversight of this population-based health promotion efforts. /2012/In 2010, PHB Helpline

received 5,305 calls.//2012///**2013/PHB received 6593 Calls in SFY 2011.**//2013//

G. Technical Assistance

Technical assistance needs are described in Form 15. Please see this form for a complete list of anticipated needs.

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 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line1, Form 2)</i>	13360844	13360844	13056199		13010428	
2. Unobligated Balance <i>(Line2, Form 2)</i>	1203156	3690302	0		0	
3. State Funds <i>(Line3, Form 2)</i>	24910587	20190934	16407811		13426982	
4. Local MCH Funds <i>(Line4, Form 2)</i>	943936	245159	814786		585714	
5. Other Funds <i>(Line5, Form 2)</i>	3700000	3702623	3700000		3365000	
6. Program Income <i>(Line6, Form 2)</i>	7247628	4414637	9449179		8981055	
7. Subtotal	51366151	45604499	43427975		39369179	
8. Other Federal Funds <i>(Line10, Form 2)</i>	1472191	1068734	3820344		10238126	
9. Total <i>(Line11, Form 2)</i>	52838342	46673233	47248319		49607305	

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

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	10500000	6939880	7209827		6241762	
b. Infants < 1 year old	9500000	10421310	8755536		9362836	
c. Children 1 to 22 years old	16600000	14079229	12677040		6714809	
d. Children with	8300000	7542788	9817467		12522663	

Special Healthcare Needs						
e. Others	1265000	2294596	790835		791985	
f. Administration	5201151	4326696	4177270		3735124	
g. SUBTOTAL	51366151	45604499	43427975		39369179	
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	94966		97260		65357	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	0		0		0	
j. Education	0		0		0	
k. Home Visiting	0		0		2082723	
k. Other						
Birth Defects	205000		0		185000	
Early Hearing	150000		0		166461	
ECCS	0		137700		150000	
Home Visiting Expans	0		0		6639138	
Newborn Screening	300000		0		270000	
PRAMS	145210		146263		162593	
Preventive Health	0		87549		87549	
Sexual Violence	0		434841		429305	
Affordable Care Act	0		2916731		0	
Early Childhood	140000		0		0	
Oral Health	437015		0		0	

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

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	18459076	12174517	15634071		14172904	
II. Enabling Services	20477487	19558662	15199791		13779213	
III. Population-Based Services	10415159	10555757	10422714		9448603	
IV. Infrastructure Building Services	2014429	3315563	2171399		1968459	
V. Federal-State Title V Block Grant Partnership Total	51366151	45604499	43427975		39369179	

A. Expenditures

On Form 3, the expended amount for Federal Allocation was lower than the budgeted amount for Federal Allocation due to increase in Other Funds from additional Temporary Assistance for Needy Families funding for Nurse Family Partnership awarded for FY 2009 for program expansion.

On Form 3, the expended amount for Other Funds was higher than the budgeted because after the Title V Budget was submitted for 2009, additional Temporary Assistance for Needy Families (TANF) Funding for Nurse Family Partnership was awarded for FY 2009 for program expansion.

On Form 4, the expended amount for Pregnant Women was higher than the budgeted amount due to overall program increase in expenditures for the expansion of the Nurse Family Partnership Program for this category.

On Form 4, the expended amount for All Others was lower than the budgeted amount due to an increase in Medicaid revenue for the Family Planning Program which decreased the federal allocation.

On Form 4, the expended amount for Administration was higher than the budgeted amount due to the DHH Information Technology Department being transferred from Office of Public Health (previously reported as direct charges) to the DHH Office of Secretary (now reported as overhead/administration charges).

On Form 5, the expended amount for Enabling Services was higher than the budgeted amount because after the Title V Budget was submitted for 2009, additional Temporary Assistance for Needy Families (TANF) Funding and State General Funds for Nurse Family Partnership was awarded for FY 2009 for program expansion.

On Form 5, the budgeted amount for Population-Based Services was higher than the expended amount due to the FY 2009 budgeted amount being set too high. The budgeted for Population-Based Services anticipated expansion and growth but not as much growth in Population-Based Services as expected was achieved.

/2012/On Form 3, the expended amount for Unobligated Balance was higher than the budgeted amount because there was an allocation made to the Genetics Program that had not been originally planned, and additional support provided to the Immunization Program.

On Form 3, the expended amount for State Funds was lower than the budgeted amount due in part to reductions in State General Funds that impacted program across OPH including the Immunization Program, and the Genetics Program, and the Maternal and Child Health Program.

On Form 3, the expended amount for Local MCH Funds was lower than originally anticipated because there was a 12.5% reduction in local government contributions which resulted in a reduced share for block grant services.

On Form 3, the expended amount for Other Funds was higher than originally budgeted because the TANF allocation was originally included in the Program Income budget, but should have been reflected in the Other Funds budget line.

On Form 3, the expended amount for Program Income was lower than originally budgeted because the TANF allocation was originally included in the Program Income budget, but should have been reflected in the Other Funds budget line.

On Form 3, the expended amount for Other Federal Funds was lower than originally budgeted because of budget reductions in the HRSA SSDI and Early Childhood Comprehensive Systems awards, the CDC PRAMS grant, and an Oral Health grant, and the discontinuation of a perinatal depression grant.

On Form 4, the expended amount for Pregnant Women was lower than originally budgeted because of budget reductions in the contracts and clinics that provided direct clinical services.

On Form 5, the expended amount for Infrastructure Building Services was less than originally budgeted as a result of budget reductions within OPH.//2012//

/2013/ On Form 3, the expended amount for Unobligated Balance was higher than the budgeted amount because there were unspent block grant funds from prior years used to cover cost.

On Form 3, the expended amount for State Funds was lower than the budgeted amount due in part to reductions in State General Funds that impacted program across OPH, including Immunization and Maternal and Child Health.

On Form 3, the expended amount for Local MCH Funds was lower than originally anticipated because there was a reduction in local government contributions which resulted in a reduced share for block grant services.

On Form 3, the expended amount for Program Income was lower than originally budgeted because the TANF allocation was originally included in the Program Income budget, but should have been reflected in the Other Funds budget line.

On Form 3, the expended amount for Other Federal Funds was lower than originally budgeted because of budget reductions in the Oral Health grant.

On Form 4, the expended amount for Pregnant Women was lower than originally budgeted because of budget reductions in the contracts and clinics that provided direct clinical services.

On Form 4, the expended amount for Children 1 to 22 years was lower than originally budgeted because of budget reductions in the School Based Health and Immunizations services.

On Form 4, the expended amount for All Others was higher than the budgeted amount because there was an allocation made to the Family Planning Program that had not been originally planned.

On Form 4, the expended amount for Administration was lower than originally budgeted because of budget reductions within OPH.

On Form 5, the expended amount for Direct Health Care Services was lower than originally budgeted as a result of budget reductions within OPH.

On Form 5, the expended amount for Infrastructure Building Services was more than originally budgeted as a result of Children Special Health Services cost were redistributed to reflect a higher percentage of infrastructure building services based upon the MCH pyramid service level. //2013//

B. Budget

The following services and programs are funded by the MCH Block Grant, Title XIX, patient fees, insurance reimbursements, state, and local funds:

1. Maternity
2. Family Planning Program
3. Child Health - Preventive/primary services for children birth to 21.

4. Immunization Program
5. Children's Special Health Services/Genetics Program
6. Adolescent and School Health

The MCH Block Grant supports the state and regional administrative and consultative staff who are responsible for setting standards of care, developing policies and programs, training field staff, providing quality assurance, and conducting surveillance. The amount budgeted for the state Office of Public Health MCH and CHSCN Programs represents the cost of building the capacity of the state to meet the goals and objectives and address the priority needs of the MCH and CHSCN Programs. In addition, other core public health services, direct personal health services, enabling services, and population-based services are included in the following budget. The amounts for each of the MCH population sub-groups are presented in the attachment Budget Table 2011, Tables 1, 2 and 3./2012/The amounts for each of the MCH population sub-groups are presented in the attachment Budget Table 2012, Tables 1, 2 and 3./2012//**2013/ The amounts for each of the MCH population sub-groups are presented in the attachment Budget Table 2013, Tables 1, 2 and 3./2013//**

The service areas (reporting categories), which relate to preventive and primary care services for children, are provided in Table 2 (see attachment Budget Table 2011). The amount of funds budgeted in these service areas for fiscal year 2011 exceeds 30 percent of the total MCH Block grant. Thus, there is no need to redirect the MCH program in order to comply with this requirement. Compliance verification based on the actual funds disbursed will be performed and documented by the Fiscal Office at the end of each state fiscal year./2012/See Budget Table 2012./2012//**2013/See Budget Table 2013./2013//**

A minimum of 30 percent of federal funds received for use in subsequent fiscal years and the associated match will be budgeted for use in programs that provide services for children with special health care needs. The amounts listed on Table 3 (see attachment) will be budgeted for fiscal year 2011. Compliance verification based on the actual funds disbursed will be performed and documented by the Fiscal Office at the end of each state fiscal year./2012/Louisiana will satisfy the 30-30 requirements for the federal allocation, however, matching funds will not necessarily be allocated in the same proportions./2012//

Sources of State Match and Overmatch Funds

Funds for Maternal and Child Health Services will be obtained from state general funds. /2012/Local government contributions and program income are additional sources./2012//

Program Income

Program income comes from Title XIX funds, Temporary Assistance for Needy Families (TANF) funds, fees, and third party payers. Table 4 (see attachment) presents the distribution of this income by program component./2012/TANF has been moved to "Other Funds" on Form 3. The fees referenced here are patient fees./2012//

Budgeting for Cross cutting Programs

The Office of Public Health is able to associate all expenditures including each staff person's work activity with the correct funding source by a system using reporting categories. The Office of Public Health budget is divided into many service areas, each identified by a reporting category. Most Office of Public Health employees utilize this Reporting Category system to allocate their time and other expenditures to a particular project or service area. This system allows staff working across many programs to allocate their time and other expenditures appropriately.

Use of Overmatch Funds

There is no overmatch that is under the control of the State Title V Agency that is used to match other federal programs.

Fees

Maternal and child health patients receiving services at parish health units and are above 100% of the poverty level are charged \$5 per clinic visit and \$5 for pharmacy services. Individuals receiving only immunizations, and that are above 100% of the poverty level, are charged \$10.00. Family planning patients are charged fees according to a sliding fee scale.

Administrative Costs

Administrative costs are the portion of costs incurred by the following service units that are directly allocated to Maternal and Child Health Services Programs in accordance with Sections 3 and 5 (where applicable) of the Department of Health and Hospitals Cost Allocation Plan:

Office of Assistant Secretary-Management Information Systems (MIS)

Human Resources Section - Policy, Planning and Evaluation

Administrative Services Operations and Support Services

Statewide Costs (Purchasing, Civil Service, Treasurer, Fiscal, etc.)

/2012/This section should read as follows: Administrative costs are the portion of costs incurred by the following service units that are directly allocated to Maternal and Child Health Services Programs in accordance with the Department of Health and Hospitals Cost Allocation Plan: Office of Assistant Secretary-OPH; OPH-Center Organizations; Policy, Planning and Evaluation; Administrative Services Operations and Support Services; DHH-Office of the Secretary (Management Information Systems (MIS); Fiscal Services; Human Resources Section; etc.)//2012//

Collectively these are referred to as Executive Overhead costs. Compliance verification of the 10 percent administrative restriction will be performed and documented by the Fiscal Office at the end of each state fiscal year. The estimated administrative costs for the total budget are \$5,201,151 for fiscal year 2010-2011. The estimated Federal share is \$1,336,084 or 10.0% of the federal funds requested./2012/The estimated administrative costs for the total budget are \$4,177,270 for fiscal year 2011-2012. The estimated Federal share is \$1,305,619 or 10.0% of the federal funds requested.//2012//**2013/The estimated administrative costs for the total budget are \$3,735,124 for fiscal year 2012-2013. The estimated Federal share is \$1,301,043 or 10.0% of the federal funds requested.//2013//**

Administrative Cost Limit - The administrative budget represents no more than 10.0% of the federal funds requested./2012/The 10% limit represents the limit on the federal share.//2012//**2013/The 10% limit represents the limit on the federal share.//2013//**

"30-30" Minimum Funding Requirements - The preventive and primary care services for children represent 33.9% of the Block Grant and Children with Special Health Care Needs represent 30.0% of the Block Grant budget. The definitions and descriptions of the services for these project components can be found in the program narratives./2012/The preventive and primary care services for children represent 31.4% of the Block Grant and Children with Special Health Care Needs represent 30.7% of the Block Grant budget.//2012//**2013/The preventive and primary care services for children represent 32.7% of the Block Grant and Children with Special Health Care Needs represent 30.8% of the Block Grant budget.//2013//**

Administrative Cost Limit - The administrative budget represents no more than 10.0% of the federal funds requested.

Maintenance of State Effort - The State Office of Public Health intends to pursue and expects to obtain state general funds for Maternal and Child Health Services that equals or exceeds the level of such funds provided during state fiscal year 1989. Compliance verification will be performed and documented by the Fiscal Office at the end of each state fiscal year. The state support in state fiscal year 1989 was \$6,207,276.

Allocation for Activity Conducted to Continue Consolidated Health Programs

The following federally funded programs were consolidated by the Maternal and Child Health Block Grant in fiscal year 1981-82 in Louisiana:

1. Maternal and Child Health Program;
2. Crippled Children's Services Program (in Louisiana called Children's Special Health Services);
3. Supplemental Security Income/Disabled Children's Program
4. Lead Based Paint Poisoning Prevention Program (previously funded only in City of New Orleans in Louisiana);
5. Genetic Diseases Program (incorporated previous funds for sickle cell disease at Flint Goodridge Hospital in New Orleans);
6. Sudden Infant Death Syndrome (SIDS) not funded in Louisiana; and
7. Adolescent Pregnancy Program not funded in Louisiana.

The following state funded programs in effect in Louisiana at the time of Block Grant Legislation in 1981 were also incorporated into the Maternal and Child Health Block Grant:

1. Genetic Diseases Program statewide screening for certain inherited disorders such as PKU, hypothyroidism, and sickle cell anemia.
2. Sudden Infant Death Syndrome (SIDS) Program follow up and counseling of affected families statewide.

Special Projects In Effect Before August 31, 1981

1. Maternal and Infant Care Project discontinued;
2. Children and Youth Project discontinued;
3. Family Planning absorbed into general Family Planning Program; Title V funding for Family Planning Program is budgeted at \$1,000,000;/2012/Title V funding for Family Planning Program is budgeted at \$500,000.//2012//
4. Dental Health for Children reduced services; current funding for Dental Services for Children's Special Health Services New Orleans District Office;
5. Neonatal Intensive Care absorbed by Louisiana State University Medical Center in Shreveport.

An attachment is included in this section. VB - Budget

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.