



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

**State Narrative for
Maryland**

**Application for 2012
Annual Report for 2010**



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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

The required assurances and certifications have been signed by Ms. Bonnie S. Birkel, Director of the Center for Maternal and Child Health and housed in the Center for Maternal and Child Health's central offices. The assurances and certifications will be made available to the Maternal and Child Health Bureau upon request.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

The public was invited to review a summary MCH plan for 2011 and to comment on the State's current MCH priorities and performance measures through a web based survey. The survey tool will remain available for public comment throughout the coming year. Survey results will be reviewed and compiled bi-monthly to assist in identifying emerging MCH needs. Comments and recommendations generated by the survey will be considered for incorporation into MCH needs assessment and planning efforts over the next five years. Comments will be summarized and included in next year's application. Links to both the needs assessment and the 2011 application will be available on both the CMCH and OGCSHCN Web sites.

For the Title V Needs Assessment, copies of a 15 page summary of the needs assessment process and the eight selected priority needs were distributed to 200 MCH stakeholders participating in the stakeholder survey and stakeholder meeting and to the Parents Place listserv. Responses thus far have been received from 25 individuals representing a broad range of groups including state agencies, the Maryland Academy of Pediatrics (MD-AAP) and local health departments.

Parents of CSHCN from The Parents' Place of Maryland were participants in preparation and review of the CSHCN portions of the block grant application.

Comments have been incorporated into the needs assessment report. Additional input will be sought through regional meetings in the fall.

/2012/ The online survey was updated for the 2012 application and stakeholders were asked to review the State's Plan for 2012 and to comment. In addition, the Department of Health and Mental Hygiene sought comment on the State's proposed Health Improvement Plan for 2011-2014. Many of the objectives in the Plan align with current Title V performance measures and indicators. A summary of the public comments will be provided at the MCHB meeting in August.

Public input on Maryland's Title V CYSHCN activities is provided on an ongoing basis through several mechanisms. A close working partnership between OGCSHCN and Maryland's Family to Family Health Information Center, The Parents' Place of Maryland (PPMD) allows constant family and consumer input. OGCSHCN and PPMD jointly lead Maryland's Community of Care Consortium (CoC), a working group of diverse stakeholders, including families, providers, advocates, consumers, administrators, and professionals from the public and private service systems, which meets quarterly. OGCSHCN regularly updates and solicits feedback from this group on all Title V CSHCN activities, creating a feedback and planning loop between OGCSHCN and Maryland CYSHCN stakeholders that has proven to be invaluable to the work of Title V CSHCN. For more information on how public input provided by the CoC and PPMD plays a key role in Title V CSHCN please see the narrative discussions on National Performance Measures 2,3,4,5, and 6 and State Performance Measures 6, 7, and 8; as well as the Agency Capacity section dealing with OGSHCN. Specific to the 2010 Block Grant report and 2012 Block Grant application, public input was provided on the sections for CYSHCN by the staff of The Parents' Place of Maryland, and a summary of the Block Grant report sections dealing with CSHCN was presented at the July 27, 2011 CoC meeting.

This year, Title V public input also focused on the State's Plan for reducing infant mortality, a priority for Center for Maternal and Child Health as well as the State's Governor and Health Secretary. Several strategies were employed to obtain broad and substantive input regarding the strategies delineated in the Plan for Reducing Infant Mortality in Maryland. Recommendations were obtained from the Infant Mortality Breakout Session at the Governor's Forum on Children and Health in January 2011 and at a meeting in February 2011 with pediatricians from across central Maryland entitled, "The Role of Community Pediatricians in Preventing Infant Mortality". The Plan was also posted on DHMH's Babies Born Healthy web site (<http://dhmh.maryland.gov/babiesbornhealthy/>) with a survey to gather public input. The Plan and survey were promoted to local health departments and partners across Maryland.

A total of 339 Marylanders responded to the survey. Among respondents, 53% stated that the nature of their interest in the survey was as a health care worker, 19% as a Maryland resident, 8% as a patient/consumer, 8% as an advocate, and 6% as a public policy maker. Most of the health care worker respondents were RNs (50%), followed by MDs (11%), health educators (9%), certified nurse midwives (5%), and a variety of other providers including case managers, certified nurse practitioners, social workers, and behavioral health, among others. Twenty-three of Maryland's 24 jurisdictions were represented, with the largest numbers of respondents coming from Montgomery County (11%) followed by Baltimore City (9%), Baltimore County (9%) and Wicomico County (9%). Seventy-three percent of respondents stated that they 'strongly agree' or 'agree' that the Plan focused on the correct strategies and 50% said they 'strongly agree' or 'agree' that the Plan will reduce infant mortality rates among African Americans in Maryland.

The following strategies, obtained through public input, will be added to Maryland's Plan for Reducing Infant Mortality and considered in the Title V approach to programmatic activities to reduce infant mortality and related risk factors:

- . Conduct an awareness campaign to deliver consistent messaging on reproductive life planning, Safe Sleep, pregnancy risks, breastfeeding, the importance of prenatal care, the availability of services, etc., with targeted outreach to important populations (such as African American women, teens, males, youth in foster care, substance users, undocumented women, women who have had a previous negative birth outcome, etc.).**
- . Facilitate real time access to data (including birth records, death records, Pregnancy Risk Assessment forms, hospital and practice-specific outcomes, SUID/SIDS deaths, Fetal Infant Mortality Review, Child Fatality Review, Managed Care Organizations, etc.) to**

address disparities and inform interventions.

. Expand partnerships to include Certified Nurse Midwives, MD State Department of Education, Department of Human Resources, consumers, community organizations and businesses, academic centers, private providers/clinics, health care payers, Federally Qualified Health Centers, and advocates, with the purpose of improving and better coordinating care/services and addressing disparities. //2012//

II. Needs Assessment

In application year 2012, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The 2010 Title V Needs Assessment is attached in section III and contains the full, comprehensive assessment for Maryland. Since submission of the 2010 needs assessment, the Center for Maternal and Child Health has engaged in additional needs assessment activities:

Home Visiting Program

The Center conducted a comprehensive, statewide home visiting needs assessment to meet federal funding requirements for both the Title V Block Grant and new home visiting funds. To identify at risk communities, Maryland looked at 15 indicators that put children and families at-risk: prematurity, low birth weight births, infant mortality, late or no prenatal care, teen births, poverty, unemployment, WIC participation, Medicaid participation, child abuse and neglect, domestic violence, school readiness, high school drop-out, crime and substance abuse. Maryland defined elevated risk as a unit (census tract, ZIP code, or jurisdiction) with a rate substantially greater than the State average for that indicator. Rates that were greater than one standard deviation from the mean were considered elevated. Maryland's analysis identified 368 potential communities at risk (having at least one elevated indicator). Maryland defined communities at-risk as those with 10 or more elevated indicators. This resulted in a total of 46 communities at-risk, representing six jurisdictions (Baltimore City; Dorchester, Washington, Wicomico, Prince George's, and Somerset Counties).

Teen Pregnancy Prevention and PREP

In preparation for implementation of the two new ACA programs (i.e., PREP and abstinence education) to reduce teen pregnancy and related risk factors, Maryland reviewed data on teen birth and sexually transmitted disease rates. CMCH analyzed data on teen births throughout the state between 2005 and 2009 and identified a teen birth rate (15-19 years) of 32.8 births per 1,000 populations. A slight majority were African American (52.2%), followed by White Non-Hispanic (30.4%) and Hispanic (15.6%). The majority of teen births in this time period occurred in the Baltimore Metro area (49.8%) followed by the D.C. Metro area (27.6%). Baltimore City teen births accounted 25% of the total. Eleven jurisdictions were identified as having teen birth rates above the state average of 32.8 births per 1,000 population.

Women's Health

In May 2011, the Center for Maternal and Child Health completed the Health of Maryland Women 2011 Databook. This publication provides an overview of key health issues for women in Maryland by race and ethnicity, as well as across the lifespan. The 2011 report identified key health issues within the Maryland female population. In 2009, 10% of Maryland reported being uninsured. This is less than the 13% of females nationwide. The Health of Maryland Women 2001 report also identified that heart disease and cancer were responsible for nearly half (48%) of all female deaths in 2009. The leading cause of death for women ages 15 through 24 was accidents, while cancer and heart disease were the leading causes of death of women 25 years of age and over. Sexually transmitted infections are still a significant issue for young women in Maryland. Maryland also identified a significant increase in overweight and obese women in Maryland, from 50% in 2001 to 57% in 2009.

Maryland PRAMS

In December of 2010, CMCH published the Maryland PRAMS Report for 2009 births. PRAMS also published reports and briefs on pre pregnancy obesity (November 2010), maternal age (December 2010), postpartum depression (January 2011), perinatal factors in Maryland

(February 2011) and intimate partner violence (March 2011).

OGCSHCN

In response to findings about Maryland's children with special health care needs (CSHCN) population from the 2010 Title V Needs Assessment, Maryland's Office for Genetics and Children with Special Health Care Needs (OGCSHCN) has made several structural changes to best meet the state level priorities for CSHCN (see the narratives for state performance measures 6, 7, and 8 for more information, as well as the Agency Capacity section dealing with OGCSHCN.) During the second half of 2010 and in 2011, OGCSHCN continued data analysis activities and an error in the preliminary data analysis of the 2010 Maryland Parent Survey, conducted for the 2010 Title V Needs Assessment, was discovered. The analysis in question had been performed by a graduate student at Johns Hopkins University under the direction of a professor in the Bloomberg School of Public Health, who was under contract to conduct the analysis with Maryland's Center for Maternal and Child Health. While OGCSHCN and The Parents' Place of Maryland (PPMD)- who conducted the survey - were completing additional analysis activities, the error with the Johns Hopkins analysis was discovered. An incorrect denominator was used and this resulted in a roughly 2% under-reporting rate for certain characteristics of responding families with at least one child or youth with special health care needs (CYSHCN.)

Below are the corrected versions of sentences/paragraphs from the population-based assessment for Maryland CYSHCN from Maryland's 2010 Needs Assessment that include data cited from the 2010 Maryland Parent Survey:

The 2010 Maryland Needs Assessment Parent Survey (Maryland Parent Survey) found that, of the responding families with at least one CYSHCN, over 20% were receiving some form of assistance through the Free and Reduced Meal program, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), or Food Stamps.

The 2010 Maryland Parent Survey asked respondents if their children engaged in or experienced specific problematic behaviors. Among families of CYSHCN, almost 26% reported that their child had problems with anger/conflict management, more than one-fifth reported experience with bullying, and 22% reported that their child had experience with depression (see Table 2).

According to the 2010 Maryland Needs Assessment Parent Survey (Maryland Parent Survey), 28% of parents of CYSHCN reported that their family needed dental care that was delayed or not received; one quarter of families reported needing mental health services that were delayed or not received; and over one-fifth reported that their family needed medical care that was delayed or not received (see Figure 12).

More recent data from the 2010 Maryland Survey found that, among families of CYSHCN, over 38% reported that they found it necessary to change their working hours or stop working to care for their CYSHCN.

The 2010 Maryland Parent Survey asked respondents whether or not they were having difficulty paying for basic needs, such as clothing and food. Table 4 shows the percentage of families of CYSHCN who have difficulty paying for particular needs. Of the families with CYSHCN, nearly one-quarter reported difficulty paying for medical prescriptions, 20% had difficulty paying for utilities, about 17% reported difficulty paying for clothing, and 16% of the families had difficulty paying for housing.

According to the Maryland Parent Survey, over one-fifth of responding families with CYSHCN needed assistance with child care. Fifteen percent of families sought assistance for child care, and of those families, around 37% were satisfied with the assistance they received.

More recent data from the 2010 Maryland Parent Survey indicates that out-of-pocket costs for families of CYSHCN in Maryland are rising; of the responding families with CYSHCN, almost 28% spent \$1000-\$5000 on out-of-pocket expenses for their CYSHCN care, while almost 15% spent

over \$5000 (see Figure 13).

According to the 2010 Maryland Parent Survey, over one-quarter of responding families with CYSHCN needed assistance with respite care. Seventeen percent of families sought assistance for respite care, and of those families, less than 33% were satisfied with the assistance they received.

The 2010 Maryland Parent Survey asked respondents whether or not their child needed certain services typically provided through public schools, whether or not the family sought the needed services, and whether or not they were satisfied with the services they received. The responses are summarized in Table 6. Among families of CYSHCN, the service needed most frequently was speech, occupational, or physical therapy (62%), followed by evaluations from the child's school (54%). When a service was needed, about 70% of respondents reported seeking out the service for their CYSHCN. Satisfaction rates varied -- the highest rate of satisfaction was reported for speech, occupational, or physical therapy (32%).

The 2010 Maryland Parent Survey asked respondents if their CYSHCN had an IEP, IFSP, or 504 plan and if so, were they satisfied with the services the child was receiving through the plan. Almost 86% of all respondents said that their child has either an IEP or IFSP, and over 11% said their child has a 504 plan. Satisfaction rates for IEPs or IFSPs were about 56% among respondents, while the satisfaction rate for 504 plans was about 44%. Among parents whose CYSHCN have IEPs, a little over 30% report that their child's health care needs are addressed in his/her IEP.

More recently, the 2010 Maryland Parent Survey found that 42.4% of parents of CYSHCN are very satisfied with their child's medical care, and almost 42.3% are somewhat satisfied.

More recent data from the 2010 Maryland Parent Survey shows that, among respondents with CYSHCN, over 90% report that they take their child to a doctor's office most often when the child is sick.

More recent data from the 2010 Maryland Parent Survey show that over 25% of families of CYSHCN needed mental health services but those services were delayed or not received.

According to the 2010 Maryland Parent Survey, over 8% of families with CYSHCN had a problem getting health insurance for their child with special needs.

III. State Overview

A. Overview

Maryland has been aptly described as "America in Miniature." Although a small state in size and population, Maryland has great geographic and demographic diversity. This diversity creates unique challenges for the health care system in Maryland and barriers to care for many Maryland residents. The State is characterized by mountainous rural areas in the western part of the State, densely populated urban and suburban areas in the central and southern regions along the I-95 corridor between Baltimore and Washington D.C., and flat rural areas in the eastern region. The "Eastern Shore" borders Delaware, the Atlantic Ocean and the Chesapeake Bay, the largest estuary in the U.S. The Bay is a treasured geographic asset but the fact that it bisects the state presents special challenges for Eastern Shore residents. Maryland is comprised of 24 political jurisdictions -- 23 counties and the City of Baltimore. Nine of the counties are on the Eastern Shore.

The racial/ethnic distribution of the Maryland population of 5.6 million is equally diverse: White (64.1%), Black or African American (30.0%), Asian or Pacific Islander (5.4%), and American Indian (<1%). Nearly 7% of the population (6.7%) is comprised of individuals of Hispanic origin. Minorities represented 42% of the State's 2008 population of 5.6 million. Latinos continue to be the fastest growing racial/ethnic group, representing over 6% of the State's 2008 population. While nationally, the majority of Hispanics migrate from Mexico, Maryland's Hispanic immigrants are predominantly from South and Central America. Racial/ethnic minorities now represent a majority of the babies born in Maryland (54.2% in 2008). Minority populations in Maryland continue to grow as the State's white population declines. Maryland's undocumented immigrant population is estimated to be 250,000 (Pew Hispanic Center 2008).

The prevalence and impact of health disparities continue to be significant nationally and in Maryland. The 2008 National Healthcare Disparities Report from the Agency for Healthcare Research and Quality states that nationally, 60% of disparities in quality of care measures are either not improving or actually getting worse over time. In Maryland, racial and ethnic minority disparities exist for ten of the 14 leading causes of death. Areas of significant disparity include infant mortality, maternal mortality, child deaths, cardiovascular disease, cancer, diabetes, HIV/AIDS, kidney disease, asthma, health insurance coverage, ability to afford health care, and utilization of mental health services. Maryland's high infant mortality and persistent racial/ethnic disparities in infant mortality continue to be major challenges. In 2008, Maryland's infant mortality rate was 8.0 infant deaths per 1,000 live births, virtually unchanged since 1998 and ranking Maryland 39th in the U.S. African American infant deaths occur at more than double the rate of White, Hispanic, and Asian infant deaths in Maryland.

//2012/ Maryland's infant mortality rate declined to 7.2 infant deaths per 1,000 live births in 2009. However, there was a worsening of the racial disparity between African Americans and Whites. //2012//

An estimated 1.2 million of Maryland's 5.6 million residents are women of childbearing age (ages 15-45) according to the most recent U.S. census (2008) estimates. The State's 1.5 million children and adolescents ages 0-19 included: 296,425 young children under the age of five; 361,155 elementary school aged children ages five to nine; and 773,937 adolescents ages ten to 19. Another 377,174 Marylanders were young adults ages 20-24. Senior citizens aged 65 and over, represented 11.4% of the population.

Maryland's workforce is one of the best educated in the nation. Over a third of Maryland's population aged 25 and older held a bachelor's degree or higher in 2008. More than 146,455 businesses employ 2.29 million workers. Of those employed in 2008, 72% of people were private wage and salary workers; 23% were federal, state or local government workers; and 5% were self-employed. Health care represents a \$38.5 billion industry in Maryland with per capita spending on health care reaching \$6,374 in 2007. Hospital care represented the largest category

of expenditures and accounted for one-third of expenditures in 2007.

As one of the wealthiest states in the nation, Maryland had the second lowest poverty rates, both overall and among children in 2008. However, poverty rates in Maryland continue to vary by age, race/ethnicity and jurisdiction. U.S. Census estimates for 2008 indicate that 8.2% of Marylanders were poor. Poverty rates ranged from a high of 23.1% in Somerset County to a low of 4.3% in Howard County. An estimated 137,831 Maryland children ages 0-17 (10.4%) lived in poverty in 2008. By jurisdiction, child poverty rates ranged from a high of 27.9% in Somerset County to a low of 4.9% in Howard County. The state's median household income stood at an estimated \$70,482 in 2008 and by jurisdiction ranged from a high of \$101,876 in Howard County to a low of \$39,426 in Somerset County.

Despite Maryland's continued relative affluence, the current recession has had a profound impact in Maryland, particularly in state government where revenue shortfalls have left a \$700 million budget deficit. As a result, local health department funding was cut by 45% between FY 2009 and FY 2011 which necessitated lay-offs that included local MCH staff. A state government "temporary salary reduction plan" (mandatory furlough days) has been in effect for two years. Health clinicians (physicians, nurse-midwives, nurse-practitioners and physician's assistants) working in state facilities were exempt in FY 2009 but there have been no exemptions in FY 2010 or in FY 2011.

//2012/ Mandatory furlough days ended in State fiscal year 2012. //2012//

Health care workforce shortages/distribution affects many Maryland communities. Twenty-two of Maryland's 24 jurisdictions are currently either entirely or partially federally designated as medically underserved areas for primary care services. These shortage areas exist even though the ratio of primary care physicians to the population is higher in Maryland than the national average. This shortage is thought to be due to the high number of Maryland physicians employed by government research facilities, the military and medical schools in non-direct health care positions. Four of Maryland's 24 jurisdictions are currently classified as being underserved for dental health services/manpower and six jurisdictions are classified as underserved for mental health services. Federally qualified community health centers are located in 18 jurisdictions.

Maryland has 34 birthing hospitals, with only two nurse-midwife operating birthing centers. The distribution and level of care among the birthing hospitals is unusual -- there are 7 Level I facilities, 11 Level II facilities, and 16 Level III facilities. The voluntary Maryland Perinatal System Standards further distinguish the Level III hospitals into Level IIIA, IIIB, and IIIC. All but two of the Level III facilities are in the Baltimore or Washington D.C. metropolitan areas. Maryland's all-payer rate setting system for hospitals, in place for thirty (30) years, is the only such system in the U.S.

In spite of Maryland's relative affluence and significant health care assets, health indicators for the State remain mixed. In the 2009 Kids Count Data Book (Annie E. Casey Foundation), Maryland ranked 25th on ten indicators of child well-being. According to the 2007 National Survey of Children's Health, the prevalence of children aged 0-17 years who have special health care needs is 20.1% in Maryland, higher than the national prevalence of 19.2%. Obesity and obesity-related illnesses such as type 2 diabetes are documented to be increasing among children and adolescents. The 2005 needs assessment reported that health providers and school health personnel were increasingly identifying depression and mental health disorders as problems among adolescents. In the 2010 needs assessment, these same health concerns continue to affect Maryland children.

//2012/ Maryland continued to rank 25th in the 2010 Kids Count Data Book. //2012//

However, progress has been made on many fronts. Fewer women are smoking during pregnancy and more are initiating breastfeeding in the early postpartum period. Teen birth rates as well as child and adolescent death rates continue to decline. More children are being screened for lead exposure and fewer are being found with elevated blood lead levels. There are

fewer uninsured children and more young children are being fully immunized. Fewer adolescents are smoking and juvenile arrests for violent crimes are down. More detailed MCH-related health status indicators are reported on in the other Narrative Sections and/or the Health Status Indicator Section. Emerging health trends, problems, gaps and barriers are also identified in the 2010 Needs Assessment Report.

State Health Priorities

//2012/ The Maryland Department of Health and Mental Hygiene is currently developing a State Health Improvement Plan (SHIP) for 2011-2014. This Plan will provide a framework to support improvements in the health of Marylanders and their communities. It includes measurable objectives and targets in key areas of health, with a special focus on health equity. There are currently five draft focus areas: 1. Improve reproductive health care and birth outcomes; 2. Ensure that Maryland indoor and community environments are safe and support health; 3. Prevent and control infectious disease; 4. Prevent and control chronic disease; and 5. Ensure that all Marylanders receive the health care they need. Organizers are currently reviewing public comments and the final Plan is scheduled to be released in late July. Local and regional coalitions will be formed to develop local implementation plans aimed at achieving SHIP objectives of regional and local priority. //2012//

In August 2009, Governor Martin O'Malley identified the reduction of infant mortality by 10% by 2012 as one of the State's top 15 strategic policy goals through an initiative termed the Governor's Delivery Unit (GDU) Plan. The GDU Plan for infant mortality reduction builds on the State's Babies Born Healthy Initiative by expanding prevention services, improving infrastructure, and building new models and systems of care. Initially, three jurisdictions (Baltimore City, Prince George's and Somerset Counties) with high infant mortality rates and racial disparities have been targeted. The DHMH Center for Maternal and Child Health (CMCH) is the lead agency with collaboration from other DHMH programs including the Office of Minority Health and Health Disparities, Medicaid, the Alcohol and Drug Abuse Administration, the Mental Hygiene Administration, WIC, and the local health departments in the three target jurisdictions, as well as the Department of Human Resources (DHR) and the Governor's Office for Children.

***//2012/ Governor O'Malley was elected to a second term in November 2010. In January 2011, Dr. Joshua Sharfstein replaced John Colmers as the Health Secretary. //2012//
//2012/ Dorchester County was added as a GDU county in 2011. //2012//***

The Governor's initiative builds on the Babies Born Healthy Initiative using a life course approach for implementing programs and services to address the needs of women and infants prior to, during and following pregnancy. Family planning services are being expanded in target jurisdictions to a broader Comprehensive Women's Health model, with the goal of healthier women prior to and between pregnancies. Medicaid, in collaboration with DHR, has established a new Accelerated Certification of Eligibility (ACE) enrollment process at both local health departments and local departments of social services. Medicaid coverage for pregnant women begins within 48 hours of an abbreviated application process and continues up to 90 days while a full Medicaid application is completed, with a goal of earlier entry into prenatal care. "Quickstart" prenatal care services have been established in the target jurisdictions with expanded screening and referral services and deployment of community outreach workers, with a goal of risk-appropriate early prenatal care. A standardized post-partum discharge referral process for birthing hospitals statewide is being piloted in the three target jurisdictions, assuring coordination between hospitals, providers, local health departments and community services, with a goal of risk-appropriate follow-up services for mothers and infants. Promoting "Safe Sleep" is a key component.

Access to oral health care remains a priority for Maryland children and families. Maryland efforts to create an oral health safety net have increased significantly as a result of the tragic death of Deamonte Driver, a 12 year old Prince George's County resident, from an untreated dental abscess. This sentinel event occurred in February 2007 amid already growing concern about

inadequate access to dental care. In response, DHMH Secretary John Colmers established a Dental Action Committee (DAC) which made seven major recommendations with a goal of establishing Maryland as a national model for children's oral health care. In response to DAC recommendations, the Maryland General Assembly approved an appropriation of \$14 million (annually) to increase Medicaid dental rates to enhance the dental public health infrastructure and increase access to dental public health services for low-income children. Six new public health dental clinics have been established in regions of the State where there had been no dental public health program or facility. Support for school-based dental programs has been increased. By the end of 2010, residents in every Maryland jurisdiction will have access to a safety-net or school-linked dental clinic. Since July 2009, EPSDT medical providers including pediatricians and nurse practitioners are allowed reimbursement for the application of fluoride varnish to very young children not currently being seen by dentists.

//2012/ The Dental Action Committee transitioned to the Dental Action Coalition. This May, the Coalition along with the Health Secretary and others published the State's first five year Oral Health Plan. In addition, Maryland was named as the top performing state in the nation for children's oral health by the PEW Trust. //2012//

Lack of health insurance coverage remains a barrier to health care for an estimated 12.9% of all Maryland residents; 9% of children and adolescents ages 19 and under are uninsured. The Medicaid Program, known in Maryland as the Medical Assistance Program, serves as the major source of publicly sponsored health insurance coverage for children and adolescents. The Maryland Children's Health Program (MCHP) began operating as a Medicaid expansion program on July 1, 1998. The MCHP program expanded comprehensive health insurance coverage to children up to the age of 19 with family incomes at or below 200% of the federal poverty level (FPL). In 2001, Maryland initiated a separate children's health insurance program expansion, MCHP Premium. In FY 2008, 359,039 children and adolescents were enrolled in the Medicaid Program at some point during the year, while 120,906 were enrolled in MCHP. MCHP also provides insurance coverage for pregnant women with incomes between 185% and 250% of the federal poverty level. In FY 2008, Medicaid covered hospital delivery costs for approximately one-third of Maryland births.

Over the last three years, Maryland has expanded access to health insurance coverage to more than 161,000 Marylanders, 78,500 of whom are children under the Working Families and Small Business Health Coverage Act. The Act extends Medicaid coverage to parents and other family members caring for children with incomes up to 116% of the federal poverty level. On July 1, 2008, Medical Assistance benefits expanded to include comprehensive health care coverage for many more parents and other family members caring for children. Eligibility depends on family size and income. The income limit is about \$21,200 for a family of three. There is no asset limit when applying, no face-to-face interview is required and there are options to apply online, by mail or by fax.

//2012/ Legislation passed in 2011 extends Medicaid coverage for family planning services to women with family incomes between 116% and 250% of the federal poverty level. This expansion is projected to extend eligibility to an additional 34,000 women when it becomes effective on January 1, 2012. //2012//

Reducing health disparities continues to be a major priority in Maryland. In a memo sent to all DHMH employees on April 14, 2010, Secretary Colmers reiterated Maryland's commitment to addressing disparities, stating: "As Maryland prepares to implement health care reform, it is essential that we confront the disparities that plague far too many members of our minority communities. Eliminating disparities in health access and outcomes are a critical part of the DHMH mission and our day-to-day operations." The DHMH Office of Minority Health and Health Disparities (OMHDD), was established in statute by the 2004 General Assembly through enactment of House Bill 86. OMHDD has been directed by Carlessia Hussein, RN, DrPH since its inception. Dr. Hussein reports directly to Secretary Colmers, and OMHDD serves as a resource for training and consultation on minority health issues and cultural competence throughout the department, for local health departments, and for community-based organizations.

OMHDD has primarily focused its efforts in the areas of cancer and tobacco which reflects a major funding source, the Cigarette Restitution Fund. OMHDD has had a number of accomplishments from its early work to reduce smoking and cancer disparities; the all-cause cancer mortality disparity was reduced by over 50% between 2000 and 2005. In 2008, OMHDD joined CMCH as a partner in the Babies Born Healthy Initiative, and more recently has become a major partner in Governor O'Malley's Infant Mortality Initiative. CMCH partners with OMHDD on asthma disparities.

Improving health care quality and controlling health care costs remain priorities. The Maryland Health Quality and Cost Council, chaired by the Lt. Governor and the DHMH Secretary, was established by executive order in 2007 to develop recommendations for improving health care quality and reducing health care costs in the State. In 2009, the Health Quality and Cost Council recommended the promotion of Healthiest Maryland, a Statewide movement to create a culture of wellness--an environment that makes the healthiest choice an easy choice. The three components of Healthiest Maryland are Healthiest Maryland Businesses, Healthiest Maryland Communities, and Healthiest Maryland Schools. Within each of the sectors, there is a peer-to-peer recruitment campaign to engage leadership and conduct an organizational assessment, referral to resources and technical assistance, and recognition of successful implementation of policies and environmental change. In addition, corresponding State-level policies and environmental changes will contribute to the culture of wellness throughout Maryland.

The Health Quality and Cost Council has identified obesity prevention as a major priority and is working with the DHMH Office of Chronic Disease Prevention (OCDP) to develop policies to promote access to healthy foods and opportunities for physical activity, particularly for populations who experience health disparities or who are at vulnerable periods in the life course. Black, Hispanic, and low-income Marylanders have higher rates of obesity, poor diet, and physical inactivity. Instilling healthy lifestyle habits in childhood is one way of forestalling the rising rates of child and adult obesity. Women of childbearing age are another important population because a growing body of evidence demonstrates a link between fetal exposures and risk for obesity in adulthood. Three specific Healthiest Maryland objectives that are related to maternal and child health are: promoting workplace wellness in industries that employ women of childbearing age, promoting lactation support in the workplace, and promoting implementation of wellness policies in licensed child care and schools. CMCH and the Maryland WIC program are partners with the Office of Chronic Disease Prevention on breastfeeding promotion and childhood obesity prevention.

//2012/ Under the leadership of the Office for Chronic Disease Prevention, Maryland recently applied for a federal Community Transformation Grant to prevent and control obesity, hypertension and diabetes in at risk communities. If successful, grant funds will be used to build on components of the Healthiest Maryland Initiative. //2012//

In March 2010, the Governor created the Maryland Health Care Reform Coordinating Council to advise the administration on policies and procedures to implement recent and future federal health care reform legislation. The Council will make policy recommendations and offer implementation strategies to keep Maryland among the leading states in expanding quality, affordable health care while reducing waste and controlling costs.

//2012/ The Council released its final recommendations in January 2011. The 2011 Maryland Legislature outlined a plan for moving forward with health care reform efforts in Maryland including Maryland's approach to the Health Benefit Exchange requirement. //2012//

The Family Health Administration's priorities will continue to focus on strengthening programs, as well as revitalizing public health data systems, building public health partnerships (with the academic centers, professional and advocacy groups, and others), and strengthening operational aspects of public health administration (e.g., budget, personnel, procurement, legislation, information technology). In addition, a major FHA focus will be on leadership development with special attention paid to developing and mentoring the next generation of public health leaders.

MCH/CSHCN Program Priorities

Priorities for the Maryland Title V Program are aligned with the state priorities described above. Priorities reflect the ongoing needs assessment process and are determined in partnership between the Center for Maternal and Child Health (CMCH) and the Office for Genetics and Children with Special Health Care Needs (OGCSHCN) in collaboration with sister programs within the Family Health Administration (FHA), other units within DHMH, other state agencies and stakeholders. There are many services for CSHCN available in the State and the OGCSHCN provides funding to a significant portion of them. The OGCSHCN and its partners work to create and sustain a community-based, coordinated, family-centered, culturally competent system of health care and related services for children and youth with special health care. Current priorities are:

- Reducing infant mortality and racial disparities in birth outcome: Despite ongoing fiscal constraints, both the Governor and the Legislature have maintained state funding for the Babies Born Healthy Initiative. As noted above, Babies Born Healthy funding supports a new Governor's Initiative to reduce infant mortality in Maryland by 10% by 2012.

- Assuring access to family planning services: This includes assuring that the program maximizes efficiencies and minimizes costs while continuing to offer convenient no cost/low-cost services through a diverse network of providers, to reach more women in need. This is to be done without sacrificing the current level of comprehensiveness or quality of services. Family planning is a strategy for reducing infant mortality, and serves as the base for expanding services under the Governor's initiative.

- Advancing new prevention priorities in the areas of environmental health: This includes improving asthma management and promoting healthy nutrition/physical activity to address obesity and overweight across the life span. CMCH is the recipient of a CDC asthma intervention grant and also is responsible for administering the legislatively mandated Asthma Control Program.

- Early Childhood Comprehensive Systems (ECCS): CMCH administers the MCHB ECCS program and works in partnership with many state agencies in systems building activities. On July 9, 2010, CMCH submitted an application for the new Section 511 Maternal, Infant, and Early Childhood Home Visiting Program. This new federal funding will provide important support for a more fully integrated system of care aimed at improving outcomes for families.
//2012/ Maryland completed the home visiting needs assessment and submitted applications for 2010 and 2011 funding. The State also applied for competitive developmental funding. //2012//

- Adolescent health systems development: This is a developing priority for both CMCH and OGCSHCN. CMCH hopes to partner with OGCSHCN, perhaps using a model similar to SECCS, to develop a comprehensive inter-agency approach for improving adolescent health.
//2012/ CMCH applied for and is currently administering both Abstinence Education and Personal Responsibility and Education Program (PREP) funds made available under the Affordable Care Act. //2012//

- Strategic planning: During the coming year, CMCH and OGCSHCN will collaborate on refining the five year MCH strategic plan based on the MCH Needs Assessment, with further input from local health departments, health providers, family groups, community-based organizations, advocacy groups and other MCH stakeholders.

- Epidemiological capacity: Maryland continues to face substantial gaps in data needed to assess and monitor the health of its women and children. Recommendations for additional surveillance are included in the MCH Needs Assessment.

•Strategic partnerships: In order to address CSHCN core outcomes in Maryland, the Maryland Community of Care Consortium (CoC), initiated through the D70 grant, has created a broad alliance of diverse stakeholders to improve systems of care for Maryland CSHCN and their families. Multiple State agencies, academic and community providers of every sort, families, professional organizations, CYSHCN focused voluntary groups and community groups are engaged in collaborative efforts. In the past year, the OGCSHCN and the CoC have worked together to identify strategies in support of action plans for the state to strengthen partnerships, youth transition, and data systems within the system of care for CYSHCN. In addition, OGCSHCN has expanded partnerships with other government and community agencies. Enhanced or new relationships include the Maryland Health Care Commission, the Maryland Developmental Disabilities Council, and the Maryland Center for Excellence in Developmental Disabilities.

•Successful transition of all youth to adulthood: The OGCSHCN and its partners will work to improve the supports for CYSHCN approaching transition, beginning with supports for transition planning. Currently, Maryland lags behind the nation; ranking 42nd in the nation with only 38% of Maryland families of YSHCN aged 12 to 17 reporting that their child received the services necessary to make appropriate transitions to adult life. In the past year, OGCSHCN has created a Transition Coordinator position, has joined Maryland's Interagency Transition Council, and has partnered with the Maryland State Department of Education on multiple initiatives related to youth transition to adulthood. OGCSHCN has also developed the parent survey around youth transition issues that will be administered each year for the next five years to provide data for this priority's outcome measure.

•Improve Data Systems and Sharing: Improve state and local capacity to collect, analyze, share, translate and disseminate MCH data and evaluate programs. Maryland collects state and jurisdiction level data that would be useful to analyze and evaluate on behalf of the population of CYSHCN and other maternal and child health populations. By developing data sharing plans between agencies, Maryland will better target efforts to improve systems of care for CYSHCN and to provide timely information to stakeholders. OGCSHCN has established several data-sharing agreements with other state agencies during the past year.

//2012/ By 2012, the Title V Program plans to designate a Life Course Theory (LCT) Coordinator. Along with the SSDI Project Coordinator, the Life Course Coordinator will work with key MCH staff to facilitate integration of the life course model into Title V programming. A Life Course Data Workgroup will be formed to facilitate a broader, more integrated, life course approach to using data to design, implement and measure programs and policies, and eventually, making such data available to stakeholders. Workgroup members will invite the participation of partners within and outside DHMH and LCT metrics will be piloted and tested for the 2015 Needs Assessment. //2012//

Other health priorities for the State are childhood injuries, asthma, lead, obesity, depression and other mental health disorders. Injuries remain the leading cause of child and adolescent deaths. Two major environmentally linked health conditions--asthma and lead poisoning--continue as major causes of childhood morbidity. An estimated 190,000 Maryland children and adolescents have asthma. In 2007, the Maryland Legislature passed the Clean Indoor Air Act which prohibits smoking in most workplaces and resultantly reduces exposure to second hand smoke, a contributing factor to asthma for some Marylanders. In 2008, 106,452 children between the ages of 0-72 months were tested for lead exposure. Of those children, 489 (0.5%) had elevated blood lead levels of ≥ 10 ug/dL. Much of the decline in blood lead levels is the result of implementation and enforcement of Maryland's "Reduction of Lead Risk in Housing" law. The law requires each pre-1950 rental dwelling to be issued a Full Risk Reduction certificate at tenant turnover.

B. Agency Capacity

Both the Center for Maternal and Child Health (CMCH) and the Office for Genetics and Children with Special Health Care Needs (OGCSHN), hereafter referred to collectively as the "MCH Program," share responsibility for MCH Block Grant development and implementation. The MCH Program operates within the DHMH Family Health Administration which is also home to the Maryland WIC program, the Office of Chronic Disease Prevention, the Center for Health Promotion and the Office of Oral Health. Much more about the MCH Program and other agencies within FHA can be found at <http://fha.maryland.gov>. The MCH Program works with state and local agencies to ensure coordination of services for all women and children, but particularly those with limited access to care.

The mission of the Maryland's MCH Program is to protect, promote and improve the health and well-being of women, children and adolescents, including those with special health care needs. Major goals include improving pregnancy and birth outcomes, improving the health of children and adolescents, including those with special health care needs, assuring access to quality health care services, eliminating barriers and health disparities, and strengthening the MCH infrastructure. MCH programs and services in Maryland are provided at each of the four levels of the MCH pyramid to protect and promote the health of women and children, including those with special health care needs. Both CMCH and OGCSHCN work collaboratively to ensure that Title V funds are administered efficiently and according to best practice standards in public health.

The MCH Program is responsible for addressing several federal and state mandates for improving the health of women and children. State statutes and regulations relevant to the capacity of the Title V MCH Block Grant Program include the following:

Diseases of Pregnancy and Childhood (Health-General Article, SS18-107, Annotated Code of Maryland) -- Directs the Secretary to devise and institute means to prevent and control infant mortality, diseases of pregnancy, diseases of childbirth, diseases of infancy, and diseases of early childhood as well as to promote the welfare and hygiene of maternity and infancy. This mandate applies to programs administered within CMCH and OGCSHCN.

Child Fatality Review Teams (Health-General Article, SSSS 5-701 et seq., Annotated Code of Maryland) -- Establishes multidisciplinary, multi-agency State and local child fatality review teams for the purpose of preventing child deaths. Administrative support is to be provided by the CMCH.

Maryland Asthma Control Program (Health-General Article, SSSS 13-1701 et seq., Annotated Code of Maryland) -- Establishes the Maryland Asthma Control Program within DHMH. The Program is administratively housed within CMCH.

Maternal Mortality Review Program (Health-General Article, SSSS13-1201 et seq., Annotated Code of Maryland) -- Establishes a program to review maternal deaths in partnership with MedChi (the State Medical Society) and provides certain immunity from civil liability and criminal disciplinary actions. Support is provided to MedChi by CMCH.

Children's Environmental Health and Protection Advisory Council (Health-General Article, SSSS13-1501 et seq., Annotated Code of Maryland) -- Creates a Council which is charged with identifying environmental hazards that may affect children's health and recommending solutions.

Lead Poisoning Screening Program (Health-General Article, SS18-106, Annotated Code of Maryland) -- Establishes a Lead Poisoning Screening Program to assure appropriate screening of children. This Program is administratively placed within CMCH.

School Health Program (Education Article, SS7-401, Annotated Code of Maryland) -- Requires the State Department of Education and the Department of Health and Mental Hygiene to jointly

(1) develop public standards and guidelines for school health programs; and (2) offer assistance to the county boards and county health departments in their implementation.

Child Death Review (House Bill 705 (2009) -- Child Fatality Review - Child Death Review Case Reporting System (codified at Health-General Article, SSSS5-701 and 5-704, Annotated Code of Maryland)); COMAR10.11.05 Child Death Review Case Reporting System) -- Authorizes the members and staff of the State Child Fatality Review Team to provide identifying information related to cases of child death in Maryland to the National Center for Child Death Review (NCCDR). The information transfer will occur in accordance with a data use agreement that requires the NCCDR to act as a fiduciary agent of the State and local Child Fatality Review Teams. The bill also outlines the confidentiality and discovery protections related to information provided to the NCCDR. CFR was established by statute in 1999 with enactment of Senate Bill 464.

Fetal and Infant Mortality Review (House Bill 535 (2008) -- Morbidity, Mortality and Quality Review Committee (codified at Health-General Article, SS18-107, Annotated Code of Maryland)); COMAR 10.11.06 Morbidity, Mortality, and Quality Review Committee -- Pregnancy and Childhood) -- Protects Fetal and Infant Mortality Review (FIMR) records from being released in a legal action and provides FIMRs immunity from civil liability and criminal disciplinary actions; establishes an infrastructure to coordinate FIMR with other related reviews such as Child Fatality Review, Maternal Mortality Review, and other reviews of morbidity and mortality associated with pregnancy, childbirth, infancy, and early childhood.

Lead Poisoning Screening Program - Implementation (COMAR 10.11.04) CMCH is administratively responsible for this program but collaborate with partners that include the Maryland State Department of Education and Department of Environment which have companion regulations.

Family Planning (Family Law Article, SS2-405, Annotated Code of Maryland) -- Requires DHMH to provide a family planning brochure which is distributed to all marriage license applicants by county clerks. CMCH's Family Planning Program is responsible for providing the family planning information required by this statute.

Perinatal Systems Standards -- the standards are "voluntary" but have been incorporated in the following regulations: COMAR 10.24.12 (State Health Plan for Facilities and Services: Acute Hospital Inpatient Obstetric Services); COMAR 10.24.18 (State Health Plan for Facilities and Services: Specialized Health Care Services -- Neonatal Intensive Care Services); COMAR 30.08.01 (MIEMSS -- Designation of Trauma and Specialty Referral Centers -- General Provisions)

Identification of Infants (Health-General Article, SSSS20-401 and 20-402, Annotated Code of Maryland) -- Specifies the types of procedures to identify a newborn infant to be used by all institutions or related facilities that deliver an infant from its mother, and specifies the information that must be included in each identification procedure and requirements for verification that the identification procedure was performed.

Family Planning Counseling and Services Referrals (Human Services Article, SS5-309, Annotated Code of Maryland) -- Requires the Department of Human Services to administer a Family Investment Program (FIP) whose purpose is to support family efforts to achieve self-sufficiency through services and financial aid geared to individual family needs. In part, FIP provides referrals to FIP recipients for family planning counseling and services, as appropriate, in a manner that is noncoercive, confidential, and does not violate the recipient's religious beliefs. CMHC's Family Planning Program provides the family planning referral information required by this statute.

Hereditary and Congenital Disorders Program (Health-General Article, SSSS13-101 et seq.,

Annotated Code of Maryland) -- Establishes an Advisory Council and programs to address hereditary and congenital disorders. Originally passed in 1973, this statute was amended in 2008 to put newborn screening in statute. Newborn screening was previously governed by regulations. The language added in 2008, re-establishes the State Public Health Laboratory as the sole laboratory authorized to perform first tier newborn screening, ending the problems caused by allowing a commercial laboratory to compete with the State Public Health Laboratory.

Newborn Screening (COMAR 10.52.12 Screening for Treatable Disorders in the Newborn Child) -
- Establishes a voluntary program to offer newborn screening for treatable metabolic disorders. Originally promulgated in 1975, these regulations were modernized to conform to the 2008 establishment of a Statewide system for newborn screening in statute. (see Health-General Article, SS13-111, Annotated Code of Maryland) Informed consent is no longer required for screening. The model is now informed dissent with written documentation of parental refusal. This program is jointly administered by the Laboratories Administration (lab analysis and short-term follow up) and by the OGCSHCN (long-term follow up).

Hereditary Diseases (COMAR 10.52.01 General Regulations for Hereditary Diseases) (several programs related to genetic disorders are mandated in regulation rather than statute) -- Establishes quality assurance standards for hereditary and congenital disorders services procured by the State. These regulations, previously administered by OGCSHCN, are now administered by the Laboratories Administration within DHMH.

Sickle Cell Anemia (Health-General Article, SSSS18-501 et seq., Annotated Code of Maryland) -- Establishes a program for screening newborns for sickle cell anemia, monitoring each affected infant's health and providing prenatal education regarding sickle cell anemia. The program is jointly administered by the Laboratories Administration (lab analysis and short-term follow-up) and by the OGCSHCN (long-term follow up, health monitoring and health education). In 2006 and 2007 this statute was amended to provide for a Statewide Steering Committee to improve services for adults with sickle cell disease.

Screening for Neural Tube Defects in the Fetus (COMAR 10.52.14) -- Establishes screening protocols for neural tube defects in the fetus during the second trimester of pregnancy. This testing is supported for uninsured women receiving services through local health departments by the OGCSHCN in partnership with the University of Maryland School of Medicine, Division of Human Genetics.

Program for Hearing Impaired Infants (Health-General Article, SSSS13-601 et seq., Annotated Code of Maryland) -- Establishes a program for universal hearing screening of newborns and early identification and follow-up of infants at risk for hearing impairment. This program is administered by OGCSHCN. The corresponding regulations are COMAR 10.11.02 (Identification of Infants).

Birth Defects (Health-General Article, SS18-206, Annotated Code of Maryland) -- Requires hospitals to report birth defects to the Secretary. Also requires the Secretary to monitor birth defects trends. Originally passed in 1982, this statute was amended in 2008 to expand its authority to collect data on any significant birth defect, not just a list of "sentinel birth defects and to clearly establish the programs authority to review medical records. This program is administered by OGCHSN in collaboration with Maryland's Environmental Pubic Health Tracking Program.

Program for Crippled Children (Health-General Article, SS15-125, Annotated Code of Maryland) -
- Establishes a program to identify and to provide medical and other services to "children who are crippled or who have conditions related to crippling." Based on this legislation, OGCSHCN administers the Children's Medical Services (CMS) Program, which is the payer of last resort for specialty care for low income uninsured or underinsured CSHCN. The corresponding regulations, COMAR 10.11.03 (Children's Medical Services Program), are much more modern in terminology.

Center for Maternal and Child Health (CMCH)

The mission of the Center for Maternal and Child Health (CHMH) is to improve the health and well-being of all women, newborns, children and adolescents in Maryland. CMCH focuses on prevention across the lifespan of women and children and serves as DHMH's primary prevention unit for unintended and adolescent pregnancy; infant mortality, low birth weight, fetal alcohol spectrum disorders, childhood lead poisoning, poor asthma outcomes, and racial disparities in outcomes for women and children. The Center collaborates with other FHA units, DHMH units and other State agencies to address: access to prenatal care, breastfeeding promotion, childhood obesity prevention, cervical and breast cancer screening, access to family planning, screening and treatment of sexually transmitted diseases, immunizations, child abuse and neglect, early childhood mental health, postpartum depression, suicide, substance abuse, children's environmental health, and services to rape victims. A leading strategy is systems building through partnerships with Medicaid; other State agencies; local health departments; academic medical centers; professional organizations (ACOG, AAP), private non-profits (Planned Parenthood of Maryland); federally qualified health centers (FQHCs); and advocacy groups.

CMCH manages a budget of approximately \$27 million drawn from ten different federal grants federal grants and one State general fund initiative, Babies Born Healthy. Major sources of federal funding include the Title V-MCH Block Grant and the Title X Family Planning Grant. CMCH has a staff of ~35 professionals that include physicians, nurses, social workers, epidemiologists, educators, community outreach specialists, administrators, and administrative support staff. At any given time, there are also as many as four public health interns and two preventive medicine residents.

Many MCH program priorities are cross-cutting and overlap, so there are no true "silos" within CMCH contrary to the visual image provided by the attached organizational chart.

Key MCH Program Components - CMCH

Women's Health/Family Planning: An important goal within CMCH's mission to improve the health of women of reproductive age by assuring that comprehensive, quality family planning and reproductive health care services are available and accessible to citizens in-need. The program provides contraceptive and reproductive health care to over 70,000 clients each year through a statewide network of over 80 ambulatory sites located in local health departments, outpatient clinics, community health centers, Planned Parenthood affiliates, and private provider offices. Family planning clinics in 3 jurisdictions are piloting an expanded model of care for more comprehensive women's health based largely on MCHB funded "Women Enjoying Life Longer (WELL) Project" in Baltimore County. Adopting a life span approach and developing new comprehensive women's health strategies is an important opportunity for both Title V-MCH and Title X-Family Planning.

Maternal health: CMCH works with local health departments, FQHCs, and hospital to assure access to maternal health services, including medical care, risk assessment, prenatal education, case management, smoking cessation counseling, genetic screening, high-risk referral, home visiting, assistance in obtaining hospital-based services, and referral for family planning, and preconception health care. In collaboration with Medicaid, CMCH supports the Toll Free Maternal and Child Health Hotline (1-800-456-8900) that is linked with the federal hotline 1-800-311-BABY.

CMCH is also working with FQHCs that do not currently provide prenatal care and/or primary prevention services for women to increase local health service capacity. Local health department were once the primary prenatal care providers for low-income and uninsured pregnant women. Their role changed to eligibility and enrollment support when the decision was made to put prenatal care into the Medicaid managed care program, HealthChoice. While virtually all pregnant women who are U.S. citizens or legal immigrants have access to prenatal care under

Health Choice, approximately 5,000 Maryland births are to undocumented immigrants. This has forced many health departments to return to some level of safety net provider.

Fetal and infant mortality reviews: FIMRs have been underway in all 24 jurisdictions since 1998. FIMRs not only provide important insight into opportunities for systems improvement, they have also served as an important mechanism for local and regional communication, coordination and collaboration on other MCH issues.

PRAMS: The Pregnancy Risk Assessment Monitoring System (PRAMS), a CDC supported statewide survey that identifies and monitors selected maternal behaviors, has been a major source of enhanced surveillance since its inception in Maryland in 1999. The Maryland response rate is among the best of PRAMS states.

Child, adolescent and school health: In the area of child, adolescent and school health, CMCH's goal is to promote and protect the health of Maryland's 1.5 million children and adolescents, ages 0-21, by assuring that comprehensive, quality preventive and primary services are accessible. Activities and strategies include funding and support for early childhood initiatives including home visiting, early childhood mental health and promotion of access to a medical home; initiatives that increase blood lead testing, particularly in 'at risk' areas; adolescent health initiatives including teen pregnancy prevention programs; the Maryland Asthma Control Program; and school health programs, including medical consultation and development of guidelines. Title V funds support screening for lead poisoning; and vision and hearing problems in school aged children. CMCH also works to prevent child and adolescent deaths by, for example, providing leadership for a statewide child fatality review process to determine necessary systems changes; promoting asthma surveillance, planning and interventions to prevent deaths, and collaborating with the Mental Hygiene Administration on adolescent suicide prevention.

In 2008, CMCH played a major part in the establishment of an Adolescent Health Colloquium in partnership with the Johns Hopkins Center for Adolescents (CAH). Several CMCH staff were members of this group and contributed to the development of a new publication "The Teen Years Explained -- A Guide to Health Adolescent Development" published by Johns Hopkins with support from the CDC. CMCH has purchased the guide for use with local Interagency Committees on Adolescent Pregnancy. The guide can be downloaded by going to <http://www.jhsph.edu/adolescenthealth>.

Local health departments: Over half of the MCH Block Grant funding goes to support the local public health infrastructure for MCH Maryland's 24 local health departments. All but Baltimore City are considered units under DHMH authority with local health officers jointly appointed by local government and the DHMH Secretary. MCH funding is included in local health department core funds, (allocated by formula) and in categorical grants that include the Improved Pregnancy Outcomes (IPO) Program. IPO funding supports FIMRs, outreach, and enabling services. A larger MCH proportion of funding goes to Baltimore City where infant mortality, teen pregnancy, and childhood lead poisoning remain important issues.

Special Initiatives/Accomplishments - Center for Maternal and Child Health

Babies Born Healthy Initiative and GDU: In 2007, the Maryland General Assembly approved funding for the "Babies Born Healthy" (BBH) initiative to reduce the State's high infant mortality rate. The initiative has focused on prevention services and quality improvement, with the belief that improving infant health requires a comprehensive, multifaceted approach that encompasses family, community, and systems factors associated with poor pregnancy outcomes. The initiative has advanced perinatal standards and quality improvement activities in 25 hospitals through a partnership with the Maryland Patient Safety Center. It has also been strengthening provider capacity and expertise for high risk pregnancies via telemedicine consultation in partnership with Maryland's two academic medical institutions. Women's health services have been enhanced in partnership with WIC. The Office of Minority Health and Health Disparities has established

community-based coalition building activities and a pilot "perinatal navigators" program two jurisdictions with Babies Born Healthy funding. BBH has served as the important base for the Governor O'Malley's Delivery Unit Initiative to reduce infant mortality by 10% by 2012.

The Babies Born Healthy Initiative has also provided start-up funding to the DHMH Vital Statistics Administration to implement the new web-enabled electronic birth certificate (EBC) in January 2009 for enhanced surveillance. The new EBC adopts the revised U.S. Standard Certificate of Live Birth in Maryland which includes numerous new and revised data items that are critical for public health purposes. The new system will improve the timeliness, completeness, and accuracy of vital records data, and will allow for easier electronic matching of files. One limitation, however, is that a large proportion of Maryland births occur out-of-state (primarily in Washington DC) and these will not be reported in the new system.

Perinatal Standards: Maryland has had voluntary perinatal standards in place since 1998. The standards are periodically reviewed and updated as needed or in accord with new AAP/ACOG Guidelines for Perinatal Care. CMCH convenes and leads the Perinatal Clinical Advisory Committee (PCAC). Members include representatives from ACOG, AAP, ACNM, AWHONN, the Maryland Hospital Association, the Maryland Patient Safety Center, MedChi, the Maryland Association of County (and Baltimore City) Health Officers, Medicaid, and the Maryland Institute for Emergency Medical Systems and Services (MIEMSS). The standards were last revised and reissued in 2008.

The standards have been adopted in regulation by MIEMSS for the designation of "perinatal referral centers" -- hospitals that can receive maternal and neonatal transfers. CMCH funds a position at MIEMSS to support this process. Hospitals requesting designation must file a lengthy application and undergo comprehensive site reviews every 5 years that include outside experts as well as clinical staff from CMCH.

Maternal mortality: In March 2010 Amnesty International released a report entitled, "Deadly Delivery: The Maternal Health Care Crisis in the USA," stating that Maryland's maternal mortality ratio (MMR) is 16.5 deaths/100,000 births, ranked 48th among states. This report includes MMR data compiled by the National Women's Law Center, based on CDC's National Center for Health Statistics (NCHS) 1999-2004 data. As noted in the report, maternal mortality surveillance based solely on death certificates result in undercounting of maternal deaths. Maryland Maternal Mortality Reviews utilizes enhanced surveillance methods include reviewing medical examiner records and comparing the death certificates of women of reproductive age with birth certificates to establish whether a woman had given birth within a year of her death. Enhanced surveillance may identify as many as 90 percent more maternal deaths than providers reported on death certificates. CMCH's Medical Director for Women's Health, Dr. Diana Cheng, co-authored a paper with Dr. Isabelle Horon, Director of the DHMH Vital Statistics Administration, "Intimate Partner Homicide Among Pregnant and Postpartum Women" which was published in June 2010 issue of Obstetrics & Gynecology. The article summarized pregnancy-associated homicide perpetrated by current or former intimate partners in Maryland from 1993-2008, and found it to be most prevalent among women who were African American and under 20 years of age. Homicides occurred most often during early pregnancy.

//2012/ Three new federal ACA programs began in FY 2011 -- the Maternal, Infant and Early Childhood Home Visiting Program (\$1.0 million), the Personal Responsibility and Education Program (\$962, 931), and Abstinence Education (\$486,000). All are formula grants. //2012//

Office of Genetics and Children with Special Health Care Needs (OGCSHCN)

The mission of the OGCSHCN is to assure a comprehensive, coordinated, and consumer-friendly system of care that meets the needs of Maryland's children and youth with special health care needs and their families. The vision of OGCSHCN is to become a nationally recognized leader in

developing the unique potential of each Maryland child and young person served through its comprehensive, fully integrated and consumer-friendly system of care. The OGCSHCN strategy is to identify CSHCN as early as possible and facilitate their access to all needed services to optimize outcomes for children and families.

Key Program Components - Office for Genetics and Children with Special Health Care Needs

The OGCSHCN has very strong partnerships with the academic tertiary /specialty care centers. The OGCSHCN provides grant funding to the academic tertiary care centers to partially subsidize both genetic services and specialty care. Maryland CYSHCN primarily access services at the Johns Hopkins Medical Institutions (JHMH) including the Kennedy Krieger Institute (KKI), the University of Maryland Medical Center (UMMC) and Children's National Medical Center (CNMC). Through its Centers of Excellence Systems grant program, the OGCSHCN provides a partial subsidy to these institutions to support specialty care clinics, outreach specialty clinics, complex care management clinics, wrap around and enabling services. The grants fund a resource liaison function at each center, that is, one or more positions dedicated to assisting families to navigate the system. In terms of genetic services, the Maryland Genetics Network grants fund the academic genetics centers to provide genetic services at their institution, consultations to affiliated community institutions and to operate outreach genetics clinics in 7 locations in low population density areas of the state. The genetics grants also fund specialized laboratory services to promote accessibility and to provide biochemical expertise that is not available elsewhere.

Grants to the academic medical centers also provide partial support for specialty clinics, such as the Comprehensive Hemophilia Treatment Center, Pediatric Sickle Cell Treatment Centers, and transition Clinics for youth with sickle cell disease, hemophilia and diabetes.

The OGCSHCN funds the Local Health Departments (LHD) to provide care coordination and case management for CSHCN and respite care, outreach specialty clinics and provider and family education. This funding also allows for periodic needs assessments and, special projects such as the medical home project in Baltimore City. OGCSHCN reestablished regular regional meetings for LHD CSHCN coordinators to foster education and co-planning.

The OGCSHCN funds 2 organizations, the ARC of Montgomery County and PACT (an affiliate of the KKI) in Baltimore County, to provide medical day care for severely involved, medically fragile, technology-dependent children, 6 weeks to 5 years of age.

Several disorder-specific groups receive subsidies to provide peer support, specialty camps, and respite care for children with disorders such as sickle cell disease, PKU, and neurofibromatosis. One grant partially subsidizes pre-school vision screening in Head Start programs through the Rosalie Sauber Pre-School Vision Screening Program of the Maryland Society for Sight.

The main non-state agency partner of the OGCSHCN is the Parent's Place of Maryland (PPMD), the Family Voices chapter for Maryland. Beginning in 1998, the OGCSHCN provided a grant to support PPMD's role in providing the family and community perspectives for policy and planning, to assist in identifying gaps in services for CYSHCN, to compile information on resources in a database and disseminate this information to parents of CYSHCN (the Family to Family Health Education and Information Center), to maintain a network of regional resource parents, to assist parents of CYSHCN to find needed resources on an individual basis and to develop parent leaders in the community. PPMD is the main partner of the OGCSHCN in building the infrastructure for a comprehensive, community based, culturally competent, family centered, user-friendly system of care for CYSHCN.

In 2008 PPMD, in partnership with the OGCSHCN, Johns Hopkins Bloomberg School of Public Health, and the Maryland Chapter, American Academy of Pediatrics, applied for and was awarded a D70 State Implementation Grant for Integrated Community Systems of Care for

Children and Youth with Special Health Care Needs (CYSHCN) from HRSA. The major strategy was to form a "Community of Care Consortium" (CoC) to engage diverse partners in shared planning, implementation, and evaluation of strategies to achieve all 6 core outcomes for CYSHCN. Consortium partners include families of CSHCN, representatives from advocacy groups, physicians, other providers, health care facilities, academic institutions, government and professional organizations, public payers, MCOs, policy analysts and state governmental agencies.

The CoC has been meeting quarterly for almost 3 years and has working committees around core outcomes to evaluate strategies and assist the member organizations of the CoC to implement evidence-based practices to improve systems of care for CSHCN. One project to assist local pediatric practices to standardize and improve developmental screening and referral into their workflow has engaged 30 practices in the Baltimore metro area and hopes to engage more practices statewide through partnerships with managed care and other practice organizations. The CoC has proven to be the best mechanism to achieve the formidable task of integrating the components of the existing community based services, since all stakeholders are involved. PPMD and the CoC have been intimately involved with the preparation of the MCH Block Grant Application for 3 years and with the Needs Assessment last year. PPMD was represented at the MCH Block Grant review for the past two years.

Special Initiatives/Accomplishments - Office for Genetics and Children with Special Health Care Needs

During the past year, OGCSHCN underwent an administrative and structural realignment to better meet the needs of Maryland's CYSHCN population as identified through the 2010 Needs Assessment. The OGCSHCN was re-engineered to increase effectiveness and efficiency, and strategies were developed to create a focus on collaboration and teamwork both internally and with external partners. As a result, chronic staffing vacancies have been filled, new positions have been created, and new programmatic priorities have been determined and disseminated. Now that the office is fully staffed, OGCSHCN was also able to reestablish a leadership role in the CoC and the Maryland Statewide Services for Adults with Sickle Cell Disease Steering Committee. As part of this structural realignment, OGCSHCN worked with internal and external stakeholders, including families and grantees, to review the MCH Funding and Services pyramid and evaluate how it categorizes its programs, services, grants, and other activities by pyramid level. This resulted in a large shift in categorizations between what constitutes infrastructure building and direct services. This redefinition also helped to drive the direction of strategic planning, including budgets, for FY13 (the first year significant programmatic and budgeting changes can be implemented.)

In accordance with the state's "Data Systems and Sharing" priority and with office needs, OGCSHCN evaluated its data systems and formulated an office-wide plan to organize and streamline the various data sets and points collected by its programs and initiatives. Accomplishments to date include the integration of the Infant Hearing Program and Birth Defects Reporting and Information System (BDRIS) databases; planned enhancement and expansion of this database; collaboration with outside partners including the Maryland Center of Excellence for Developmental Disabilities to design a reporting system and database for OGCSHCN grantees and LHDs; and the ongoing development of OGCSHCN's Children's Resource map and database (tracking provider and family resources for health care and related services for Maryland CYSHCN.) These data developments have allowed OGCSHCN to build partnerships that lend expertise and personnel that make it possible to apply for external sources of funding to promote OGCSHCN's mission.

BDRIS, administered by OGCSHCN, is now in compliance with state legislation to provide information and resources to families of children born with birth defects in Maryland. The CoC reviewed a sample letter and documents that are sent to parents and families to this program, and provided significant input to the redevelopment of those documents, making them more

family-friendly and culturally competent. A newly established working relationship with Maryland's Vital Statistics Administration will allow for increased rates of identification and follow-up for BDRIS (as well as the Infant Hearing Program-IHP), and a new provider manual for the BDRIS program has been developed as well as a Care Notebook to distribute as a resource for families to manage their child's care. Parents have reviewed the care notebook materials and their suggestions for updates and changes are being incorporated. The BDRIS program now has a diverse working advisory committee that includes families of CYSHCN.

OGCSHCN has reached a working agreement with the Maryland State Department of Education (MSDE) to share outcome data from MSDE's Infants and Toddlers Program on infants and young children identified through OGCSHCN's Infant Hearing Follow-up Program. This will increase the capability of IHP to evaluate program outcomes and ensure that children with or at risk for hearing loss are receiving necessary services and care.

OGCSHCN, in partnership with The Parents' Place of Maryland (PPMD) completed preparations for a Family and Youth Advisory Council for Maryland's Title V CSHCN program, administered through OGCSHCN. OGCSHCN is now ready to recruit members and hold the first quarterly meeting of the Council.

Several OGCSHCN programs have been streamlined to reflect the newly identified state Title V priorities and OGCSHCN needs. All of the programs providing follow-up for infants have been reorganized to follow a model where children are identified through screening, followed until a diagnosis is made, and then referred for ongoing medical care, early intervention and needed support services (this includes the Infant Hearing, BDRIS, Sickle Cell Disease, and Newborn Screening Long Term Follow-up Programs.) The grants review process for OGCSHCN was also redesigned to be aligned with federal and state Title V program priorities and guidelines. OGCSHCN also reassigned a staff position as a Youth Transition Coordinator in order to address the state and federal Title V youth transition priority, and developed a parent survey around youth transition issues that will be administered each year for the next five years.

C. Organizational Structure

The Department of Health and Mental Hygiene (DHMH) is one of six State agencies that comprise Governor Martin O'Malley's Children's Cabinet. The other agencies are the Department of Human Resources (DHR), the Maryland Department of Education (MSDE), the Department of Juvenile Services (DJS), the Department of Disabilities (DOD) and the Department of Budget and Management. The Children's Cabinet is coordinated by the Governor's Office for Children (GOC). The GOC Executive Director, Rosemary King Johnston, chairs the Children's Cabinet. DHMH is the designated agency responsible for administering Title V Maternal and Child Health Block Grant funds.

DHMH Secretary John M. Colmers, the former director of the Maryland Health Care Commission, was appointed by Governor O'Malley in 2007. Secretary Colmer's priorities include expanding health insurance coverage, improving the quality of health care services and controlling health care cost growth. In October 2008, Secretary Colmers named Frances B. Phillips, RN, MHA as DHMH Deputy Secretary for Public Health Services. Ms. Phillips oversees the Family Health Administration, the new Infectious Disease and Environmental Health Administration (formerly the Community Health and AIDS Administrations), the State Laboratory, the Office of Preparedness and Response, and the Office of the Chief Medical Examiner. At the same time, a new DHMH Deputy Secretary for Behavioral Health and Disabilities was established; Renata J. Henry was named as first Deputy Secretary to hold this post. Behavioral Health includes the Alcohol and Drug Abuse Administration, the Mental Hygiene Administration, and the Developmental

Disabilities.

/2012/ Governor O'Malley was recently elected to his second term. John Colmers resigned as Health Secretary in January 2011 and replaced by Dr. Joshua Sharfstein. Dr. Sharfstein is the former Health Commissioner for Baltimore City and formerly served as a Deputy Director of the Food and Drug Administration under the Obama Administration. //2012//

The Title V Program is within the Family Health Administration (FHA) under the direction of Russell W. Moy, MD, MPH. Dr. Moy reports directly to the Deputy Secretary for Public Health Services, Ms. Frances Phillips. With the retirement of long-time Deputy FHA Director, Joan Salim, on June 30, 2010, FHA has been reorganized with two Deputy Directors. The Deputy Director for Family Health Services is David S. Long. Mr. Long now oversees the Center for Maternal and Child Health, the Office for Genetics and Children with Special Health Care Needs, and the Office of the Maryland Women, Infants and Children (WIC) Program. He is also responsible for oversight of two chronic disease hospitals and legislation/regulations, and information technology within FHA. Donna Gugel is Deputy Director for Prevention and Disease Control which includes the Center for Cancer Surveillance and Control, the Center for Health Promotion, Education and Tobacco Control, and the Office of Chronic Disease Prevention. She also has responsibility for financial management, health policy and planning, and office systems and support services. The State Dental Director, Dr. Harry Goodman, heads the Office of Oral Health and reports directly to Dr. Moy.

FHA oversees a diverse array of public health programs within eight offices and two chronic rehabilitative facilities. The target population includes Maryland's total population of 5.6 million people, covering the lifespan from pregnancy to adulthood. Within the total population, at risk and vulnerable populations including low income, uninsured and medically underserved populations are programmatically identified and safety net services are provided.

Current organization charts for DHMH, FHA, CMCH and OGCSHCN are attached.
An attachment is included in this section. IIC - Organizational Structure

D. Other MCH Capacity

Maryland's MCH Program includes a highly skilled and diverse team of public health professionals representing a variety of disciplines. This team plans, manages, and monitors Title V activities for Maryland from the downtown Baltimore offices of Maryland's State Office complex. In addition, MCH staff in local health departments, including a cadre of community health nurses, physicians, program administrators and clerical personnel, are also supported by Title V funds.

Center for Maternal and Child Health (CMCH)

CMCH currently has 35 full and part-time staff providing 34.6 FTEs. As noted on the attached organizational chart, CMCH is organized into four units. The largest of these, Perinatal and Reproductive Health, has 10 FTEs at the central office and 3 FTEs assigned in the field with direct clinical duties. The majority of the positions in this unit are federally funded by Title X. Maryland's commitment to workforce development is evidenced by the number of graduate student internships. Several CMCH staff have faculty appointments or serve as instructors in MPH programs at Johns Hopkins and University of Maryland.

CMCH is directed by Bonnie S. Birkel, CRNP, MPH. Ms. Birkel is a trained nurse practitioner with a Master of Public Health degree and over 25 years of experience in public health. She is responsible for MCH policy development and is the official spokesperson for all MCH and family planning related areas. She has served as CMCH's Director since its inception in 2000.

/2012/ Maura Dwyer, DrPH, was hired as the CMCH health policy analyst in 2011. Dr. Dwyer works closely with Ms. Birkel on the Governor's Delivery Unit Initiative to reduce

infant mortality. //2012//

Dr. S. Lee Woods, a neonatologist with a Ph.D. in genetics, serves as Medical Director for CMCH. Dr. Woods oversees and provides medical consultation on clinical policy, quality improvement, and legislative issues. Dr. Woods serves as CMCH's primary liaison with the DHMH Office of Communication for public affairs, and also was recently appointed as Secretary Colmer's designee as Chair of the Morbidity, Mortality and Quality Review Committee.

Dr. Woods is supported by Cheryl DePinto, MD, MPH, Medical Director for Child, Adolescent and School Health, who is board certified in pediatrics and adolescent medicine and serves as Principal Investigator (PI) for the CDC Asthma cooperative agreement; Diana Cheng, MD, Medical Director for Women's Health who is a board certified obstetrician/gynecologist, and serves as the PI for the CDC PRAMS cooperative agreement; and Pamela S. Putman, RN, BSN, MPH who is the senior MCH Nurse-Consultant and serves as Chief of MCH Systems Improvement which includes oversight of the statewide Improved Pregnancy Outcome Program.

Yvette McEachern, M.A., serves as Director of Federal/State MCH Partnerships. Ms. McEachern serves as the Title V Administrator and SSDI Project Director in Maryland and oversees development of the Title V application including data collection, performance monitoring and needs assessment. Ms. McEachern has over 20 years experience as a health policy analyst, research statistician, and program administrator. Key staff in Ms. McEachern's unit include Mary LaCasse, Early Childhood Program Manager and Prevention Coordinator; Christine Evans, the Title V-designated Adolescent Health Coordinator and Teen Pregnancy Prevention Coordinator; Rachel Hess-Mutinda, the Asthma Program Administrator, and Linda Nwachukwu, Asthma Epidemiologist.

//2012/ Ms. McEachern was selected as a 2011-2012 MCH Public Health Institute Fellow. Her personal development project will focus on implementing the life course model in MCH programs. //2012//

//2012/ In 2011, three new Affordable Care Act federally funded programs were added to this unit - Abstinence Education, Personal Responsibility and Education Program (PREP) and the Maternal, Infant and Early Childhood Home Visiting Program. Christine Evans serves as the Abstinence Education Coordinator and administrators to coordinate the PREP and Home Visiting Programs are currently being recruited. //2012//

//2012// Dr. Dwyer was appointed the SSDI Project Director in 2011 with support provided by Joan Salim as the SSDI health policy analyst. Andrea Bankoski replaced Linda Nwachukwu as the asthma epidemiologist. //2012//

Marsha Smith, MD, MPH, Director of Perinatal and Reproductive Health, oversees the federal Title X Family Planning Program, the Title X HIV Integration Project, and the Babies Born Healthy Initiative. She has responsibility for oversight of clinical services under the family planning program and supervises a staff of 12. Dr. Smith has been appointed as Secretary Colmer's designee to the State Child Fatality Review Team and oversees the Maternal Mortality Review Program. Dr. Smith is a board-certified pediatrician with previous public health experience as the Medical Director for the Baltimore City Health Department's STD program, and as Acting Assistant Health Commissioner in Baltimore.

Lee Hurt, MS, MPH has served as the MCH Epidemiologist since 2007. She is a doctoral student at the George Washington University School of Public Health. Ms. Hurt is the CMCH's primary liaison for data with the Medicaid program, with other units within the Family Health Administration, other DHMH Administrations (including the Vital Statistics Administration), and Children's Cabinet agencies. Ms. Hurt also oversees the PRAMS program.

//2012/ Office for Genetics and Children with Special Health Care Needs (OGCSHCN)

Following several years of chronic under-staffing, OGCSHCN is now operating at full staff capacity with 23 staff members, 22 of whom are centrally located. Key leadership positions within the office have been filled, and new staff positions were created and filled that are reflective of newly identified priorities.

OGCSHCN welcomes Donna X. Harris, BS to her new position as Office Director. Ms. Harris has been with the OGCSHCN as Deputy Director since 1999, was the Acting Director of OGCSHCN following the retirement of the previous director earlier this year, and has over 16 years of experience in public health. Ms. Harris' training is in Special Education and she has hands-on experience working with children with learning disabilities, and working with community organizations in health promotion activities.

Additionally, the OGCSHCN welcomes Deborah Badawi, M.D. as the new Medical Director. Dr. Badawi is a developmental pediatrician with 19 years of experience. She has been specifically serving CYSHCN for 15 years. Her current responsibilities include program management and development for various initiatives, interfacing with state and local medical professionals and associations, legislative and clinical guidance, and grants management and support. Immediately prior to her work with OGCSHCN, she was the Medical Director of the Maryland School for the Blind for eight years.

Meredith J. Pyle, BA is the Health Policy Analyst and Title V CSHCN Specialist for OGCSHCN. She has over seven years' prior experience working with young CSHCN and their families and previously worked with OGCSHCN as a graduate research assistant for almost four years. She is pursuing a doctoral degree in public policy. Ms. Pyle's current responsibilities include a variety of analytic, administrative, and coordinative tasks in support of statewide public health policy development and strategic planning, as well as developing program implementation and program evaluation strategies that align with federal MCHB/Title V guidelines and state regulations and mandates. Ms. Pyle was the project manager for the CYSHCN 2010 statewide Title V Needs Assessment.

OGCSHCN welcomes Tanya D. Green, M.S., CCC-A. Ms. Green is the Director of the Maryland Infant Hearing Program (IHP) with and brings over seventeen years of experience as an educational and clinical audiologist to her position. Her career path, which includes hospital, university, public school, and private practice experience, has always included an emphasis in the hearing, communicative, and educational needs of children. Ms. Green's current responsibilities include overseeing MD IHP, procuring program funding, and building strategic partnerships with MD EHDI stakeholders. Erin D. Filippone, M.Ed., CCC-A, has served as a senior audiologist with the Infant Hearing Screening Program for 5 years and served as acting chief during the recent recruitment for a new director. She has extensive previous experience as the audiologist in a pediatric ENT practice.

OGCSHCN welcomes Debra Harper-Hill, R.N. as the new Program Chief for the Birth Defects Reporting and Information System, Metabolic Nutrition and Sickle Cell programs. Debra comes to the Office with over 20 years of experience in healthcare management in various communities, with an emphasis in managed care. Mrs. Harper-Hill has specific experience program components such as budgeting, cost control, operations, and staffing. She is also the parent of a child with special health care needs.

Patricia Williamson, BSN, RN has served as the chief of the Children's Medical Services program for 7 years. She oversees medical eligibility for the program and reviews and preauthorized all services provided through CMS. Her previous experience with the medical assistance program has been very valuable in assisting eligible families to apply for medical assistance or other programs that may provide broader coverage than CMS.

Stephanie Hood, BA has served as a follow up coordinator for the IHP for 4 years and brings experience in case management. This year, Ms. Hood assumed the role of Youth Transition Coordinator for OGCSHCN and currently splits her time between both positions. Ms. Hood has several years experience working with at-risk children and youth and their families, providing health education, workforce development, and other support services. OGCSHCN is in the process of hiring an additional follow up coordinator for IHP and at that time, Ms. Hood will devote her attention to the Youth Transition Coordinator position full-time.

Javier Figueroa-Ray, BA, MA, has served for 4 years as the bilingual (Spanish/English) Outreach Coordinator for Montgomery and Prince George's Counties, assisting eligible families to apply for CMS and assisting with the case management for Spanish speaking families. His background in social work and community organization is extremely valuable to the program. He also assists eligible families to apply for primary care through the Primary Care Coalition.

OGCSHCN has plans to fill a newly created CSHCN Resource Coordinator position with a parent or parents of children with special health care needs. //2012//

E. State Agency Coordination

Center for Maternal and Child Health

As noted in Section C, the Governor's Office for Children (GOC) is the coordinating unit for the Children's Cabinet. CMCH has been invited to brief the Children's Cabinet on a number of important MCH issues including: FASD, teen pregnancy, infant mortality, and most recently, home visiting. GOC is a partner in the Governor's Infant Mortality Initiative, and has agreed to serve in an advisory and decision-making role for the new federal home visiting program which will be administered by CMCH. CMCH represents DHMH at annual briefings by GOC to the Maryland General Assembly Joint Committee on Children, Youth and Families. CMCH also works directly with the Children's Cabinet agencies in a number of programmatic areas. CMCH shares responsibility for school health with the Maryland Department of Education, provides consultation and technical assistance on adolescent health and teen pregnancy prevention to the Department of Juvenile Services, and collaborates with the Department of Human Resources on child abuse and neglect, teen pregnancy prevention, outreach for family planning, and early initiation of prenatal care. At the local level, GOC funds Local Management Boards (LMBs) in every jurisdiction. The LMBs are comprised of the local agency counterparts to the Children's Cabinet agencies. The GOC has provided CMCH with the most recent needs assessments completed by LMBs for the MCH Home Visiting Needs Assessment.

//2012/ CMCH is collaborating with the Governor's Office for Children to implement the new home visiting program. An Advisory Group comprised of key State agency staff and other stakeholders has been formed to provide input on program development and implementation. //2012//

CMCH works very closely with the Maryland Department of the Environment (MDE) and the Department of Housing and Community Development (DHCD) on childhood lead poisoning prevention. CMCH represents the Title V program on the Governor's Lead Commission; Medicaid is also represented on the Commission. In FY 2010, CMCH began collaborating with the Maryland Community Health Resources Commission to establish infant mortality reduction as a priority for Commission grants to safety net providers (primarily FQHCs). CMCH provides technical assistance for review of proposals, and has joined in site visits to grantees with Commission staff.

CMCH plays a major leadership and coordination role within the Family Health Administration and partners with the Maryland WIC program (preconception health, family planning outreach, breastfeeding promotion), the Center for Health Promotion (smoking cessation, injury prevention,

intimate partner violence), the Office of Chronic Disease Prevention (women's health, childhood obesity), the Center for Cancer Surveillance and Control (cervical cancer screening), and the Office of Oral Health (child health, perinatal health). Within DHMH, intra-agency partners include the behavioral health programs: the Mental Hygiene Administration (early childhood mental health, youth suicide, and perinatal depression) and the Alcohol and Drug Abuse Administration (perinatal substance abuse, Fetal Alcohol Spectrum Disorders), the Vital Statistics Administration (surveillance), the Office of the Chief Medical Examiner (child fatality, maternal mortality) and the newly formed Infectious Disease and Environmental Health Administration (STIs, immunization, asthma, lead poisoning, and the Children's Environmental Health and Protection Advisory Council). CMCH's collaboration with the DHMH Office of Minority Health and Health Disparities (OMHDD) has already been discussed earlier in the narrative. OMHDD is the primary resource for assuring cultural competency among DHMH and local health department staff. CMCH is frequently a training partner with OMHDD and has representation on the OMHDD Maryland Health Professional Education Committee.

CMCH is represented on the Maryland State School Health Council; the School--Based Health Advisory Council; the Partnership for a Safer Maryland (Injury Prevention); the Maryland Immunization Partnership Committee; the State Early Childhood Advisory Council; the Early Childhood Mental Health Steering Committee; the Maryland Developmental Disabilities Council; the Maryland Caregiver Support Coordinating Council; the Early Head Start Policy Council; the Latino Community Health Care Access Coalition; and the Maryland Suicide Prevention Commission. CMCH is also represented on the National Association of FASD State Coordinators.

//2012/ A Personal Responsibility and Education Program Planning Team comprised of representatives from CMCH, and the Sexually Transmitted Infections/HIV Administration are guiding program development and implementation. //2012//

Office for Genetics and Children with Special Health Care Needs (OGCSHCN)

OGCSHCN has working relationships with the following agencies/offices within DHMH: the Center for Maternal and Child Health, the Laboratories Administration, Environmental Health Protection and Tracking Program, Vital Statistics Administration (VSA), the Developmental Disabilities Administration, the Mental Hygiene Administration, and Medicaid. Other state agencies that OGCSHCN works with include the Department of Disabilities, the Interagency Transition Council, the Maryland State Department of Education (MSDE), 22 of the 24 Local Health Departments in Maryland, and the Maryland Center of Excellence for Developmental Disabilities. In addition to these government entities, OGCSHCN works with numerous community organizations on a regular basis.

Within DHMH, OGCSHCN has had a close collaboration with the Laboratories Administration (Labs) from the early 1960s and the development of newborn screening. The OGCSHCN and the Labs began AFP screening in 1981 serving a largely low income population. With the Medicaid expansions and the resulting decline in uninsured pregnant women, testing volume became too low to justify the State AFP lab and the OGCSHCN provided a partial subsidy to the AFP/Multiple Marker screen lab at University of Maryland Medical Center to serve the remaining patients.

Within FHA, OGCSHCN has collaborated with the Office of Oral Health to educate CYSHCN stakeholders of Oral Health initiatives in the state through a presentation at a quarterly Community of Care Consortium (CoC) meeting. Plans to develop a system of oral health services for CSHCN is a future goal and because great strides have been made in Maryland for children's oral health, it seems possible that a pilot program for CSHCN oral health could be developed in the next several years.

OGCSHCN has expanded its relationship with several departments in MSDE, including the Infants and Toddlers program, the Office of Special Education, and the Office of Student Support

Services. OGCSHCN is working with Infants and Toddlers through a data sharing agreement to get outcome data on infants and young children identified through IHP as having a confirmed hearing loss or being at risk for hearing loss. IHP uses an eSP™ database, maintained through OZ Systems, and plans to enhance this database to interface with the BDRIS program, VSA, and MSDE Infants and Toddlers program have been developed and are in the implementation stage. These enhancements will allow OGCSHCN programs the ability to do more timely follow up with families to ensure that infants receive appropriate services as soon as possible. Additionally, OGCSHCN and MSDE have partnered on several initiatives to improve youth transition to adulthood, including adding information on health care transition to MSDE's Family Transition Guide (which is distributed to families of students with IEPs who are 14 years of age or older), and plans to develop health care transition training materials for school nurses and health aides.

OGCSHCN partners with the academic tertiary care centers by providing a partial subsidy for their specialty clinics and their genetics clinics. Genetics and pediatric specialty clinics rarely break even and the State grants offset their losses. In return, the centers provide care for CSHCN in their own institutions, within their referral networks and through a series of outreach clinics to bring these specialized services to outlying parts of the State. Local health departments and sometimes local community hospitals host these outreach clinics. OGCSHCN hopes to expand the outreach clinic network to include specialties such as mental health, neurology, and behavioral and developmental health in underserved regions of the state. Primary partners are Johns Hopkins Medical Institutions (JHMI) including the Kennedy-Krieger Institute, the University of Maryland Medical Center (UMMC) and Children's National Medical Center (CNMC).

The OGCSHCN has a very close partnership with Parents' Place of Maryland (PPMD), the Maryland Family Voices chapter. PPMD is a broad umbrella organization advocating for families of CSHCN. Together, PPMD and OGCSHCN lead the CoC. This statewide Consortium includes CYSHCN stakeholders from various public and private entities. Government agencies who participate in the CoC include various offices from DHMH, DDA, Medicaid, the DD Council, DHR, MHA, MSDE, several local health departments, and several local Infants and Toddlers programs.

OGCHCN also has representation on numerous interagency councils, task forces, and committees. These include various committees of the Maryland Chapter of the American Academy of Pediatrics, the Advisory Council for Hereditary and Congenital Disorders, the Advisory Council for Hearing Impaired Infants, the State Interagency Coordinating Council for Infants and Toddlers, the Traumatic Brain Injury Advisory Council, the Maryland Dental Action Coalition, the Interagency Transition Council, the Developmental Disabilities Care Givers Support Coordinating Council, and the Maryland Alliance of PKU Families.

Coordination with Medicaid

Both CMCH and OGCSHCN have at least quarterly coordination meetings with key staff in Medicaid. An updated Title V/Title XIX/Title X/WIC cooperative agreement between the Family Health Administration and Medicaid has been approved. The seventeen page document contains eight sections: administration and policy; reimbursement and contract monitoring; data exchange; outreach and referral activities; training and technical assistance; provider capacity; system coordination; and quality assurance. Each of these sections is further organized into sections for primary preventive services and oral health; pregnant women and infants; children with special health care, and family planning. CMCH also has established a formal MOA with Medicaid for collaboration and cost-sharing for the Medicaid Prenatal Risk Assessment which is used by prenatal providers statewide. CMCH and Medicaid recently collaborated on a special project with University of Maryland College Park to develop outreach strategies to increase utilization of family planning and early initiation of prenatal care in Prince George's Co. As previously noted, Medicaid is partner in the Governors infant mortality initiative.

F. Health Systems Capacity Indicators

Introduction

Health capacity indicator data is collected from several sources including Vital Statistics, the Injury and Sexually Transmitted Infections surveillance systems, and State program databases. These data are used to monitor capacity needs that may have either a negative or positive effect on the health of Maryland children. The data are distributed to MCH staff at the State and local levels to assist with program planning and policy development.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	35.4	37.7	37.3	41.4	41.4
Numerator	1303	1409	1412	1575	1575
Denominator	368199	374133	378334	380606	380606
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010

Data Source: HSCRC, 2009; data for 2010 not currently available

Notes - 2009

Data Source: HSCRC, 2009

Narrative:

The State's ability to address asthma from a public health perspective has been influenced by legislation mandating creation of a State Asthma Control Program and CDC funding to support asthma control activities. The Maryland Asthma Control Program (MACP) addresses both pediatric and adult asthma and is administratively housed in CMCH. Maryland has received a CDC asthma grant since 2001 that supports staff salaries (i.e., an asthma epidemiologist, administrator and evaluator) and funds sub-grantees. Title V partially supports the costs of administrative staff, program printing and the purchase of educational materials. A Title V grant to Baltimore supports the City's Childhood Asthma Program.

Surveillance is the cornerstone of the Maryland Asthma Control Program. Analysis includes asthma prevalence, emergency department visit rates, hospitalization rates, mortality rates, health disparity assessment, asthma-related health behaviors, and asthma-related health care costs of self-management activities. The 2008 Maryland Asthma Surveillance Report (most recent report available) indicates that statewide, an estimated 190,000 children have been diagnosed with asthma at some point in their lifetime. This represents 13.6% of children. Between 2007 and 2009 an estimated 10.3% of children ages 0-11 had asthma. Children under the age of 5 had the highest hospitalization rate of any age group at 41.4 hospitalizations per 10,000 population in 2009. Hospitalization rates for all age groups continued to exceed the Healthy People 2020 goal of 18 hospitalizations per 10,000. Hospitalization rates for African Americans in 2009 were three times that of Whites. The emergency department visit rate was four times higher for African Americans as compared to White Marylanders.

MACP continues to work with the Maryland Department of Education, local departments of education and local health departments to implement the Asthma Friendly Schools program.

Thus far, over 40 schools have been designated as an Asthma Friendly School with over 20 more applications pending for school year 2010-2011. In addition, MACP will expand the program to include child care centers and family based programs as designated Asthma Friendly Child Care Centers. In addition, the MSDE is currently developing a Quality Improvement Ratings Scale (QRIS) to provide a framework for Quality Child Care. The MACP is working with MSDE to assure the criteria for AFCC designation will be included in the QRIS. MACP works collaboratively with a variety of stakeholders on the MACP Executive Committee and Maryland Asthma Coalition to ensure the burden of asthma is addressed in all populations and particular focus on disparate populations including children ages 0-4 and the elderly. Research shows that asthma can be effectively managed with medication and quality medical care delivered based on NAEPP guidelines. Reduction in the hospitalization rate is being addressed by provider education, promotion of appropriate medication use, and outreach to disparate populations. Medicaid data on pharmacy claims, provider visits and hospitalization rates will be used to target outreach and education efforts in 2012.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	86.0	87.9	84.1	84.8	85.1
Numerator	30488	32206	31844	31270	31405
Denominator	35450	36639	37842	36864	36888
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

Notes - 2010

Data Source: The Hilltop Institute, Medicaid and Maryland Children's Health Program (MCHP) data, Calendar Year (CY) 2010.

Notes - 2009

Data Source: The Hilltop Institute, Medicaid and Maryland Children's Health Program (MCHP) data, Calendar Year (CY) 2009.

Notes - 2008

Source: Medicaid data for Federal Fiscal Year 2008

Narrative:

Data for this indicator is provided by the Medicaid Program. Increasing percentages of infants enrolled in Medicaid are receiving at least one periodic screen. In calendar year 2010, 85% of the 36,888 infants enrolled received a screen; up from 75% in FFY 1999.

Maryland's EPSDT Program is known as the Healthy Kids Program. The Program's goal is to promote preventive health care services for children to promote early identification and treatment of health problems before they become medically complex and costly to treat. Standards for the Healthy Kids Program are developed in collaboration with the Title V Agency and other key MCH stakeholders such as the Maryland Chapter of the American Academy of Pediatrics, the

University of Maryland Dental School, and the Maryland Department of the Environment. The "Maryland Schedule of Preventive Schedule of Preventive Health Care" closely correlates to the American Academy of Pediatrics' periodicity schedule. Most infants are enrolled in HealthChoice, Medicaid's managed care program which began in 1997. Medicaid recipients enroll in a managed care organization of their choice and select a primary care provider to oversee their medical care. The HealthChoice Evaluation data for 2006 indicates that the percentage of infants (includes those enrolled in both traditional Medicaid and MCHP) receiving a well child visits increased between 2000 and 2003, from 69.2% to 79.4%. Well child visits were defined by Medicaid to include well child visits, EPSDT and preventive services.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	52.6	83.9	85.3	83.8	82.5
Numerator	201	433	1119	804	851
Denominator	382	516	1312	960	1031
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

Notes - 2010

Data Source: The Hilltop Institute, Medicaid and Maryland Children's Health Program (MCHP) data, Calendar Year (CY) 2010.

Notes - 2009

Data Source: The Hilltop Institute, Medicaid and Maryland Children's Health Program (MCHP) data, Calendar Year (CY) 2009.

Notes - 2008

Source: Medicaid data for Federal Fiscal Year 2008.

Narrative:

Maryland's CHIP Program is known as the Maryland Children's Health Program (MCHP). MCHP provides full Medicaid health benefits to children up to age 19, who meet the income guidelines. Children in families with incomes above the qualifying income for Medicaid but below 200% of FPL are eligible for free coverage. Families with incomes between 200 and 300% of poverty pay a small monthly premium. Children enrolled in MCHP are required to participate in the Maryland Health Choice Program and must join a Managed Care Organization (MCO).

In CY 2010, 85.% of the 1,031 infants (less than 1 year of age) enrolled in MCHP received at least one initial periodic screen.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	69.4	69.7	71.5	72.3	72.3
Numerator	53712	54389	55249	54223	54223
Denominator	77430	78057	77268	74999	74999
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010

Derived from 2009 Vital Statistics Administration data; data for 2010 not currently available

Notes - 2009

Derived from 2009 Vital Statistics Administration data

Notes - 2008

Derived from Vital Statistics Administration data, 2008.

Narrative:

Maryland has monitored this indicator since 2000. There has been little change over these years with approximately 70% of Maryland women receiving adequate prenatal care, according to the Kotelchuck Index. There has been a small improvement in each of the last 2 years, with 2009 data (72.3%) showing a 4% improvement from the low of 69.4% reported in 2006. Adequate prenatal care varies by race and ethnicity, from 74.6% for white women, 74.2% for Asian women, 67.7% for black women and 60.6% for Hispanic women. Medicaid status is also a factor, with 78.3% of non-Medicaid women receiving adequate prenatal care compared with 64.1% of women on Medicaid. In 2009, the percentage of Maryland women accessing early prenatal care increased slightly to 80.2%.

In FY 2010, Babies Born Healthy Initiative programs continued to focus on prevention services, quality improvement, and data systems development. A state-of-the-art web-based electronic birth certificate was implemented in January 2010, and will allow timelier and more complete reporting of data, including the timing of prenatal care. The MCH program continues to strengthening provider capacity and expertise with high-risk obstetric consultation via telemedicine and on-site services through a partnership (the MD Advanced Perinatal Support Services [MAPSS]) with the State's two academic medical institutions. Perinatal and Neonatal Learning Networks continue to advance patient safety for mothers and infants in Maryland hospitals in FY 2010. The Morbidity, Mortality, and Quality Review Committee was convened to review statewide outcomes related to pregnancy, childbirth, infancy and early childhood. Plans were begun for site visits to all level I and II hospitals in the State to monitor compliance with the Maryland Perinatal System Standards.

In FY 2010, CMCH continued work with the Governor's Delivery Unit (GDU) to achieve the Governor's Strategic Goal of reducing infant mortality in Maryland by 10% by 2012. The GDU Plan builds on the Babies Born Healthy Initiative by expanding prevention services, improving infrastructure, and building new models and systems of care. Initially, 3 jurisdictions (Baltimore City, Prince George's and Somerset Counties) with high infant mortality rates and racial disparities have been targeted. Programs and strategies focus on the three critical periods: before, during, and following pregnancy. One specific goal is earlier entry into prenatal care. Maryland Medicaid has implemented an Accelerated Certification of Eligibility (ACE) process, providing coverage for pregnant women beginning within 48 hours of an abbreviated application

process and continuing up to 90 days while a full Medicaid application is completed. The three target local health departments are implementing "Quickstart" prenatal care services, with expanded screening and referral services, and deployment of community outreach workers, with a goal of risk-appropriate early prenatal care.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	80.7	83.6	83.8	87.1	87.2
Numerator	324114	317571	333454	367410	413258
Denominator	401816	379937	397848	421616	474138
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

Notes - 2010

Data Source: The Hilltop Institute, Medicaid and Maryland Children's Health Program (MCHP) data, Calendar Year (CY) 2010.

Notes - 2009

Data Source: The Hilltop Institute, Medicaid and Maryland Children's Health Program (MCHP) data, Calendar Year (CY) 2009.

Please Note: Data is for Children Age 1-20 Years receiving a service paid by the Medicaid Program.

Notes - 2008

Source: Medicaid data for Federal Fiscal Year 2008.

Narrative:

Medicaid provides health care coverage for Maryland's poorest and most vulnerable children. Maryland has generous eligibility standards; children in families with incomes up to 300% of the federal poverty level (FPL) are eligible for full Medicaid benefits. During CY 2010, more than 400,000 eligible children and teens ages 0-19 were enrolled in Medicaid. This excludes children enrolled in the State's CHIP program, which is also administered by the Maryland Medicaid Program. Children up to age 19 in families with incomes between 200-300% FPL must pay a monthly premium (~2% of income). The premium is per family per month, regardless of the number of children covered.

The majority of Medicaid and CHIP enrolled children are required to participate in HealthChoice, Maryland's statewide mandatory managed care program. Recipients enroll in a managed care organization (MCO) of their choice and select a primary care provider to oversee their medical care. All children under age 21 are entitled to comprehensive services including EPSDT and dental services. The majority of services are part of the MCO benefit package. Some specialty

services such as OT, PT, and speech therapies are paid directly to the provider by the Medicaid program. As of 7/1/2009, dental services are no longer paid by the MCO. Medicaid now contracts with an ASO to administer the Maryland Healthy Smiles Program.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	51.6	46.7	50.7	58.8	63.6
Numerator	32065	44600	52569	64594	73745
Denominator	62166	95464	103645	109845	115992
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

Notes - 2010

Data Source: The Hilltop Institute, Medicaid and Maryland Children's Health Program (MCHP) data, Calendar Year (CY) 2010.

Notes - 2009

Data Source: The Hilltop Institute, Medicaid and Maryland Children's Health Program (MCHP) data, Calendar Year (CY) 2009.

Notes - 2008

Source: Medicaid data for Federal Fiscal Year 2008.

Narrative:

EPSDT mandates that children under than 21 have dental benefits and access to comprehensive oral health care. Maryland's dental utilization rate has been historically low. Before Maryland implemented the HealthChoice Medicaid managed care program in 1997, only 14 percent of Maryland children enrolled in Medicaid for any period of time received at least one dental service, below the national average of 21 percent. From 1997 through June 2009, Medicaid children received dental services through their MCO. Maryland used a modified HEDIS measure (number of children 4-20 who were enrolled at least 320 days) to assess the performance of the MCOs. Under managed care, Maryland's utilization of dental services improved significantly; the rates increased 180 percent from 19.9 percent in 1997 to 66.3 percent in 2010.

In June 2007, in an effort to further increase access to oral health care and service utilization, a Dental Action Committee (DAC), was convened. The DAC was comprised of a broad-based group of stakeholders concerned about children's access to oral health services. Key recommendations from the report included increased reimbursement for Medicaid dental services and the institution of a single dental ASO. The reforms recommended by the DAC have been supported and, to a great degree, instituted by DHMH to effectively address the barriers to dental care access previously experienced in the State. Dental provider rates were increased in 2008. Based on the recommendation of the DAC, effective July 1, 2009, all dental services for all Medicaid children are now provided through the state's contracted ASO, DentaQuest, which administers the Maryland Healthy Smiles program. Since the ASO began administering the

program the number of participating dental providers has increased. DentaQuest is also performing outreach and education to parents to increase the number of children who receive routine preventive care as well as follow up for any needed restorative care.

Expanded access to dental care also has been achieved through initiatives of the Office of Oral Health. As of July 1, 2009, Medicaid began reimbursing EPSDT-certified medical providers (pediatricians, family physicians, and nurse practitioners) for fluoride varnish treatment and oral assessment services provided to children between 9 and 36 months of age. The providers must first complete an Office of Oral Health training program. MCH continues to work closely with Medicaid and the Maryland Dental Action Coalition to make access to dental care and ultimately a dental home a reality for all Maryland children.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	15275	13246	13575	13856	14342
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.			Yes	Yes	
Is the Data Provisional or Final?				Final	Final

Notes - 2010

This annual indicator is zero. The OGCSHCN is currently only able to track this data in the Children's Medical Services Program. The average number of SSI recipients receiving rehabilitative services from the CSHCN program has been less than 5 for many years. Denominator data is the number of Maryland SSI beneficiaries under 16 years of age as of December 2010 (Social Security Administration.)

Notes - 2009

This annual indicator is zero. The OGCSHCN is currently only able to track this data in the Children's Medical Services Program. The average number of SSI recipients receiving rehabilitative services from the CSHCN program has been less than 5 for many years. (It is actually 3 for FY 2009.) Denominator data is the number of Maryland SSI beneficiaries under 16 years of age as of December 2009 (Social Security Administration.) obtained from the Health and Ready to work web-site.

Notes - 2008

This annual indicator is in fact zero. The Children's Medical Services Program (CMS) does not pay for care for SSI/ MA eligible children if the needed service is covered by Medicaid.

CMS will pay for needed specialty care services that are not provided by Medicaid.

The OGCSHCN is currently only able to track this data in the Children's Medical Services Program (CMS) and only two SSI beneficiaries less than 16 years of age are on the CMS eligibility list , both received services from CMS in 2007 but neither received services from CMS in 2008.

Denominator data is the number of Maryland SSI beneficiaries under 16 years of age as of December 2008 from the Social Security Administration.

Narrative:
HSCI#8

The OGCSHCN is currently only able to track this data in the Children's Medical Services Program (CMS). The average number of SSI recipients receiving rehabilitative services from the CSHCN program has been less than 5 for many years. Denominator data is the number of Maryland SSI beneficiaries under 16 years of age as of December 2010 (Social Security Administration).

This HSCI, as far as the CMS data can be interpreted, had already been met.

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2009	payment source from birth certificate	10.8	8.2	9.2

Notes - 2012

Source: Maryland Vital Statistics Administration, 2009 births

Narrative:

Prematurity and low-birth weight are the leading causes of infant deaths in Maryland. Risk factors for prematurity or low birth weight include medical conditions and complications as well as behavioral/social factors such as maternal smoking, maternal weight gain and late entry into prenatal care. In 2009, 90% of very low birth weight infants born in Maryland were delivered at high-risk facilities.

In 2009, over 9% of all Maryland babies were born at low birth weights (less than 2,500 grams). Maryland has much work to do to reach the Healthy People 2010 goals for low birth weight (5%) and very low birth weight (0.9%).

Maryland's low birth weight rate has consistently been higher than the national average (9.3% for MD in 2008 and 8.2% for U.S. in 2007). The percentage of infants born at low birth weight in Maryland fluctuated over the last 10 years, from a low of 8.7% in 2000 to highs in 2004 and 2006 of 9.4%.

The low birth weight rates for Blacks in 2009 were substantially higher than that of other racial and ethnic groups. Black babies (13.2%) were more likely than Asian (8.1%), White (7.2%), and Hispanic (7.1%) babies to be born at low birth weights. Six jurisdictions had low birth weight rates considerably above the statewide average of 9.3% in 2008: Baltimore City (12.8%), Dorchester (12.2%), Somerset (10.8%), Garrett (10.8%), Prince George's (10.6%), and Allegany (10.3%) counties. Medicaid births as compared to non-Medicaid births were more likely to be classified as low birth weight in 2009.

The Title V Agency works with local health departments, the March of Dimes, state medical

associations, advocacy groups, hospitals and community based organizations to improve women's preconception health and reduce adverse birth outcomes such as low birth weight.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2009	matching data files	8	6.4	6.7

Notes - 2012

Source: Maryland Vital Statistics Administration, 2009 deaths

Narrative:

Data for this indicator is derived from linked birth and infant death records for 2009. As was true in previous years, the data indicate that Medicaid enrolled women as compared to women with other types of insurance are significantly more likely to have a baby die within the first year of life.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2009	payment source from birth certificate	68.7	89	80.2

Notes - 2012

Source: Maryland Vital Statistics Administration, 2009

Narrative:

Data for this indicator is derived from birth records for 2009. As was true in previous years, the data indicate that Medicaid enrolled women as compared to women with other types of insurance are significantly less likely to receive early prenatal care. Early prenatal care rates have continued to decline for both Medicaid and non-Medicaid women over the past decade. National performance measure #18 discusses state activities directed at improving this situation.

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2009	payment source from birth certificate	64.1	78.3	72.3

Notes - 2012

Source: Maryland Vital Statistics Administration, 2009

Narrative:

Maryland recently began to analyze the data to be able to monitor progress on this indicator. The data show that 72% of Maryland moms are receiving adequate prenatal care according to the Kotelchuck Index. Early prenatal care in Maryland has been declining for the past several years which is a cause of concern for the Title V Program. The slight increase is promising.

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

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2010	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2010	300

Notes - 2012

Kaiser Family Foundation, State Health Facts, Maryland Medicaid, 2010

Notes - 2012

Kaiser Family Foundation, State Health Facts, Maryland Medicaid, 2010

Narrative:

Maryland Medicaid covers infants in families with incomes up to and including 185% of the Federal Poverty Level. The MCHP program covers infants in families with incomes between 185 and 300% of the poverty level.

CMCH supports and participates in many programs to address the needs of this age group. Patient safety for mothers and infants in MD hospitals is enhanced through a Perinatal Collaborative, and a newly formed Neonatal Collaborative, in partnership with the MD Patient

Safety Center. Standards for obstetric and neonatal care in MD hospitals were updated in 2008. High-risk obstetric services are provided by the MD Advanced Perinatal Support Services (MAPSS), a statewide program of telemedicine and on-site consultation provided by the State's academic medical centers. The Office for Genetics and Children with Special Health Care Needs also supports programs for children with metabolic diseases, hemoglobinopathies and birth defects.

Other programs include the MD Asthma Control Program; MD Asthma Coalition; Teen Pregnancy Prevention; Lead Poisoning Prevention Commission; Fetal Alcohol Spectrum Disorders Coalition; Fetal and Infant Mortality Review; Child Fatality Review; Maternal Mortality Review; and a legislatively mandated Morbidity, Mortality and Quality Review Committee to review statewide outcomes related to pregnancy, childbirth, infancy and early childhood that will convene in early FY 2010.

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

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2010	133 100
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2010	300

Notes - 2012

Kaiser Family Foundation, State Health Facts, Maryland Medicaid, 2010

Notes - 2012

Kaiser Family Foundation, State Health Facts, Maryland Medicaid, 2010

Narrative:

Medicaid eligibility coverage for young children extends to families with incomes up to 133% of the federal poverty level (FPL). Coverage for older children extends to families with incomes up to 116% of the poverty level. Maryland's MCHP Program extends coverage for children in families with incomes up to 300% of the poverty level.

Maryland's MCHP Program is one the richest in the nation in terms of the types of services covered as well as income eligibility. Assets are not considered in determining eligibility. It is a Medicaid expansion program and CHIP children receive the same benefits as children who are eligible for Medicaid.

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

INDICATOR #06 The percent of poverty level for eligibility in the State's	YEAR	PERCENT OF POVERTY LEVEL
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Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.		Medicaid
Pregnant Women	2010	250
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women	2010	

Notes - 2012

Kaiser Family Foundation, State Health Facts, Maryland Medicaid, 2010

Notes - 2012

Kaiser Family Foundation, State Health Facts, Maryland Medicaid, 2010

Narrative:

Maryland Medicaid provides coverage for pregnant women with income levels up to 250% of the Federal Poverty level. In Maryland, pregnant women are not covered by MCHP. In 2010, there were 37,204 pregnant women enrolled in Medicaid.

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

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

least every two years (like PRAMS)		
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Notes - 2012

Narrative:

The MCH Program has access to timely population based and program data from several sources. Maryland has established and is working on improving routine access to four of the eight linked data sets and surveys identified in Title V Block Grant Health Systems Capacity Indicators #9(A) and (B): 1) the annual linked birth-death certificate database, 2) a linked birth and newborn screening file; 3) birth defects surveillance system, 4) the hospital discharge database, 5) the Pregnancy Risk Assessment Monitoring System (PRAMS), 6) the Youth Risk Behavior Surveillance System (YRBS), 7) linked birth and Medicaid files, and 8) linked birth and WIC files. Analyses and reports generated from these databases have been used to conduct surveillance, develop MCH reports and enhance MCH program and policy development. In addition, the MCH Program has been working with Medicaid to gain direct access to a Medicaid database, on an as-needed basis. This connection is being utilized to link Healthy Kids data with information from the Medicaid managed care enrollee database for a study on childhood obesity.

Maryland became a PRAMS state in 1999 and released its first PRAMS Report covering 2001 births in April 2004. PRAMS reports for the 2002-2005 birth cohorts have been completed. PRAMS data will be used to track and monitor several state and national performance measures including unintended pregnancy and breastfeeding; and to conduct in-depth analyses to guide planning for perinatal systems building.

Since the mid-1990's, Maryland's SSDI Project has focused on improving epidemiologic and data capacity at the State level; strengthening the State's ability to assess annual targets for Title V performance measures; and improving State and local capacity to assess and prioritize needs, develop annual plans, and monitor program performance.

Maryland continues to negotiate with WIC and the Vital Statistics Administration to obtain electronic access to files relevant to MCH data analysis and needs assessment.

The Title V progress has direct access linked infant birth and death certificates.

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

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

Notes - 2012

Narrative:

Maryland used funds received from the tobacco settlement to establish the legislatively mandated Tobacco Use Prevention and Cessation Program. The Program was required to collect baseline data on tobacco use habits among youth (middle and high school students) and adults at the state and local levels. These surveys were to be repeated at least every other year for use in monitoring achievement of program goals. Baseline data for the Maryland Youth Tobacco Survey was collected in the fall of 2000. A second survey was completed in the fall of 2002. A third

survey was completed in 2006. The results of the three surveys were summarized in a 2007 report, which clearly showed a steady decline in the rate of smoking initiation among underage youth across this time period. The surveys show that tobacco use by youth attending public high schools declined from 23% in 2000 to 14.7% in 2006.

Maryland became a YRBS state in 2004. Students completed the first survey in April 2005. The survey was conducted again in 2007, and 2009. For 2009, 18% of high school students taking the YRBS survey reported using some kind of tobacco product on at least one day during the previous 30 days. Nationally the prevalence was much higher at 26%.

IV. Priorities, Performance and Program Activities

A. Background and Overview

This section describes Maryland's progress on required national and state performance measures and documents accomplishments in 2010, current activities and the State's plan for FY 2012. In many cases, the most current available data is for calendar (CY) or state fiscal year (FY) 2008. Therefore, for many performance measures, we were unable to report on progress for FY 2010. In several instances, the data for the year 2010 will not be available until the fall of 2011 or later. As this data becomes available, it will be incorporated into subsequent applications.

In FY 2010, Maryland's Title V Program served approximately 402,030 pregnant women, infants, children, and women of childbearing age. As this report will show, Maryland was able to meet or surpass many of its target objectives for 33 performance and outcome measures. This year, Maryland found the following improvements:

- . Overall, infant mortality declined to a low of 7.2 per infant deaths per 1,000 live births in 2009.
- . The teen birth rate continued to decline.
- . More pregnant women are receiving prenatal care services within the first trimester of pregnancy and more women are receiving quality prenatal care services as measured by the Kotelchuck Index.
- . More children enrolled in the State's Medicaid Program are receiving dental services.
- . The rate of child deaths due to motor vehicle accidents is declining.

Challenges include:

- . Increasing racial disparities in infant mortality rates with African American babies now dying at three times the rate of White infants.
- . Increasing rates of hospitalizations among children ages 0-4 with asthma.
- . Increasing numbers of Chlamydia cases among teens.

Maryland's MCH Program seeks to improve and enhance the health of all Maryland women, infants, and children including those with special health care needs through funding of Title V and state supported activities and programs. The Program's vision includes a State in which: all pregnancies are planned, all babies are born healthy, all children including those with special needs reach an optimal level of health, and all women and children have access to quality health care services. Title V activities discussed in this document are designed to reflect this vision.

Activities and services are delivered at each level of the MCH pyramid and directed at each of the Title V population groups: pregnant women and infants, children and adolescents, and children with special health care needs. Reducing infant and child mortality and improving health outcomes are program priorities as described in the next section. All activities and programs are linked to these outcome measures.

B. State Priorities

The State's Title V MCH priorities have not changed since submission of the 2010 MCH needs assessment.

Maryland's priority MCH needs for 2011-2015 remain as:

#1. Women's Wellness: Improve the health and wellness of women during the childbearing years (ages 15-44) to ensure that women are healthy at the time of conception.

Women's wellness or the health of women prior to conception was recognized as an important MCH need by respondents to the MCH Stakeholder Survey and during both rankings at the

March Stakeholder meeting. Women's wellness is a broadly focused issue and Title V staff agreed to narrow the focus for purposes of the needs assessment to address reducing unintended pregnancy through provision of family planning services. Maryland is also moving toward enhancing family planning clinical services to include a comprehensive set of women's wellness services not specifically related to or required for contraception or contraceptive management. These include screening and/or services related to chronic disease, nutrition, overweight/obesity, smoking cessation, mental health, substance abuse, domestic violence, preconception planning, or assisting with access to health insurance or primary care. The provision of family planning services also serve as primary prevention strategy for reducing poor birth outcomes. The proposed State Negotiated Performance Measure: Percentage of Maryland mothers with intended pregnancies: 56.6% in 2008 (PRAMS) (also chosen as a priority measure in 2005).

2: Healthy Pregnancy, Pregnancy Outcomes and Infants: Promote healthy pregnancies, pregnancy outcomes and infants by reducing risky behaviors (e.g., substance abuse) and improving access to prenatal care.

Reducing infant mortality and related risk factors is a public health priority in Maryland. Significant progress toward reducing infant mortality and improving birth outcomes in Maryland that had been achieved during the 1990's has now stalled, with little improvement made for nearly a decade. Governor O'Malley has identified a 10% reduction in infant mortality in Maryland by 2012 as one of his top policy goals. MCH stakeholders noted that healthy pregnancies and pregnancy outcomes are more likely to occur when mothers are healthy at conception; receive adequate, quality prenatal care; have adequate social and emotional supports; and avoid risky behaviors such as smoking and alcohol and drug use. PRAMS data show that 8% of Maryland women drank in their third trimester of pregnancy. This was viewed as unacceptable by Title V staff and stakeholders and once again, it was decided that additional outreach and education to both women and health care providers is needed. Therefore, the proposed state performance measure remains as: Percentage of women who use alcohol during the last three months of pregnancy (Data source: MD PRAMS Survey)

#3. Healthy Children: Promote early and middle childhood health, healthy child development and parent-child connectedness by increasing access to evidence based home visiting programs

Healthy children require healthy families and/or family support systems, quality early education, safe and nurturing home and learning environments, and access to quality preventive and primary health care. For many Maryland children and families, these requirements have been fully or at least partially met. For others, many challenges exist.

- . An estimated one in ten Maryland children ages 0-18 lived in households with incomes below the poverty level in 2008. More than 8,000 Maryland children lived in foster care homes at some point in 2009.
- . In 2009, there were 31,206 investigations of child abuse and neglect conducted in Maryland. In 20% of the cases (6,312), the findings were substantiated.
- . One in five pregnant women do not receive prenatal care within the first trimester in 2008.
- . According to the 2007 National Survey of Children's Health, 41.4% of Maryland children ages 0-17 do not meet the AAP criteria for having a medical home and 6% do not have a usual place for sick and well care.
- . Approximately 244,000 Maryland children have special health care needs.

Similar to findings from the 2005 needs assessment, Title V heard about the need to support and strengthen families to assure that children remain healthy and thrive. This need for support is cross-cutting and required for all Maryland families, especially socio-economically disadvantaged families. However, the Title V Program also recognizes that families with young children are especially vulnerable and in need of services that enhance their ability to address their health needs, meet their developmental needs, and support school readiness.

Over the next five years, the Title V Program will promote healthy children by improving access to home visiting programs in areas of greatest risk. The availability of new federal funding provides the state with an opportunity to expand access to evidence based home visiting programs. Improving access to these home visiting programs was identified by stakeholders as a priority primary prevention strategy for poor birth and child health outcomes. The proposed State Performance Measure is the Number of children enrolled in evidence based home visiting programs in Maryland (Data Source: Maryland Title V Program Data).

#4. Access to Health Care for Children: Improve access to preventive, primary, specialty, mental health and oral health care as well as health insurance coverage for all children including those with asthma and other special health care needs

Both data examined for the 2010 population based assessment and comments made by MCH stakeholders through surveys and key informant interviews continually spoke of the need to improve access to health care -- preventive, primary, specialty, mental health, oral health -- for children and adolescents, particularly those that are low-income and/or uninsured children. Major issues identified include the following the shortages and maldistribution of health manpower, language barriers, transportation, and difficulties, and provider unwillingness to accept Medical Assistance.

These data also continued to reveal unacceptable levels of morbidity and mortality among children in the early and middle childhood periods. Areas of continuing concern included asthma, overweight and obesity, dental caries, and mental health/behavioral problems. This priority was selected to ensure continued focus on improving the health of children in the early and middle years. For example, asthma currently affects approximately 123,000 Maryland children ages 0-17 and is the leading cause of hospitalization for children in the elementary and middle school years as well as leading reason for school absenteeism. Asthma is a controllable disease when properly managed. The use of hospital emergency departments for routine asthma management can be an indicator of poor asthma management. The Maryland Asthma Control Program which is administratively housed in the Center for Maternal and Child Health is implementing a statewide plan to reduce mortality and morbidity from asthma by promoting educational and other to improve asthma management. The use of the hospital emergency department for asthma control will continue to be used as the state performance measure for this priority. Proposed State Negotiated Performance Measure: Rate of emergency department visits for asthma per 10,000 children, ages 0-4: 184 in 2007. This compares unfavorably to the Healthy People 2010 goal of 80.

5. Reduce Childhood Obesity: Promote needed actions to reduce overweight and obesity among children and adolescents

Childhood overweight/obesity was identified as a priority issue both in the 2005 and 2010 MCH needs assessment. Since the 2005 needs assessment when reducing overweight and obesity across all age groups was identified as a priority, adult and early childhood obesity rates have continued to rise in Maryland. The White House Task Force on Childhood Obesity, in its May 2010 report to President Obama, called the childhood obesity epidemic in America a national health crisis. Nationally, almost one in every three children (31.7%) ages 2-19 is overweight or obese. The 2007 National Survey of Children's Health estimates that more than one in four Maryland children ages 10-17 are overweight or obese.

Rising rates of childhood overweight and obesity were repeatedly identified as a concern in stakeholder surveys and discussions. Because obesity is continuing to increase, is a leading cause of premature death, and remains a significant risk factor for several chronic conditions including type 2 diabetes, heart disease, cancer and asthma, Title V staff strongly believed that this issue should remain a priority focus area. The proposed State Negotiated Performance

Measure: Percent of Maryland Medicaid recipients ages 2-19 years that are obese. (Data Source: Maryland Healthy Kids Obesity Database).

#6: Healthy and Productive Youth and Young Adults -- Transition to Adulthood: Improve supports for the successful transition of all youth to adulthood.

Youth transition to adulthood is one of the six core outcomes identified by the federal Maternal and Child Health Bureau for children and youth with special health care needs (YSHCN). Both quantitative and qualitative data collected for Maryland's 2010 needs assessment indicate that Maryland is struggling to ensure that all YSHCN receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. According to the 2005-06 National Survey of Children with Special Health Care Needs (NS-CSHCN), Maryland ranked 42nd in the nation on achieving this core outcome; less than 38% of Maryland families of YSHCN ages 12-17 reported that their child received the services necessary to make appropriate transitions to adult life. Maryland scored below the national average on many other of the 2005-06 NS-CSHCN transition indicators.

Participation in transition planning is an important step for families and YSHCN, and increasing the proportion of parents of YSHCN who report engaging in transition planning from pediatric to adult health care has been identified as a Healthy People 2020 objective. According to the 2008 Maryland Community of Care Consortium for CSHCN 2008 Summit Youth Transition Workgroup, Maryland has multiple activities in the state focused on improving this core outcome, but these attempts seem fractured and do not appear to have a common end goal. The state lacks a clearly defined, comprehensive, coordinated system of care to facilitate success in transitioning YSHCN from pediatric to adult-based health care. The issue is compounded by the problem of youth in this age group accessing their own health insurance. Maryland plans to address these barriers by focusing on training families on the transition process as well as by identifying opportunities for collaboration among agencies and organizations working on youth transition issues in the state. The proposed State Negotiated Performance Measure: The percent of YSHCN families who participate in transition planning for their child: 48% in 2009 (Source: Maryland Parent Survey.)

#7: Strategic Partnerships: Sustain, Strengthen and Maximize Strategic Partnerships through the Community of Care Consortium to address CSHCN core outcomes in Maryland

Supporting the development and implementation of comprehensive, culturally competent, coordinated systems of care for CSHCN has been identified as a critical objective for states by the federal Maternal and Child Health Bureau. State Title V programs have been asked to work with family advocates, providers, and other partners to achieve success on the six core outcomes for CSHCN. In 2008, the Parents' Place of Maryland (PPMD) was awarded a federal "State Implementation Grant for Integrated Community Systems for Children and Youth with Special Health Care Needs" in partnership with the State's Title V program for CSHCN (the Office for Genetics and Children with Special Health Care Needs, or OGCSHCN), the Maryland Chapter of the American Academy of Pediatrics, and the Women's and Children's Health Policy Center at the Johns Hopkins Bloomberg School of Public Health. Through the grant and partnerships, PPMD developed the Maryland Community of Care Consortium for CSHCN (or CoC). Since its inception in the fall of 2008, the CoC Consortium has created a broad alliance of diverse stakeholders in collaborative efforts to improve systems of care for Maryland CSHCN and their families. They oversee and spread the use of evidence-based and best practice strategies both at the state and local levels, using mini-grants to support implementation. Much of the Consortium's work is aligned with the Healthy People 2020 objective to increase the proportion of CSHCN who receive their care in family-centered, comprehensive, coordinated systems.

At a needs assessment stakeholder meeting in March, key Title V CSHCN staff and parent advocates, working together as a group, identified ongoing stakeholder partnerships as the primary method through which several core outcomes for CSHCN in Maryland should be

addressed. Earlier in the meeting, a broad collection of stakeholders from across Maryland had selected those core outcomes as top priority needs for the CSHCN population in the state, including medical home, that families receive needed services through easy-to-use, community-based systems of care, and adequate health insurance and financing. Stakeholders agreed that the improvement of CYSHCN outcomes requires a system-oriented, partnership-based approach that incorporates infrastructure, population-based services, enabling services, and direct services. Stakeholders also concurred that the role of the Consortium is essential to the health of Maryland's Title V program, as the state's CSHCN program office has suffered unprecedented personnel erosion and remains understaffed to the point where fulfilling Title V obligations to Maryland's CYSHCN is virtually impossible without the support and leadership of the Consortium. The proposed State Negotiated Performance Measure: Percent of CoC members who report five or more collaborative activities in the previous 12 months; 51.8% in 2008 (Source: Maryland Community of Care Partnership Profile).

#8: Data Systems and Sharing: Improve state and local capacity to collect, analyze, share, translate and disseminate MCH data and evaluate programs

Consistent state level data that indicate the well-being of Maryland's CYSHCN population are crucial to measuring the state's progress on the six core outcomes for this population. However, availability of these data are limited due to agency silo issues and fragmentation among government and non-government agencies and organizations serving the CYSHCN population in Maryland. The data most commonly used to measure Maryland's performance around the six core outcomes are national data from two surveys, the National Survey of Children's Health (NSCH) and the National Survey of Children with Special Health Care Needs (NS-CSHCN). While these surveys provide valuable information every five years and allow state-to-state and state-to-nation comparisons of critical data points and outcomes, they do not provide yearly, statewide, or jurisdiction level data that would help Maryland target resources within the state to improve outcomes for CYSHCN. At a needs assessment stakeholder meeting in March, key Title V CSHCN staff and parent advocates, working together as a group, identified the lack of data sharing among agencies as one of the most significant barriers. The need for data sharing and integration in support of MCH populations is recognized in the Healthy People 2010 developmental objective HP2010 23-2: Increase the proportion of Federal, Tribal, State, and local health agencies that have made information available for internal and external public use in the past year based on health indicators related to Healthy People 2010 objectives. The proposed State Negotiated Performance Measure: % of performance measure benchmarks Maryland has reached toward implementing a Data Sharing plan. and direct services.

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	2006	2007	2008	2009	2010
Annual Performance Objective	95	95	95	99	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	170	182	199	199	120
Denominator	170	182	199	199	120
Data Source			NBS	NBS data	National

			databases (NSS, NEST, StarLIMS, Pediatrix	bases (StarLIMS and Sickle)	Newborn Screening Information 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?				Final	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	100	100	100	100	100

Notes - 2010

This year's data comes from the National Newborn Screening & Genetics Resource Center's National Newborn Screening Information System. According to Maryland Labs Administration, this data does not reflect suspected cases of hemoglobin disorders, as those take at least one year to diagnose and would not yet be reported by the program. Suspected cases of hemoglobin disorders totaled 70 for CY2010.

Notes - 2009

Newborn screening data is reported by calendar year, CY 2009, to be consistent with the reports to the National Newborn Screening and Genetics Resource Center (NNSGRC).

A new performance measure is formulated as control of newborn screening laboratory testing was returned to the State. HB 216 (2008) gave the State Public Health Laboratory the sole authority to perform first tier newborn screening tests for Maryland babies. The bill went into effect 01/01/2009. 2008 data was fragmented -being collected from 4 different databases in 2 different labs. 2009 data was gathered from only 2 databases.

While we would like to maintain our record of treating 100% of confirmed cases, we are aware that a single case lost to follow up would significantly decrease our performance. It seems unrealistic to believe that a case could never be lost to follow up- although we are very tenacious.

Notes - 2008

Newborn screening data is reported by calendar year, CY 2008, to be consistent with the reports to the National Newborn Screening and Genetics Resource Center (NNSGRC).

A new performance measure is formulated as control of newborn screening laboratory testing was returned to the State. HB 216 (2008) gave the State Public Health Laboratory the sole authority to perform first tier newborn screening tests for Maryland babies. The bill went into effect 01/01/2009- so 2008 data is still fragmented -being collected from 4 different databases in 2 different labs. However, data will be better in the coming year being gathered from only 2 databases.

While we would like to maintain our record of treating 100% of confirmed cases, we are aware that a single case lost to follow up would significantly decrease our performance. It seems unrealistic to believe that a case could never be lost to follow up- although we are very tenacious.

The number of confirmed cases includes 103 sickling disorders but only 39 of them have "gold standard" confirmation. Only these 39 were reported to the NNSGRC. The remaining 64 have 2 abnormal NBS specimens but no electrophoresis done at over 3 months of age and no DNA.

a. Last Year's Accomplishments

Newborn screening (NBS) data is reported by calendar year, CY 2010, to be consistent with the reports to the National Newborn Screening and Genetics Resource Center.

Maryland screens for all the disorders recommended by the ACMG, the AAP and the March of Dimes including the secondary targets, except for Severe Combined Immune Deficiency (SCID) which was recently added to the recommendations. The lab will be moving to a new building in 2013 and will be able to build the required lab for DNA testing and plans to start SCID screening as soon as possible thereafter.

Legislation advocating mandatory newborn screening was defeated. Maryland families seldom refuse NBS. The Advisory Council on Hereditary and Congenital Disorders (ACHCD) (with expert medical, DHMH, consumers, families, and legislative representation) voted to move from informed consent to the informed dissent model used by most other states. Current regulations allow either approach.

The ACHCD studied the issue of storage and use of left over blood spots. A comprehensive policy was drafted and was under discussion.

The follow up of babies with abnormal SCD newborn screening results referred to Childrens' National Medical Center suffered when new legal personnel became concerned that reporting the results of the definitive diagnostic work up back to the NBS program might violate HIPAA. Maryland laws mandating reporting back to the NBS program and charging the DHMH with monitoring the baby's health don't apply across state lines. A Data Sharing Agreement was drafted and approved by the Maryland Attorney General and CNMC signed it.

OGCSHCN houses Maryland's Birth Defects Reporting and Information System (BDRIS.) BDRIS is a population-based birth defects reporting registry which collects birth data from birth hospitals and birthing centers throughout Maryland. The mission of BDRIS is to work collaboratively with the reporting institutions to confidentially identify and track all birth defect patterns and trends in specific geographical locations. The reported data is used for the evaluation and monitoring of such trends and to provide referral assistance to those families affected by a birth defect. In addition, the data is used to expand knowledge, raise awareness, and educate health care providers, and the community in identifying the potential causes and prevention of birth defects. In 2008, Maryland state legislation (Health Article-General Section 18-206: Annotated Code of Maryland) revised the number and type of birth defects to be reported to the state for infant and family follow-up through the BDRIS program. Prior to 2008, only the 12 sentinel birth defects recognized by the World Health Organization were reported in Maryland; the new legislation changed this to require reporting and follow up on all birth defects. Once a hospital reports a birth defect, the BDRIS program follows up with families of live infants identified with a birth defect to provide parent education and information and resources on condition-specific services. In FY2010, the BDRIS follow up program chief retired, leaving the position vacant. A data manager was hired for the BDRIS program.

The NBS program follow up works with each child's primary care provider (PCP) and family and makes every effort to find a primary care provider who can provide care in a medical home for each child with a confirmed diagnosis. The unit continues to work with the State genetics / tertiary care centers to provide diagnostic evaluations. The unit also works with the metabolic genetics, endocrine, hematology and CF centers to assure ongoing care for confirmed cases. In FY 2010, the OGCSHCN provided long-term follow-up services including case management, nutritional management, counseling, health education, and family support to families with confirmed metabolic disorders and children with sickle cell disease. The genetics centers served over 7,000

individuals and provided over 9,965 laboratory services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support newborn screening for all the disorders recommended by the March of Dimes, the AAP and the ACMG for all Maryland babies.	X		X	X
2. Support the BDRIS staff.		X	X	X
3. Provide short term follow up assuring that all abnormal or inadequate test results are followed to resolution (Labs Administration.)		X	X	
4. Support the Advisory Council on Hereditary and Congenital Disorders to continue to refine lab testing and follow up protocols.				X
5. Support the State's designated metabolic, endocrine, hematology and CF centers through small grants.	X	X		X
6. Provide metabolic nutritionists from the OGCSHCN to provide case management and nutritional therapy.	X	X		
7. Provide follow-up for sickle cell disease patients through the 6th birthday and continue to develop resources for transition and care for them as adults.	X	X		
8. Continue to educate providers and parents.	X	X	X	X
9.				
10.				

b. Current Activities

OGCSHCN is phasing out its direct care coordination for metabolic nutrition services and is redirecting patients to appropriate genetic centers (supported by OGCSHCN) for care coordination. This has resulted in the elimination of one OGCSHCN nutritionist position and a shift in job duties for a second OGCSHCN nutritionist. The second nutritionist provided .50 FTE during FY2011 for metabolic nutrition care coordination to ensure a smooth transition for patients to the genetic centers.

In the BDRIS program, a new program chief was hired and additional administrative OGCSHCN staff was reassigned to the program to assist BDRIS in meeting its legislative mandates. These additional resources have made it possible for the program to meet a state mandate that all parents of children identified with a birth defect receive education and information about services and resources. For the first time in several years, the program is now in compliance with state regulations

In the 2011 Maryland legislative session, the legislature passed SB 786 Newborn Screening-Critical Congenital Heart Disease, which establishes an expert panel through the state Advisory Council on Hereditary and Congenital Disorders, to examine the impact of mandating critical congenital heart disease screening for newborns in Maryland. The Council will develop recommendations on the feasibility of implementing mandated screening of this type.

c. Plan for the Coming Year

In the coming year, OGCSHCN will continue to partner with the Labs Administration in administering certain aspects of the NBS program.

OGCSHCN will also continue to streamline and improve follow up programs including SCD and BDRIS. The SCD long-term follow up program was reorganized during FY2011. The yearly physicians annual report form for SCD patients was revised and streamlined to capture pertinent patient data and a new SCD follow up database has been developed. New follow-up protocols have been developed. An initial phone call is made to the child's pediatrician with a follow up call to the parent to confirm that the child has a hematologist and to assess how the family is managing the child's care. The parent then receives an educational packet about SCD, the follow-up program, and resources and services available for their child. Support services continue until the child's 6th birthday. There are plans to hire a nurse to provide additional follow up services through the SCD program. A resource sharing partnership between the Infant Hearing Program and BDRIS resulted in the automatic generation of letters for families of infants identified with a birth defect, similar to follow up letters for families generated for the Infant Hearing program. This has allowed for greater efficiency among program staff and more timely follow up with families.

OGCSHCN has developed plans to enhance the Infant Hearing Program's database to benefit all of OGCSHCN's follow up programs. Enhancements include automatic downloading capabilities between the program, birth hospitals, selected pediatric practices, and the VSA. Grant funding requested from the CDC for these activities was awarded and implementation will commence.

Depending on the findings of the state Advisory Council on Hereditary and Congenital Disorders regarding the feasibility of critical congenital heart disease screening, OGCSHCN will develop appropriate plans to implement a follow up program for infants who screen positive.

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:	74999					
Reporting Year:	2010					
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.
Phenylketonuria (Classical)	74319	99.1	29	0	0	
Congenital Hypothyroidism (Classical)	74319	99.1	894	23	23	100.0
Galactosemia (Classical)	74319	99.1	24	1	1	100.0
Sickle Cell Disease	74319	99.1	184	64	64	100.0

Biotinidase Deficiency	74319	99.1	97	1	1	100.0
Cystic Fibrosis	74319	99.1	30	8	8	100.0
Homocystinuria	74319	99.1	143	0	0	
Maple Syrup Urine Disease	74319	99.1	44	1	1	100.0
beta-ketothiolase deficiency	74319	99.1	3	0	0	
Tyrosinemia Type I	74319	99.1	97	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	74319	99.1	11	1	1	100.0
Argininosuccinic Acidemia	74319	99.1	3	0	0	
Citrullinemia	74319	99.1	3	0	0	
Isovaleric Acidemia	74319	99.1	12	0	0	
Propionic Acidemia	74319	99.1	12	0	0	
Carnitine Uptake Defect	74319	99.1	0	0	0	
3-Methylcrotonyl-CoA Carboxylase Deficiency	74319	99.1	17	3	3	100.0
Methylmalonic acidemia (Cbl A,B)	74319	99.1	72	0	0	
Multiple Carboxylase Deficiency	74319	99.1	0	0	0	
Trifunctional Protein Deficiency	74319	99.1	4	0	0	
Glutaric Acidemia Type I	74319	99.1	13	1	1	100.0
Sickle Cell Anemia (SS-Disease)	74319	99.1	68	39	39	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	74319	99.1	309	2	2	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	74319	99.1	22	5	5	100.0
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	74319	99.1	4	0	0	
3-Hydroxy 3-	74319	99.1	0	0	0	

Methyl Glutaric Aciduria						
Methylmalonic Acidemia (Mutase Deficiency)	74319	99.1	72	1	1	100.0
S-Beta Thalassemia	74319	99.1	18	7	7	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	2006	2007	2008	2009	2010
Annual Performance Objective	71	72	55	55.5	56
Annual Indicator	68.1	54.8	54.8	54.8	54.8
Numerator	142329				
Denominator	209000				
Data Source			SLAITS 2005-2006	SLAITS 2005-2006	SLAITS 2005-2006
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
	2011	2012	2013	2014	2015
Annual Performance Objective	56.5	57	57	57	57

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.

Notes - 2008

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

According to the 2005-06 National Survey of CSHCN (NS-CSHCN), just under 55% of Maryland families of CYSHCN report that they are partners in decision-making and are satisfied with the services they receive, compared with over 57% nationally.

OGCSHCN continued its support of The Parents' Place of Maryland (PPMD), a non-profit, family-directed and staffed center serving parents of children with disabilities and special health care needs. PPMD houses the Maryland Chapter of Family Voices. PPMD and OGCSHCN have an ongoing partnership in a number of activities, including the Family-to-Family Health Education and Information Center, a statewide resource about the health care system which provides information, support, advocacy, and referrals for families of CYSHCN. In FY2010, PPMD parent staff provided individual assistance to 1350 parents of CYSHCN and 803 professionals through telephone, email, and face-to-face meetings. Approximately 11% of parents who received assistance specifically requested help with partnering and decision making with their children's providers. PPMD has fostered relationships with a number of organizations connected with ethnic/racial minority populations and provides materials and trainings in Spanish and uses community contacts for translation in other languages. PPMD has been very successful in its minority outreach efforts; 41% of those served were minority parents. PPMD sends out a monthly newsletter (ParentTalk) covering both health and education topics; in FY10 PPMD sent out 10 newsletters that reached a total of at least 22,680 individuals.

PPMD continued the Family as Faculty program this year with UMD School of Medicine and Johns Hopkins School of Public Health, facilitating home visit matches followed by a debriefing for pediatric residents and students with diverse families of CSHCN on a monthly or bi-monthly basis. Evaluations of this program continue to be positive. PPMD conducted a variety of workshops for both parents and professionals to increase partnership and advocacy skills and effectively access health care services for CYSHCN. In FY10, PPMD conducted 108 training events across the state for 3188 parents and providers.

OGCSHCN support enables PPMD to identify and support emerging parent leaders to participate in leadership and policymaking activities through sponsored parent participation in the Health LEADers programs. LEADers graduates are linked with various state and local committees, councils, and task forces to provide a family perspective. OGCSHCN support also enables PPMD staff to participate in a number of venues, providing parent input into health policy and program design activities. In FY10, 34 parents and family members of CYSHCN participated in the Health LEADers program.

PPMD staff were instrumental in the writing and review of last years Title V MCH Block Grant report and Needs Assessment. An OGCSHCN staff person partnered with CMCH and PPMD to develop a statewide survey of parents of CSHCN as part of the 2010 Title V Needs Assessment. Families had multiple ways to access the survey: paper, online, and in-person. Parents were hired to conduct the survey in areas which often have low response rates, i.e. southern Maryland, Prince George's County, Baltimore City, and the Eastern Shore. Gathered data was used in the Title V Needs Assessment and was analyzed and disseminated to CYSHCN stakeholders and parents through reports and presentations. PPMD also had critical input at each phase of the project: staff helped identify the final CYSHCN priorities for the state and to develop associated performance measures. PPMD's Executive Director attended the Block Grant review with Maryland's Title V team at MCHB.

OGCSHCN continued to work with PPMD on their State Implementation Grant for Integrated Community Systems for CYSHCN. A part-time OGCSHCN staff member provided leadership/staff support to continue the activities of the Maryland Community of Care (CoC) Consortium for CYSHCN. The CoC holds quarterly meetings and identifies priorities, including building relationships between families and professionals through education and joint training. The CoC facilitated family-professional partnerships by having parents participate in provider workshops/trainings on early and continuous screening for special health care needs and medical home.

OGCSHCN employed a parent of CSHCN. The parent of an adult with Sickle Cell Disease worked in SCD follow-up (though retired in FY11.)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support The Parents' Place of Maryland to provide families of CYSHCN with a central source of information, education, direct family support and referrals		X		X
2. Support The Parents' Place of Maryland to provide parent training, including Health TIES (Training, Information, Education, and Support) program		X		X
3. Support parent input into health policy and program designactivities				X
4. Support employment of family members of CYSHCN through PPMd		X		X
5. Collaborate with partners to collect data and information from families of CYSHCN via multiple sources				X
6. Support The Parents' Place of Maryland to maintain and expand a Families as Faculty Program				X
7. Work with The Parents' Place of Maryland and other stakeholders to further develop a Community of Care Consortium for CYSHCN in Maryland that promotes and supports family-professional partnerships				X
8. Include parents in preparing the Title V Block Grant application				X
9. Include parents in developing the Title V Needs Assessment				X
10.				

b. Current Activities

OGCSHCN supports programs that gather data/information from families of CYSHCN to assess their needs and ensure that families have a voice in program/policy decisions. PPMd and OGCSHCN continue to analyze, translate, and disseminate data from the 2010 Maryland Parent Survey conducted for the 2010 Needs Assessment. PPMd was a participant in the advisory workgroup that engineered the reorganization of OGCSHCN and continued to aid and advise during the implementation of the recommended changes. The OGCSHCN continues to provide staff support to the CoC. The CoC continues to hold quarterly meetings and in FY11, OGCSHCN was able to increase its staff participation in CoC meetings. The CoC held its January 2010 quarterly meeting in Annapolis in order to raise awareness among state lawmakers of current issues facing CYSHCN and their families. Over 35 parents attended and several lawmakers attended. Parents also visited their state representatives in their offices. PPMd once again provided assistance in preparing the MCHB Title V Block Grant for this application year. OGCSHCN and PPMd have cemented plans for a Family Advisory Council for the Title V CSHCN program and the first meeting should take place in the first quarter of FY12. Parents of CYSHCN, who are Health LEADers trained by PPMd, are providing input and advice on OGCSHCN activities and resource materials.

c. Plan for the Coming Year

The activities described will continue. PPMd will continue to work closely with Title V CSHCN staff to develop and implement action plans for each of the state priorities, one of which is to strengthen and sustain partnerships, including parent partnerships. CoC is a racially, ethnically, culturally, linguistically, socioeconomically, and geographically diverse group, including the parents and other family members of CYSHCN. Their charge is identifying and implementing strategies to promote family-professional partnerships and cultural competency in all of their activities. The Mini-Grant program (grants to be awarded for community implementation during

the Project) of CoC requires family participation and strategies for cultural competency in all projects.

Family members are required participants in all activities. New family members will be paired with experienced parent professionals (PPMD regional parent coordinators) for mentorship and support. Mentors will assess the information and training needs of new family members and provide individual/group training and include them in the leadership training activities of PPMD's Family-to-Family Health Education and Information Center. Families receive stipends for their participation and reimbursement for travel/childcare. CoC strives to accommodate special needs of its members including sign and foreign language interpretation. PPMD has Spanish-speaking staff to provide interpretation and translation of written materials. OGCSHCN intends to fund CoC in FY13 once the D70 grant (the current source of funding) ends and thus will support the sustainability of the above activities and parent involvement in those activities.

OGCSHCN houses Maryland's Infant Hearing Program (IHP.) The IHP applied for HRSA funds to improve program outcomes. One of the major goals for which funds would be used is to increase family and parent involvement in all aspects of the program, and objectives include the creation of a plan for parent involvement in developing and implementing IHP policies and programs; the design and implementation of parent outreach, network, education and training through a sub-grant award to a parent organization(s); and parent participation in the annual national EHDI conference.

OGCSHCN partnered with PPMD in applying for a HRSA State Planning Grant to develop a statewide plan for improving the service system for children with autism spectrum disorder and other developmental disabilities.

The Title V CSHCN program will include PPMD in preparing the MCHB Title V Block Grant report for 2011/13 and in developing action plans around state and national priorities identified in the Title V 2010 Needs Assessment. OGCSHCN has instituted a new grants review process for the funds it awards. A component of this process is an outside review committee, and two of the members of this committee are parents of a child with special health needs in Maryland. OGCSHCN is hiring parents to staff its resource line.

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	2006	2007	2008	2009	2010
Annual Performance Objective	61	62	46	46.5	47
Annual Indicator	56.3	45.6	45.6	45.6	45.6
Numerator	117667				
Denominator	209000				
Data Source			SLAITS 2005- 2006	SLAITS 2005- 2006	SLAITS 2005- 2006
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
	2011	2012	2013	2014	2015
Annual Performance Objective	47.5	48	48	48	48

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

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 - 2008

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

a. Last Year's Accomplishments

OGCSHCN continues to support Maryland genetics centers to provide a medical home for their patients. The Complex Care Program at Children's National Medical Center supports medical homes by bridging/filling the gap between primary care providers and tertiary services provided by the medical center. Both clinical and care coordination services are offered. In FY10 there were 295 visits (including clinic and hospital) for 262 patients, of which 43 were new to the program. This represents fewer patients and visits than in FY09. Johns Hopkins University Systems Development for CSHCN focuses on patients at Harriet Lane Clinic with asthma, ADHD, and SCD and has developed a system to identify and electronically track them. Care managers are assigned to work with those patients and their families to coordinate services and treatment with hospitals and other providers, and they have developed a system of enhanced communication between HLC providers and specialists. In FY10, 800 patients with asthma, 306 patients with ADHD, and 50 patients with SCD received care at HLC. 58 pediatric residents at HLC receive multiple trainings on the medical home model, and a web-based medical home training module is utilized by residency programs across the country and in FY10 more than 1500 residents were trained.

OGCSHCN continued to work with PPMD on their D70 Systems Grant for CYSHCN. A part-time OGCSHCN staff member provided leadership/staff support to continue the activities of the Maryland Community of Care (CoC) Consortium for CYSHCN. The inaugural summit for the CoC was held in November 2008 and was attended by over 100 physicians, other professionals, and families. The Medical Home Workgroup focused on improving access to medical homes for CSHCN. They identified and prioritized strategies to improve access to medical homes statewide. Medical home training and education continues to be a focus of the Consortium.

PPMD, through their Family as Faculty program in partnership with UMD School of Medicine and Johns Hopkins School of Public Health, facilitates home visit matches followed by a debriefing for pediatric residents and students with diverse families of CSHCN on a monthly or bi-monthly basis. In the debriefings with a PPMD staff person, students are provided with information on the medical home concept and the need for families of CYSHCN to have a medical home. All UMD combined or categorical pediatric residents participate in this program during their behavioral developmental pediatrics rotation.

Improving the system of care coordination through local health departments (LHDs) has

continued to be an OGCSHCN priority. Due to ongoing budget cuts, capacity of the LHDs to provide care coordination for CYSHCN continues to shrink. With OGCSHCN support, in FY10 13 LHDs provided case management services for a total of 1002 CSHCN and their families. There were 1421 contacts among LHDs to collaborate with primary care providers, and 891 families received information about medical homes through workshops or outreach from LHDs. 11 LHDs provided respite care in FY10 to 523 CSHCN and their families.

The Baltimore City Health Department (BCHD), with support from OGCSHCN, expanded its "Medical Homes Project" aimed at improving the quality of medical homes for children. This project improves the rates with which pediatric primary care providers in Baltimore City effectively screen young children for developmental delays. An article describing the findings was published in a peer-reviewed journal in FY10. In FY10, this project was chosen by the leadership of the CoC to participate in the NICHQ Learning Collaborative for D70 State Implementation Grantees, and as a result key continuous quality improvement measures were incorporated into project activities. The project expanded into practices outside of Baltimore City. Over 150 participants including physicians, social workers, nurses, case managers attended "public health detailing" presentations conducted by the project. And 8 primary pediatric care practices were retrained on developmental screening and referrals in FY10.

The Maryland chapter of the American Academy of Pediatrics (MD AAP) and the CoC partnered in a series of 4 regional forums to discuss medical home and the integration of medical home approaches into the pediatric practices in their regions. A planned statewide medical home forum was not held as planned.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support the Complex Care Program at Children's National Medical Center	X	X		X
2. Support efforts to educate families and providers about medical home partnerships through dissemination of materials		X		X
3. Fund gap-filling care coordination for CYSHCN through local health departments, and make needed quality improvements to the system	X	X		
4. Support multiple efforts to improve developmental screening and appropriate referral for all children within the medical home through policy-level and practice-level change				X
5. Work with The Parents' Place of Maryland and other stakeholders to continue with the Community of Care Consortium for CYSHCN in Maryland that promotes and supports medical home improvement				X
6. Support Johns Hopkins University to continue to implement a medical home model for selected high prevalence, high impact and/or high cost conditions within the Harriet Lane Clinic	X	X		
7. Support The Parents' Place of Maryland to maintain and expand a Families as Faculty Program that incorporates medical home education for medical and public health students				X
8. Support MD AAP and the CoC partner in a series of regional medical home forums to bring together physicians, allied health providers, local health departments, community service providers, families.				X
9.				
10.				

b. Current Activities

As part of its ongoing reorganization, in FY11 OGCSHCN hired a Title V CSHCN Specialist/Health Policy Analyst to work on the D70 grant in addition to other projects. The Medical Homes Project continued to operate and expand into more practices with the support of the CoC, PPMD, and OGCSHCN. One of the participating groups, Johns Hopkins Community Physicians (JHCP), requested implementation of the program statewide in all 18 of their practices. The program has moved into areas surrounding Baltimore City. An effort to include family practitioners (FPs) in addition to pediatricians (approximately half of the practices in JHCP do not have pediatricians so children are seen by FPs) is underway. A new group, Baltimore Medical Services, joined the project and would like to implement it at all 6 of their practices that serve children. At a quarterly meeting of the CoC in FY11, attendees reviewed strategies developed at the 2008 Summit to advance medical home in Maryland. Progress on strategies was reviewed and next steps and appropriate partners to pursue strategies were identified. A strong focus is realigning provider compensation to support the use of medical home components within practices. The CoC also funded a project through their mini-grants program to the One World Center for Autism in Prince George's County to develop training materials for families and providers around medical home.

c. Plan for the Coming Year

The activities described above will continue. A position has been identified in OGCSHCN that includes a medical homes coordinator function, which would be responsible for implementing medical home leadership activities in the state. This would enable progress on the medical home goal for the CoC and for the state on this national performance measure. One of the CoC's mini-grants funded a project, COMMHAT, which provides training and support to pediatric practices in Western Maryland to integrate mental health with medical homes.

During FY11, the Improving Medical Home Partnerships for Specialty Access through Coordination and Training (IMPACT) program was initiated. Through an MOU between OGCSHCN and the University of Maryland, this project is developing specialty modules to prepare medical home providers to better handle common specialty concerns in their offices. A collaborative care agreement is also being developed for use by practices that participate in the specialty module training. Pediatric practices in Maryland's Medicaid patient-centered medical home initiative will be targeted for these interventions. In FY12 an evaluation component will be added to determine system impact on health outcomes.

The Medical Homes Project will continue to operate and expand into more practices with the support of the CoC, PPMD, and OGCSHCN. One of the currently participating practices, East Baltimore Medical Center (EBMC) expressed an interest in branching out from the already implemented improved developmental screening and referral processes and incorporating more medical home building processes. Due to the measurable and successful outcomes produced through this project, OGCSHCN asked the project coordinator, Tracy King, to develop a plan to expand the program statewide using a regional approach. OGCSHCN is actively seeking additional funding to implement this plan and if funding is identified, implementation will begin in the Eastern Shore region.

OGCSHCN and PPMD are planning three regional health care transition conferences to take place during FY12 during which participants will be trained in the need for and recognition of quality medical homes. These conferences will be held each year for the next five years. At the OGCSHCN sponsored MD Early Hearing Detection and Intervention (EHDI) stakeholder conference planned by the Infant Hearing Advisory Council for August 2011, the keynote speaker will be highlighting medical homes.

OGCSHCN also plans to focus on data gathering and integration as it relates to medical homes in the state. Efforts are underway to identify potential and existing sources of data and to gain

access to and integrate that data to better track progress on medical home outcomes in Maryland. A partnership has been formed between OGCSHCN and the Maryland Center of Excellence for Developmental Disabilities (MCDD) to pursue funding and collaborative activities for data system development.

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	2006	2007	2008	2009	2010
Annual Performance Objective	70	70.5	65.7	65.9	66.1
Annual Indicator	67.5	65.5	65.5	65.5	65.5
Numerator	141075				
Denominator	209000				
Data Source			SLAITS 2005- 2006	SLAITS 2005- 2006	SLAITS 2005- 2006
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
	2011	2012	2013	2014	2015
Annual Performance Objective	66.3	66.5	66.5	67	67

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

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 - 2008

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

a. Last Year's Accomplishments

According to the 2005-06 NS-CSHCN, most CYSHCN in Maryland have health insurance (97%); however underinsurance is a challenge for many families: one-third of families of CYSHCN in Maryland report that their child does not have adequate health insurance to meet her/his needs. In the past year, OGCSHCN continued to partner with The Parents' Place of Maryland (PPMD) and its Family-to-Family Health Information and Education Center. A goal of this center is to increase the knowledge and skills of parents/caregivers of CYSHCN so that they may more

effectively access health care services for their children. PPMD developed and has been continuously refining health-related workshops for families, several of which are related to insurance issues including "Choosing a Health Care Plan", "Managing the Maze", "Show Me The Money", and "Financial Hardships for Maryland Families of CYSHCN". Workshops are scheduled on an ongoing basis throughout the state, both face-to-face and by teleconference. In FY10, PPMD staff conducted 108 training events for a total of 3188 parents and professionals. Some of this training included Special Needs Coordinators from Maryland MCOs. PPMD staff members are also available to provide individual assistance to parents of CYSHCN through telephone, email, and face-to-face meetings. In FY10, individual contact was provided to 1350 parents and 803 professionals. Among parents needing help around health care financing, some examples of help requested are information on Medicaid and various questions and concerns around private insurance.

OGCSHCN co-chairs with PPMD the Maryland Community of Care (CoC) Consortium for CSHCN. The CoC is funded through a State Implementation grant awarded to PPMD, and adequate health insurance and financing is one of the core outcomes upon which the CoC is focused. During the inaugural summit for the CoC in November 2008, a group of stakeholders from around the state including representatives from Medicaid, Special Needs Coordinators from Maryland MCOs, and parents and professionals from other organizations identified barriers to adequate insurance and financing in Maryland. They found that Maryland lacks a comprehensive plan to address how services for CYSHCN are paid for and there is inadequate synthesized data to use for problem identification. Other challenges to progress on this outcome were an uneven geographic distribution of providers; the complexity of the system makes it difficult for families and providers to navigate it; a lack of clarity about eligibility for services; insurance not keeping pace w/technological advances in therapy or durable medical equipment; and an erosion of employer-based benefits due to economic distress.

OGCSHCN continued to support two of Maryland's medical daycare centers due to inadequate reimbursement from Medicaid for nursing services. In FY10 these centers served a total of 106 CSHCN.

OGCSHCN provided payment for specialty care and related services through the Children's Medical Services Program (CMS) to Maryland CYSHCN who are uninsured or underinsured and have family incomes up to 200% FPL. Recent changes to the program's eligibility guidelines, which allow the program's income eligibility to automatically update each year in accordance with the new federal poverty guidelines, as well as the continued presence of two bilingual staff served to increase the number of eligible children for the program, though one of the bilingual staff left the program partway through FY10. In FY10, CMS processed 280 applications and paid for services for 255 CYSHCN. The vast majority of the children served by the program are Hispanic immigrants. The program's Spanish-speaking staff, the Bilingual Outreach Coordinator and the Care Coordinator for Montgomery County, worked directly with families and providers to facilitate access to timely and appropriate CMS program services. The capability to directly provide Spanish-language services to CMS families continued to be invaluable to the program, and promoted greater parent-program communication as well as an increased parent education/awareness of related program services.

The Maryland Chapter American Academy of Pediatrics (MDAAP) continued Assuring Better Child Health and Development Screening Academy through CoC funding. In FY10, MDAAP continued training pediatric providers throughout Maryland on approved screening tools as well as how to seek reimbursement for screenings.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Support The Parents' Place of Maryland to educate parents of CYSHCN about health insurance and how to access services for their children through a series of workshops		X		X
2. Support parent input into policy and program design activities related to health insurance for CYSHCN				X
3. Provide payment for specialty care and related services for CYSHCN who are uninsured or underinsured with family incomes up to 200% FPL through the Children's Medical Services Program	X	X		
4. Provide outreach and case management to Hispanic families through bilingual staff in Children's Medical Services program		X		
5. Partner with MD AAP to support developmental screening trainings for pediatric providers, including coding and reimbursement				X
6. Work with The Parents' Place of Maryland and other stakeholders to continue with the Community of Care Consortium for CYSHCN in Maryland that promotes and supports adequate insurance and financing				X
7. Continue data analysis and dissemination of from the 2010 Maryland Parent Survey findings regarding adequacy of insurance and financial impacts on families of Maryland				X
8.				
9.				
10.				

b. Current Activities

As part of its ongoing reorganization, OGCSHCN hired a Title V CSHCN Specialist/Health Policy Analyst to work on the D70 grant in addition to other projects and progress on the adequate insurance goal for CoC and for the state will have additional support as a result. As part of the Baltimore Medical Homes project, developmental screening trainings with pediatric providers continued and expanded to include family practice providers. In FY11, CoC saw an increase in the number of MCO Special Needs Coordinators attending quarterly meetings. Several MCOs, including Diamond Plan and Amerigroup, which had not sent representatives in the past began attending in FY11. CMS would like to work toward an electronic payment system - crucial as some facilities decline payment that requires only paper claims to file. This decreases the number of providers that can be accessed by families within the program. CMS has been unable to update its billing system due to a lack of resources. CMS staff advocate for CSHCN in the program and work with hospital billing staff/insurance providers to pay claims and sometimes to cover insurance premiums for CSHCN who qualify for MHIP. It is more cost effective to cover such premiums than to pay for individual services. Data analysis and dissemination continues of the 2010 Maryland Parent survey, done as part of the Title V Needs Assessment. Several questions on the survey focused on insurance and related topics.

c. Plan for the Coming Year

Recently completed analysis from the 2010 Maryland Parent Survey shows that, among responding families with at least one CYSHCN (n = 772 families): 54.5% report that their child's insurance does not pay for all health services needed; 12.7% report that their child was uninsured at some point in the 12 months prior to the survey; 37.7% had CYSHCN whose conditions cause family members to cut back or stop working; and 42.5% report having to pay \$1000 or more in out-of-pocket medical expenses per year per child.

The activities described above will continue. The Bilingual Outreach Coordinator for CMS resigned near the end of FY2010. OGCSHCN is currently hiring for a bilingual nurse to serve the CMS program. Until the position is filled, there will be a reduced capacity in CMS to serve the

many Spanish-speaking families that use the program.

OGCSHCN plans to work with PPMD to prepare several issue-specific analyses of gathered data from the 2010 Maryland Parent Survey. One such issue is adequate insurance and financing. A broad analysis of questions pertaining to insurance and financing issues and delayed and unmet needs was recently completed and disseminated. Plans for additional analyses include looking for significant differences in all survey responses among families and CYSHCN with different types of insurance as well as a regional analysis of insurance and unmet needs issues. Findings will be disseminated to stakeholders through the CoC and other OGCSHCN partners.

The CoC, through the D70 grant, will continue to look for opportunities to positively impact this core outcome. At a quarterly meeting in FY11, attendees reviewed strategies developed at the 2008 Summit to improve adequate insurance and financing in Maryland. Progress on strategies was reviewed and next steps and appropriate partners to pursue strategies were identified. A strong focus, along with other initiatives, should be developing a plan to address policies for financing -- key partners would include private and public insurers, lobbyists, OGCSHCN, PPMD and other family groups, and other interested stakeholders.

PPMD will continue to provide health-related workshops for families, several of which are related to insurance issues including "Choosing a Health Care Plan", "Getting Needed Services from your Health Plan", "Appealing Health Plan Decisions", and "Understanding Medical Assistance in Maryland" across the state.

OGCSHCN will continue to look for opportunities to positively impact this core outcome in the state. Strategic plans for this outcome are in flux due to federal health care reform. OGCSHCN and its partners will continue to monitor changes resulting from this reform and will assess its impact on CYSHCN, their families, and the state.

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	2006	2007	2008	2009	2010
Annual Performance Objective	75	75.5	89.5	89.7	89.9
Annual Indicator	70.6	89.3	89.3	89.3	89.3
Numerator	147554				
Denominator	209000				
Data Source			SLAITS 2005- 2006	SLAITS 2005- 2006	SLAITS 2005- 2006
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
	2011	2012	2013	2014	2015
Annual Performance Objective	90.1	90.3	90.3	90.5	90.5

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

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 - 2008

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

a. Last Year's Accomplishments

During FY10, OGCSHCN continued to support selected outreach specialty clinics throughout the state, including genetics, developmental pediatrics, and endocrinology clinics. In FY10, an estimated 1183 individuals were served in 27 specialty outreach clinics for CYSHCN and supported by the OGCSHCN. OGCSHCN has also continued its efforts to address the need for assistance with "navigating the system" i.e. finding and accessing available resources within the community. OGCSHCN provides grant funding to four Centers of Excellence (COE) in Maryland and Washington, D.C. to support a Resource Liaison or similar personnel at each center whose function is to assist families of CYSHCN to locate needed resources within the centers and in the community. The ASK program at the University of MD places one nurse in the pediatric primary clinic to help coordinate care for children with medically complex needs; however for much of FY10 that position was vacant. The salary money was reprogrammed for the IMPACT initiative which is developing specialty modules to prepare medical home providers to better handle common specialty concerns in their offices. At Children's National Medical Center (CNMC), a resource liaison works as part of the Complex Care Program (CCP.) In FY10, the CCP saw 206 children and provided information about a variety of community resources to their families. This is a significant decrease from FY09 due to the transition of the founder of the program to the hospitalist program. Many patients followed this physician to her new clinic and CNMC is addressing this by improving outreach to families and providers about the services offered through the Complex Care Program. The Resource Finder program at Kennedy Krieger is funded in part by OGCSHCN. In FY10 they fielded 1032 inquiries from caregivers, consumers, and providers. The most frequently requested information, by a large margin was regarding providers and services.

In FY10, grants from the OGCSHCN funded gap-filling care coordination for CYSHCN in a number of jurisdictions; 1,002 children were served by staff in thirteen Local Health Departments. Grant funds from the OGCSHCN also provided 523 children with respite care in eleven counties throughout the state. For example, Somerset County provided camp scholarships in local communities for CSHCN to attend programs with their typically developing peers, and facilitating easy-to-use community-based services for CYSHCN. OGCSHCN granted money to the Kent County Health Department to conduct a needs assessment of CYSHCN in the county during FY10. The OGCSHCN also continued to provide funding to The Parents' Place of Maryland (PPMD) to expand its Family-to-Family Health Information and Education Center, which operates an information and referral line as well as a network of parent representatives throughout the state who are available to work one-on-one with families of CYSHCN. A similar "Children's Resource Line" is answered by staff at the OGCSHCN. PPMD conducted "Finding Community Resources" and "Managing the Maze" workshops for parents across the state.

OGCSHCN continues its partnership with PPMD in the Maryland Community of Care (CoC) Consortium for CSHCN. CoC is funded through a D70 grant awarded to PPMD, and family access to care for CYSHCN that is part of an integrated, community-based system of services is one of the core outcomes upon which CoC is focused. During the inaugural summit for CoC in November 2008, a group of stakeholders from around the state identified barriers to CYSHCN system navigation and disparities in accessing services in communities in Maryland. They found that there are many resources and services for families in Maryland as well as good potential for infrastructure to improve these services. The workgroup recommended several actions, including surveying and identifying successful models in local and national communities as well as surveying local entities to find out what state level issues are making the system difficult to use. OGCSHCN and PPMD staff conducted some of these activities in late FY10, and what was learned was incorporated into the FY11 OGCSHCN restructuring. Also in FY10, CoC was instrumental in providing networking and communication opportunities for providers, families, and other professionals, contributing to the ease of use of the system of services for CYSHCN and families in Maryland.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support selected subspecialty outreach clinics throughout the state	X			X
2. Support a Resource Liaison or similar personnel at 3 Centers of Excellence, and The Parents' Place of Maryland for outreach, information, and referral to families and providers		X		X
3. Support the operation of 2 medical day care centers serving medically fragile infants and young children	X	X		
4. Support the local health departments and parent organizations to provide a variety of respite services to families of CYSHCN		X		
5. Fund gap-filling care coordination for CYSHCN through local health departments, and make needed quality improvements to the system		X		X
6. Work with The Parents' Place of Maryland and other stakeholders to continue with the Community of Care Consortium for CYSHCN in Maryland that promotes and supports easy to use, community-based service systems				X
7. Conduct regional meetings for local health departments to develop collaborative relationships				X
8. Conduct Centers of Excellence and Community grantee meeting to develop collaborative relationships and to educate partners about core outcomes for CYSHCN.				X
9.				
10.				

b. Current Activities

OGCSHCN continued to support local health departments for respite care and care coordination close to home as well as specialty clinics in the Maryland and Washington, D.C. region. OGCSHCN will support Kent County in the development of an action plan to meet the needs identified through their needs assessment. OGCSHCN will continue to promote collaborative relationships among local health departments to maximize services for CYSHCN, especially in rural, underserved communities. As part of its ongoing reorganization, in FY11 OGCSHCN hired a Title V CSHCN Specialist/Health Policy Analyst to work on the D70 grant in addition to other projects. This has enabled OGCSHCN to contribute more staff time to the CoC and thus to ease

of use of the system of care for CYSHCN in Maryland. OGCSHCN Centers of Excellence grantees and PPMD met with staff to coordinate activities. Regional meetings with LHDs were conducted by OGCSHCN staff in Fall 2010. Topics of discussion and presentations focused on the new mission and priorities of OGCSHCN after the office reorganized and identifying current needs and resources in six regions of Maryland including quality medical homes. During FY11 OGCSHCN developed a statewide resource database and hired staff to research resources for CYSHCN and families in order to increase the effectiveness and usefulness of the Children's Resource Line. Additionally, OGCSHCN's online county-by-county resource map was updated and restored to full functionality.

c. Plan for the Coming Year

The activities described above will continue. OGCSHCN is currently recruiting a bilingual nurse to serve the CMS and SCD programs and this will increase the usability of both programs for Spanish speaking families. OGCSHCN hired a Resource Coordinator in FY11 but that contract ended and OGCSHCN is redirecting resources in order to hire two parents of CYSHCN to provide resource coordination, education, and training to families of CYSHCN, and also to run the Children's Resource Line and keep the resources database up-to-date.

The OGCSHCN reorganization will allow for completion of plans to work with PPMD to prepare several issue-specific analyses of gathered data on the 2010 Maryland Parent Survey. One such issue is families receiving needed services through community-based systems of care that are easy to use. Plans for analyses include looking for significant differences in responses about receiving needed services among families and CYSHCN in different regions of the state, and a qualitative analysis of responses to open-ended questions pertaining to this core outcome. Findings will be disseminated to stakeholders through the CoC and other OGCSHCN partners and will be used to inform state activities around this performance measure.

In FY11, OGCSHCN held a mandatory retraining for all of its grantees to inform them of new state Title V priorities, findings from the Title V 2010 Needs Assessment, new grant reporting requirements, and an information session on core outcomes for CYSHCN. Grantees networked and identified areas of common focus and possible collaboration in the future. Meetings of this type will be held yearly by OGCSHCN to promote cooperation among grantees.

OGCSHCN intends to fund the CoC in FY13, once the current source of funding ends, and thus will support the sustainability of the above activities through the CoC, including quarterly meetings, which help to strengthen the linkages between services and providers in the system of care for CYSHCN. In FY12, the CoC and OGCSHCN plan on funding several mini-Consortia in the outlying regions of Maryland (eastern shore, Western MD, and southern MD), where there are very few community-based services for CYSHCN. These mini-consortia will identify existing services and gaps and build new partnerships in order to creatively fill gaps and bring needed services to families in that region. The CoC will continue to look for opportunities to positively impact this core outcome. Now that the reorganization of OGCSHCN is complete, the office can resume its leadership role in the state to coordinate activities and agencies providing services for CYSHCN and families. OGCSHCN staff will continue to look for opportunities to positively impact this core outcome in the state.

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	2006	2007	2008	2009	2010
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Annual Performance Objective	11	12	38	38.5	39
Annual Indicator	5.8	37.5	37.5	37.5	37.5
Numerator					
Denominator					
Data Source			SLAITS 2005- 2006	SLAITS 2005- 2006	SLAITS 2005- 2006
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
	2011	2012	2013	2014	2015
Annual Performance Objective	39.5	40	40	40.5	40.5

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

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 - 2008

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

a. Last Year's Accomplishments

The 2005-06 NS-CSHCN estimates that 37.4% of Maryland CYSHCN ages 12-17 receive the services necessary to transition to the adult world compared with 41.2% nationally. There were significant differences between this and the 2001 NS-CSHCN but Maryland still ranks only 42nd among the states, only slightly better than ranking 44th in 2001.

The OGCSHCN continued to promote successful health care transition for youth with sickle cell disease (SCD) and diabetes (DM) through support of transition clinics at the Johns Hopkins Hospital. Youth with SCD 18 to 24 years of age are cared for jointly by the pediatric and adult hematologists in the transition clinic in the Department of Internal Medicine, prior to transfer of care to the adult hematology clinic. In FY10, the SCD transition clinic provided 450 visits to 64 patients. The transition clinic for youth with DM targets patients in their last year of high school. In this model, parents and youth are introduced to the adult endocrinologist at the transition clinic.

The adult endocrinologist meets with the patients and their parents both with and without the pediatric endocrinologist. In FY10, the clinic held a total of 24 transition clinic sessions.

The OGCSHCN funded Kennedy Krieger's (KKI) Transition Lecture Series, now completing its 8th successful year. A total of 133 youth, families and providers attended seven lectures. Topics included: "Community Works Project: How to find respite care providers"; "College and University Disability Support Services"; "Human Sexuality"; and the most well-attended lecture, "Low Intensity Support Services." Lectures are videotaped; copies are loaned to families and are available at the Regional Resource Center for Children with Special Needs on the Eastern Shore.

The Children's Medical Services Program (CMS) within OGCSHCN pays for specialty care for YSHCN enrolled in the program until the age of 22 years. Care may be covered until age 25 in some circumstances. The CMS Program staff work with YSHCN/families to assist them with transitioning into programs for adults well in advance of the time when they will lose their eligibility for the CMS program.

PPMD, partnering with the OGCSHCN, received a D70 Systems Grant for CYSHCN. OGCSHCN staff provided leadership and staff support to develop the Maryland Community of Care (CoC) Consortium for CYSHCN. The inaugural summit was attended by over 100 physicians, other professionals, and families. Participants worked in small groups, including a group focused on CYSHCN having the necessary services to make transitions to all aspects of adult life, including adult health care, work, and independence. As a result of the Summit, MSDE was supposed to include information about health transition in the manual they developed for transitioning youth and their families and was supposed to incorporate information on health transition in their statewide transition training for youth, families, and staff. This did not occur in FY10 but OGCSHCN staff had plans to meet with MSDE's Transition Coordinator to move plans forward. PPMD worked with several organizations and parent groups to conduct programs for youth in transition in Baltimore City. An OGCSHCN staff person partnered with the Maryland CMCH and PPMD to develop a statewide survey of parents of CYSHCN as part of the 2010 Title V Needs Assessment. Several questions on the survey focused on youth transition to adulthood. Due in part to the data collected from this survey, as well as the overall Needs Assessment process, youth transition to adulthood was identified as a state-level priority. A yearly survey of parents of transition-age youth is planned for FY11 through FY15 to guide planning and measure impact of state activities around this priority.

The OGCSHCN planned to continue its involvement with the Statewide Steering Committee on Services for Adults with Sickle Cell Disease as a mechanism for raising awareness of health care transition issues. The Steering Committee's responsibilities include establishing institutional and community partnerships; educating the public and health care providers; and developing a comprehensive education and treatment program for adults with sickle cell disease. The committee did not meet during FY10 but OGCSHCN had plans to reactivate the committee in FY11 if committee members did not take the initiative.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support transition clinic activities including clinics for youth with sickle cell disease and youth with diabetes		X		
2. Support monthly Transition Lecture Series for youth, families and providers hosted by Kennedy Krieger		X		
3. Provide payment for specialty care and related services for uninsured YSHCN until age 22 years through Children's Medical Services Program	X	X		
4. Partner with The Parents' Place of Maryland and the Center				X

for Maternal and Child Health to analyze data gathered from Maryland families of YSHCN on parent participation in transition planning				
5. Identify youth transition to adulthood as a state-level priority for Maryland YSHCN and begin more intensive strategic planning to improve this outcome.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The OGCSHCN reorganization has allowed for the creation of a Transition Coordinator. OGCSHCN continued to fund transition clinics and the transition lecture series and revitalized the Steering Committee for Adults with SCD. OGCSHCN, in partnership with MSDE, PPMD, and MCDD developed and piloted the Parent Survey for Transitioning Youth. The CoC conducted quarterly meetings during FY11 at which transition issues were discussed and questions for the Transition survey were developed. Other planned CoC activities around transition met with limited and varied success. PPMD conducted Transition trainings during FY11. OGCSHCN resumed the staffing of the Statewide Steering Committee on Services for Adults with Sickle Cell Disease (established in 2007 under Maryland HB 793.) The committee had not met in over two years, but is now active again. OGCSHCN hopes to use its involvement to raise general awareness of health care transition issues as well as to ensure that there are appropriate systems of primary and specialty care for CYSHCN with SCD to transition into as adults. Health care transition materials were submitted to MSDE for inclusion in the annual update of their Transition Planning Guide which is provided to students with an IEP at their transition planning meeting. OGCSHCN also staffed a table on health care transition at a recent Baltimore City School System Transition fair, and is active in the planning of an Interagency Transition Council conference coming up this fall.

c. Plan for the Coming Year

The above activities will continue. The OGCSHCN Transition Coordinator is working with PPMD on planning three regional health care transition conferences to take place during FY12. An action plan will be developed to include partnering with MSDE's school health division to provide outreach and education to school nurses and to families regarding health care transition for CYSHCN. Support and technical assistance will also be offered to OGCSHCN grantees who are involved in transition activities. Groundwork has been laid for the formation of a Family and Youth Advisory Council. OGCSHCN now has access to key stakeholders and partners to create such a council and has adequate staff to do so, and the first meeting should occur in the first quarter of FY12.

The data pertaining to transition from the 2010 parent survey continues to be analyzed and OGCSHCN plans to work with PPMD to prepare several issue-specific analyses of gathered data. One such issue is youth transition to adulthood. Plans for analyses include looking for patterns of responses among caregivers who report having participated in transition planning for their YSHCN versus those who report no participation. Findings will be disseminated to stakeholders through the CoC and other OGCSHCN partners.

The CoC, through the D70 grant, will continue to look for opportunities to positively impact this core outcome. At a quarterly meeting in FY11, attendees reviewed strategies developed at the 2008 Summit to increase the achievement of successful youth transition to adulthood in Maryland. Progress on strategies was reviewed and next steps and appropriate partners to pursue strategies were identified. A strong focus, along with other initiatives, should be on youth and family training around transition planning, while at the same time consolidating transition

resources and information in a user/family-friendly accessible database. OGCSHCN has plans to enhance its statewide resource database to include a comprehensive catalogue of transition resources for families.

The Parent Survey for Transitioning Youth will be administered during FY12-15; PPMD will disseminate the survey each year using their extensive network of parents of YSHCN. In later years of the survey a youth-answered component is planned. Results will be analyzed to inform strategic planning and for reporting for the state level priority performance measure. The state performance measure is related to parents' participation in transition planning for their YSHCN.

PPMD will continue to conduct parent trainings during FY12 using the aforementioned materials developed in conjunction with MSDE. There are plans to make KKI's Transition Lecture series more widely available throughout the state through posting videos of lectures on websites and enabling web and audio conferencing during live lectures.

OGCSHCN staff are presenting at and participating in several youth transition-themed conferences during FY12.

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	2006	2007	2008	2009	2010
Annual Performance Objective	81	83	86.5	93	83
Annual Indicator	79.9	92.4	73.6	77.9	77.9
Numerator	176242	206988	163837	178949	178949
Denominator	220579	224013	222604	229716	229716
Data Source			MMWR Report, CDC, 2008	MMWR Report, CDC, 2009	MMWR Report, CDC 2009
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	80	80	80	80	80

Notes - 2010

Source: Percentage is based on data from the MMWR Report "National State and Local Area Vaccination Coverage Among Children Aged 19-35 months, US. 2009". This percentage was applied to the estimated number of children between the ages of 1-3 in 2009 (denominator) based on U.S. Census Bureau Population Estimates to create a numerator. 4:3:1:3:3:1 series used to calculate coverage rate. Data for 2010 not currently available

Notes - 2009

Source: Percentage is based on data from the MMWR Report "National State and Local Area Vaccination Coverage Among Children Aged 19-35 months, US. 2009". This percentage was applied to the estimated number of children between the ages of 1-3 in 2009 (denominator) based on U.S. Census Bureau Population Estimates to create a numerator. 4:3:1:3:3:1 series used to calculate coverage rate

Notes - 2008

Source: Percentage is based on data from the MMWR Report "National State and Local Area Vaccination Coverage Among Children Aged 19-35 months, US. 2008". This percentage was applied to the estimated number of children between the ages of 1-3 in 2008 (denominator) based on U.S. Census Bureau Population Estimates to create a numerator. 4:3:1:3:3:1 series used to calculate coverage rate

a. Last Year's Accomplishments

According to the MMWR Report from the Centers for Disease Control and Prevention (CDC)'s sponsored National Immunization Survey (NIS), in 2009, reportedly 77.9% of Maryland children ages 19-35 months were fully immunized as defined by the 4:3:1:3:3:1 series. This percentage is above the national average of 69.9% for this time period, but failed to meet Maryland's target goal of 80% for this measure.

Immunization outreach activities were included in Maryland's Title V funded early childhood grant activities. A priority of the Early Childhood Health Plan completed by CMCH is to increase access to medical homes for young children. Immunizations are an important component of well child care to be promoted within the medical home. Education about the importance of immunizations as well as new Maryland vaccination guidelines are part of early childhood health outreach efforts.

The Infectious Diseases and Environmental Health Administration, Center for Immunization is largely responsible for statewide immunization activities in Maryland. Ongoing activities to promote early childhood immunization in FY 2010 included the distribution of immunization educational materials to the parents of every child born in the State, administration of the State's immunization registry - ImmuNet, and operation of the Maryland Vaccines for Children (VFC) Program. The Center conducts disease surveillance activity and monitoring; and provides immunization health education and resources through the Maryland Partnership for Prevention.

VFC allows enrolled physicians to provide all routinely recommended vaccines, at no cost, to children 18 years old and younger who are Medicaid enrolled; uninsured; underinsured or Native American/Alaskan Native. There are currently approximately 800 enrolled providers practicing at 1,000 public and private practice vaccine delivery sites throughout the State. Immunization Excellence Awards are given to VFC providers, who demonstrate excellence in all critical areas reviewed by the VFC Program, including immunization coverage rates of two year olds; and pediatric practice standards.

ImmuNet, the State's immunization registry, began implementation in June 2004. The registry provides a consolidated vaccination record for children enrolled, provides reminder and recall notices, and prints forms for schools, camps, and day care. To date, ImmuNet contains more than 1,000,000 patient records and 12,000,000 vaccinations and is currently used in more than 900 provider offices.

Title V also continued to support local health department efforts to inform consumers, communities and providers about the importance of immunizations. Although the majority of children are immunized in private physician offices, several local health departments continued to offer immunization clinics serving children in underserved areas of the State in 2010. MCH nursing staff in local health departments educated families about the importance of immunizations

during home visiting and early childhood programs as part of a comprehensive approach to well child care. Educational materials to promote awareness of the need for immunization continued to be a part of all MCH outreach activities. WIC Program staff determined the immunization status of their clients at every encounter.

The Maryland Partnership for Prevention (MPP), the state's immunization coalition, began offering a Practice Makes Perfect Immunization Training that provides health professionals with comprehensive resources to support promotion and administration of childhood immunizations. This half day training session provides an overview of topics that are important to safely and effectively provide immunizations, including vaccine recommendations for children, adolescents, and adults; child care and school immunization requirements; vaccine storage and handling; and the Maryland Vaccines For Children Program.

Early in the 2010 fiscal year, immunization activities were heavily focused on response to the H1N1 pandemic including influenza vaccination. While not specifically related to the 4:3:1:3:3:1 series, strengthened partnerships and communication strategies that were developed will be used for future immunization initiatives.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distribute education materials to parents of every newborn in the state that includes information on immunizations (Center for Immunizations)			X	
2. Fund local health department immunization clinic and outreach/ education activities	X		X	
3. Continue to expand the state's immunization registries, Immunet (statewide) and Baltimore City registry. Title V will support the Baltimore City registry		X		
4. Provide insurance coverage for immunizations through Medicaid and MCHP		X		
5. Administer the Vaccines for Children program (Center for Immunizations)				X
6. Promote immunizations through home visiting and early childhood programs. Promote access to medical homes for all children through Early Childhood Health Grant			X	
7. Screen for immunization status in WIC and other MCH programs			X	
8. Participate in MD Immunization Partnership				X
9. Provide outreach and education to the general public and health care providers to improve immunization levels			X	X
10.				

b. Current Activities

The Title V Program continues to support immunization outreach and education efforts provided by local health departments. Title V funds continue to directly support Baltimore City's Immunization Registry, developed independently of ImmuNet. The City's Registry maintains a database of immunization and demographic information on Baltimore City children collected from pediatric providers. To date, ImmuNet contains more than 1,000,000 patient records and 12,000,000 vaccinations and is currently used in more than 900 provider offices.

MCH staff in local health departments identifies children who are not up to date with their immunizations and refer them to a medical home. Periodically, immunization clinics continue to

be offered through local health departments.

c. Plan for the Coming Year

Activities for 2012 will include:

1. Distributing educational materials to parents of every newborn in the State that includes information on immunizations (Center for Immunizations)
2. Funding local health department immunization clinics and outreach/education activities (Center for Immunizations).
3. Continuing to expand the State's immunization registries, ImmUNET (statewide) and the Baltimore City registry. Title V supports the Baltimore City registry.
4. Providing insurance coverage for immunizations through Medicaid and MCHP.
5. Administering the Vaccines for Children Program (Center for Immunizations)
6. Promoting immunizations through home visiting and early childhood programs, including the newly developed Maryland Home Visiting Program under the auspices of CMCH.
7. Promoting access to medical homes for all children through the Early Childhood Health (ECCS) Grant.
8. Screening for immunization status in WIC and other MCH programs.
9. Participating on the State's immunization partnership, the Maryland Partnership for Prevention.
10. Providing outreach and education to the general public and health care providers to improve immunization levels.
11. Working with the Maryland State Department of Education, Office of Child Care, to increase compliance with childcare immunization requirements.

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	2006	2007	2008	2009	2010
Annual Performance Objective	17.4	16.4	16.4	17.5	17
Annual Indicator	17.5	18.3	17.4	16.3	16.3
Numerator	2118	2200	2055	1879	1879
Denominator	121211	120146	118208	115606	115606
Data Source			MD Vital Statistics, 2008; U.S. Census Bureau	MD Vital Statistics, 2009; U.S. Census Bureau	MD Vital Statistics, 2009; U.S. Census Bureau
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
	2011	2012	2013	2014	2015
Annual Performance Objective	16	16	16	16	16

Notes - 2010

Source: Maryland Vital Statistics Administration, 2009 Annual Report; population (denominator) from U.S. Census Bureau Population Estimates. Data for 2010 is currently unavailable.

Notes - 2009

Source: Maryland Vital Statistics Administration, 2009 Annual Report; population (denominator) from U.S. Census Bureau Population Estimates.

Notes - 2008

Source: Maryland Vital Statistics Administration, 2008 Annual Report; population (denominator) from U.S. Census Bureau Population Estimates.

a. Last Year's Accomplishments

Maryland's birth rate for teens aged 15-19 years of all races dropped from 32.7 per 1000 births in 2008 to 31.2 per 1000 births in 2009. This is after slight fluctuations in the rate for this age group in 2005 to 2007. The rate teen birth rate rose to a high of 34.4 in 2007 (all races). For this same time period (2005 to 2007) the teen birth rate also rose among black teens, going from 48.0 (2005) to 50.8 (2007) and Hispanic teens, going from 87.2 (2005) to 95.5 in 2007. Both of these groups have seen decreases in their teen birth rates since 2007. However in 2009, the birth rate among black teens is still nearly twice that of their White counterparts, while the birth rate for Hispanic teens is nearly three times that of White teens. The rates among these two groups also remain higher than the State average.

In 2010, teen pregnancy prevention efforts were largely addressed and coordinated through the Maryland Family Planning Program and with support from the Title V State Adolescent Health Coordinator. The State Adolescent Coordinator maintained a adolescent health/teen pregnancy prevention listserv to update members on issues of concern and monitored grants to several jurisdictions with high need.

In FY 2010, the Family Planning Program served a total of 18,146 teens ages 15-19 and 1,405 teens under the age of 15. More than 2,400 of these teens were enrolled in the one of the State's three Healthy Teen and Young Adult (HTYA) sites located in Baltimore City and Anne Arundel and Prince George's counties. HYTA clinical services are offered through model clinics which embrace a comprehensive, holistic approach to health care. The program extends special services to teens and young adults who face social, cultural, institutional, and financial barriers to care. The physical and psychosocial needs of the client are equally considered. Part of this holistic approach includes information and counseling about abstinence and delaying sexual activity in addition to assuring assess to contraceptives. The clinics are supported with outreach services based on a philosophy of "Reaching Out/Reaching In." Outreach staff actively reach out to young people where they live, go to school, work, and play. They reach in to young people to develop self-esteem, personal responsibility, and goals for the future.

In FY 2010, the Center for Maternal and Child Health submitted applications for new Affordable Care Act funding for both the Abstinence Education and Personal Responsibility and Education (PREP) programs. PREP program funds will support the implementation of evidence based programs in communities most at risk for high teen pregnancy and sexually transmitted infection rates. These include the eleven jurisdictions were teen birth rates that were higher than the statewide average in 2005-2009. Abstinence education funds were offered statewide to

jurisdictions indicating an ability to meet the required federal match.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide comprehensive family planning and reproductive health services to approximately 25,000 teens annually	X			
2. Fund 3 Health Teen and Young Adult programs promoting a holistic approach to teen pregnancy prevention	X	X		
3. Apply and administer the federal abstinence education grant. Fund abstinence education programming through grants to local health departments and other community based groups.		X		
4. Conduct training and education events including a conference for providers, adolescents and parents/caregivers to promote abstinence and reduce teen pregnancy		X		
5. Collaborate with other agencies to promote positive youth development				X
6. Monitor data and trends				X
7.				
8.				
9.				
10.				

b. Current Activities

The Center for Maternal and Child Health is continuing planning activities to administer abstinence education and PREP funds in 2011. The Baltimore City health department, in partnership with programs such as the Healthy Teen Network, the University of Maryland School of Social Work, and Planned Parenthood of Maryland, are receiving funds from PREP to administer a program targeted at foster care youth and their care givers. This program will use the Power through Choices curriculum and educate teens as well as their caregivers. In addition to this program, the State is will competitively award funds to an additional five to seven local health departments and community based groups to implement additional PREP programming. The Maryland Abstinence Education and Coordination Program is awarding funds to five to seven jurisdictions to implement the abstinence education program according to federal guidelines.

Data from Maryland PRAMS about teen pregnancy will be analyzed and published in a Focus brief later in 2011.

c. Plan for the Coming Year

MCH plans for the coming year include:

- . Continuing to provide family planning services and reproductive health programs directed at adolescent pregnancy prevention including Healthy Teen and Youth Adult sites;
- . Funding five to Abstinence Education programs for middle and high school students and their parents/caregivers in five to seven jurisdictions;
- . Using federal Personal Responsibility Education Program funds to awards funds the Baltimore City Health Department and its partners to work with youth in out of home placements. Remaining grant funds will be competitively disseminated to youth serving organization statewide;
- . Establishing a State PREP Advisory Council; and

. Monitoring and analyzing data and trends to update a State Plan for Teen Pregnancy and Sexually Transmitted Disease Prevention.

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	2006	2007	2008	2009	2010
Annual Performance Objective	30	30	42.5	52	43
Annual Indicator	23.7	42.2	42.4	42.4	42.4
Numerator	17703	25466	25457	25457	25457
Denominator	74696	60400	60040	60040	60040
Data Source			Survey of Oral Health of MD School Children, 05-06	Survey of Oral Health of MD School Children, 05-06	Survey of Oral Health of MD School Children, 05-06
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
	2011	2012	2013	2014	2015
Annual Performance Objective	43	43	45	45	45

Notes - 2010

Source: University of Maryland Dental School, Survey of the Oral Health of Maryland School Children, 2005-2006 School Year. Data for 2009 is currently unavailable.

Notes - 2009

Source: University of Maryland Dental School, Survey of the Oral Health of Maryland School Children, 2005-2006 School Year. Data for 2009 is currently unavailable.

a. Last Year's Accomplishments

Access to oral health care is a critical problem for underserved and minority populations in Maryland. The 2005 - 2006 Survey of Oral Health Status of Maryland School Children, conducted by the University of Maryland Dental School, found that 29.7% of third graders and 32.6% of Kindergarteners had untreated dental caries. Children residing on the Eastern Shore and in Southern Maryland had the highest rates of untreated tooth decay. Low-income, African-American and Hispanic children suffer even higher rates of tooth decay than White and upper-income children.

In 2010, the Office of Oral Health, released "The Burden of Oral Diseases in Maryland" report. This comprehensive report provides an overview on the burden of oral diseases in Maryland for children and adults. The report addresses oral health status, oral cancer, preventive care, access to care, disparities and education and training. One highlight of the report was the limited use of dental services during pregnancy. In 2008, 39.3% of pregnant women reported visiting the dentist in the past year. However, only one fourth of Hispanic women and one third of African American women reported visiting a dentist during their pregnancy. The report also noted that the majority (92.6%) of Marylanders are served by fluoridated water.

Following the death of Deamonte Drive due to dental complications, in 2007, Health Secretary John Colmers convened a Dental Action Committee (DAC) in response to increasing evidence of inadequate access to dental care. The DAC was charged to develop recommendations for improving access to dental services for all low income children. The Committee made seven major recommendations (60 recommendations total) with a goal of establishing Maryland as a national model for children's oral health care. One of their recommendations was to hire a full-time state Dental Director who joined the Department of Health and Mental Hygiene in January 2008. With the strong assistance and support from federal and state legislative partners, Maryland moved forward with numerous dental reforms.

Several Medicaid reforms were instituted. The Maryland Medicaid program carved out the dental program from the Medicaid program to contract with a single dental vendor, DentaQuest Dental Services, to administrate and oversee Medicaid dental services. The Maryland Medicaid dental program is now called Maryland Healthy Smiles and is working to reduce or eliminate many of the bureaucratic barriers that preclude dentists from participating in the Medicaid program. Approximately one third of the state's 4,000 dentists participate in the Medicaid program.

The Maryland Office of Oral Health in tandem with the Maryland Healthy Smiles Program implemented a new program to enable EPSDT Medicaid medical providers such as pediatricians, family medicine physicians and nurse practitioners to be reimbursed by Medicaid for assessing and applying a preventative fluoride varnish agent to very young children not currently being seen by dentists. Over 5,000 medical claims have been submitted by these medical practitioners.

The Dental Action Committee transitioned to a statewide Dental Action Coalition (MDAC) in 2010. MDAC is an independent, broad-based statewide coalition of individuals and organizations dedicated to improving the oral health of all Marylanders through increased prevention, education, advocacy, and access to oral health care. Title V is represented on the Coalition.

The Governor's FY 2010 budget included \$1.5 million to continue support for new or expanded dental public health services, especially targeting jurisdictions without public health clinics. With this funding, every county in Maryland now has a public health safety net dental clinical program. In 2007, only half of the state's jurisdictions had such programs. Funds are being used to establish new dental public health clinics and to support school based dental programs including support for a dental wellmobile.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Partner with the Office of Oral Health, Medicaid and other stakeholders to develop and sustain a statewide Oral Health Coalition focused on improving access to oral health care services and assisting with implementing recommendations				X
2. Survey preschool and school aged children to ascertain and monitor oral health status needs				X

3. Fund and support a range of oral health services for children in local health departments including diagnostic, preventative, and restorative services. Title V supports services in Baltimore City. The Office of Oral Health supports services statewide	X	X		
4. Plan and promote strategies to improve early childhood oral health				X
5. Provide insurance coverage for dental health services for children and pregnant women through Medicaid and MCHP				X
6. Administer a loan repayment program for dentists who serve low income populations (Office of Oral Health)				X
7. Fund school based dental sealant programs				X
8. Promote the P.A.N.D.A. Project, a child abuse and prevention program that trains dentists to recognize abuse				X
9. Disseminate a Resource Guide that identifies discounted and low cost dental health services available to eligible Marylanders		X		
10. Conduct a statewide pilot school sealant demonstration project in partnership with the University of Maryland Dental School to determine the most cost effective means to deliver sealants in school environments	X	X		

b. Current Activities

2011 has been an active year for oral health in Maryland. In May 2011, the Dental Action Coalition along with the Secretary of Health and Mental released the first statewide Oral Health Plan. The 31 page Plan outlines a vision of improved oral health for all Marylanders by focusing on three key areas: Access to Oral Health Care, Oral Disease and Injury Prevention and Oral Health Literacy and Education. The five year plan (2011-2015) has specific goals, objectives and activities for the three key areas. Its development, lead by MDAC, involved many key individuals working in state and local government health care agencies, academic institutions, professional dental organizations, private practice, community-based programs, the insurance industry, and advocacy groups, as well as other important stakeholders and organizations.

Also in May 2011, the Pew Children's Dental Campaign released its annual 50 state report card. Maryland received an A and was rated as the top performing state in the nation for 2011 because it was the only state to meet seven of eight policy benchmarks developed by Pew.

Maryland was also awarded a \$1.2 million federal grant to develop and implement an Oral Health Literacy Campaign to prevent tooth decay in infants and children up to three years old. The campaign's goal is to reach Medicaid-enrolled mothers and guardians of this at-risk population early and often with the knowledge necessary to prevent tooth decay and improve oral health.

c. Plan for the Coming Year

This coming year, the MCH Program will continue:

- . Participating on various statewide alliances and coalitions that address oral health including participation on the Maryland Dental Action Coalition and the Oral Health Literacy Campaign planning group;
- . Working with the Office of Oral Health, the Medicaid Program and MDAC to implement the State Oral Health Plan to improve the oral health of children in Maryland;
- . Collaborating with the Office of Oral Health in planning for the next statewide oral health survey of Maryland schoolchildren, specifically grades K and 3;
- . Assisting the Office of Oral Health in developing a formal surveillance system that includes data

from the PRAMS database for pregnant women; and

. Supporting local health efforts to improve access to oral health services for low-income children.

Office of Oral Health activities will include (1) working with the Maryland State Department of Education to develop a pilot project to demonstrate the effectiveness of a case management approach in integrating dental screenings into the current vision and hearing screening programs tied to school enrollment; (2) working with the Office of Oral Health and the University of Maryland at College Park, School of Public Health in developing a multi-cultural and age-specific oral health literacy campaign that reinforces the importance of oral health to the public and enhances their ability to navigate the dental care delivery system; and (3) working with the Office of Oral Health and University of Maryland Dental School in a pilot project to demonstrate the effectiveness of a dental case management system in improving access to oral health care services for children living in an underserved region of Maryland.

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	2006	2007	2008	2009	2010
Annual Performance Objective	3	3	3.5	2.9	3
Annual Indicator	2.5	3.1	2.3	1.7	1.7
Numerator	28	34	25	19	19
Denominator	1112945	1107687	1099652	1115865	1115865
Data Source			MD Vital Statistics, 2008	MD Vital Statistics, 2009	MD Vital Statistics, 2009
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	1.7	1.7	1.7	1.7	1.7

Notes - 2010

Source: MD Vital Statistics Administration Report, 2009; Data for 2010 not currently available

Notes - 2009

Source: MD Vital Statistics Administration Report, 2009

Notes - 2008

Source: MD Vital Statistics Administration Report, 2008

a. Last Year's Accomplishments

Injuries, including motor vehicle crashes remained the leading cause of death for children. In 2009, (the most recent year for which data is available from the Vital Statistics Administration), the death rate of Maryland Children aged 14 and younger due to motor vehicle crashes was 1.7 per 100,000. This is a decrease from 2.3 per 100,000 in 2008. In FY 2010 the MCH Program continued to provide support and technical assistance to state and local Child Fatality Review (CFR) teams, which are legislatively mandated to review child deaths in Maryland, including those caused by motor vehicle crashes.. Each year, the Child Death Report prepared by the MCH epidemiologist for the State Child Fatality Review Team identifies trends in deaths due to motor vehicle crashes.

State activities directed at preventing deaths due to motor vehicle crashes largely fall outside of the purview of the MCH Program. Maryland has enacted several strict safety belt laws. Due to an overall highly educated population, and as a result of aggressive enforcement of these laws, Maryland has a 94% seat belt usage rate, one of the highest on the east coast. Children and young people up to 16 years of age must be secured in seat belts or child safety seats, regardless of their seating positions and may not ride in an unenclosed cargo bed of a pick-up truck. Maryland law also strictly forbids driving while impaired by alcohol or other drugs and the minimum lawful drinking age is 21 years.

Maryland law requires that, "A person transporting a child under the age of 8 years in a motor vehicle shall secure a child in a safety seat in accordance with the child safety seat and vehicle manufacturers' instructions unless the child is 4 feet, 9 inches tall or taller; or weighs more that 65 pounds". Since the 1980's, the Maryland Kids in Safety Seats (KISS) Program has been the State's lead agency for promoting child passenger safety. KISS is housed in the Family Health Administration's Center for Health Promotion and Education, Division of Injury Prevention and funded by the Maryland Department of Transportation. Its mission is to reduce the number of childhood injuries and deaths by educating the public (e.g., 1-800 helpline, media campaigns, and website) about child passenger safety including the correct use of child safety seats.

During National Child Passenger Safety Month in September 2010, jurisdictions throughout the State participated in child safety seat checks and community outreach and education activities. Throughout the year, KISS staff conducted or assisted with 77 child safety seat inspection events conducted in Maryland, inspecting 1,734 seats. Staff also presented 29 presentations which reached 395 participants. Data from the National Highway Transportation Safety Association (NHTSA) indicates that the national restraint use for all children from birth to 7 years old stood at 88 percent in 2009 as compared with 87 percent in 2008.(the most recent data available). The average state-wide inspection misuse rate is 75 percent. The term "misuse" can range from incorrect restraint type, expired or damaged seats, loose harness, seat not installed tightly, or other minor or serious errors.

KISS continued to administer a loaner program that provided child safety restraints to low-income families. A total of 602 restraints were loaned in FY 2010. In addition, KISS facilitated or assisted with 10 national child passenger safety certification trainings to Marylanders, including but not limited to health care/nursing personnel fire and rescue workers, social services, foster care support staff, police cadets, law enforcement personnel, health department staff and auto dealership staff.

The Division of Injury Prevention in the Center for Health Promotion funds local injury prevention programs, several of which address motor vehicle safety. The Division has also supported the Partnership for a Safer Maryland since its inception in 2005. The Partnership brings agencies together and focuses training and education on a variety of preventable injuries. Currently there is a sub-committee addressing MVA related issues, specifically distracted driving.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct state and local child fatality review processes that include a review of deaths due to motor vehicle crashes				X
2. Enforce strict Maryland child safety seat, safety belt, and DUI laws				X
3. Enforce laws requiring children of certain weights and at certain ages to use child passenger safety seats				X
4. Educate the public about child safety seat laws and the correct use of child passenger safety seats. Administer the Kids in Safety Seats program that includes a free loaner program (Office of Health Promotion)		X		
5. Fund local injury prevention programs promoting motor vehicle safety (Family Health Administration)			X	
6. Monitor data and trends. Publish an annual child fatality review report that includes data on deaths due to motor vehicle crashes				X
7. Collaborate with other agencies and coalitions (e.g. the Partnership for a Safer Maryland, and others) to reduce injuries				X
8.				
9.				
10.				

b. Current Activities

Ongoing activities are continuing in 2011. The MCH Epidemiologist is currently completing the 2011 Annual Child Death Report. Once again, the report identifies injuries, including those due to motor vehicle accidents, as a leading cause of child deaths.

The Center for Health Promotion and Education, Division of Injury & Disability Prevention provides mini-grants to local jurisdictions to address a broad range of injury prevention topics. Five of the 19 jurisdictions receiving funds in 2011 focused on improving child passenger safety by promoting car seat loaner programs and sponsoring educational events.

c. Plan for the Coming Year

In FY 2012, the State Child Fatality Review Team and the MCH Program will continue to partner with other DHMH and state agencies to reduce child deaths due to motor vehicle crashes.

MCH will continue to be represented on the Partnership for a Safer Maryland, in its efforts to advocate for injury and violence prevention. Addressing childhood deaths and injuries due to motor vehicle crashes is one important part of the Coalition's goals.

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	2006	2007	2008	2009	2010

Annual Performance Objective	42	44	41	44	44
Annual Indicator	40.2	43.0	45.5	45.5	45.5
Numerator	31127	33565	35516	35516	35516
Denominator	77430	78057	78057	78057	78057
Data Source			NIS, CDC, 2007 and 2007 Birth Data MD Vital Stat.	NIS, CDC, 2007 and 2007 Birth Data MD Vital Stat.	NIS, CDC, 2007 and 2007 Birth Data MD Vital Stat.
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
	2011	2012	2013	2014	2015
Annual Performance Objective	46	46	46	46	46

Notes - 2010

Source: 2010 data is currently unavailable; Data on percentage of infants breastfeeding at 6 months is from the National Immunization Survey of the CDC, 2007. This percentage was applied to the infant population (denominator) in Maryland in 2007 to produce an estimated numerator.

Notes - 2009

Source: 2009 data is currently unavailable; Data on percentage of infants breastfeeding at 6 months is from the National Immunization Survey of the CDC, 2007. This percentage was applied to the infant population (denominator) in Maryland in 2007 to produce an estimated numerator.

Notes - 2008

Source: 2008 data is currently unavailable; Data on percentage of infants breastfeeding at 6 months is from the National Immunization Survey of the CDC, 2007. This percentage was applied to the infant population (denominator) in Maryland in 2007 to produce an estimated numerator.

a. Last Year's Accomplishments

The 2010 Breastfeeding Report Card (CDC National Immunization Survey for 2007 births) shows 73.4% of Maryland mothers initiating breastfeeding. This is down from the NIS Survey for 2006 births, when breastfeeding initiation in Maryland was 76.4%. However, 45.5% of Maryland mothers continue to breastfeed their child at 6 months (10.5% exclusively), up from the 43.3% for 2006 births. With the exception of breastfeeding at 6 months, these percentages are all slightly below the national averages.

Nationwide, the CDC reports continued racial disparity in breastfeeding rates. For 2007 births (latest data), nationally 58.1% of non-Hispanic Black, 76.2% of non-Hispanic white, and 80.6% of

Hispanic mothers reported ever breastfeeding. Maryland PRAMS data for 2009 births show less racial disparity in breastfeeding rates in Maryland with 79% of non-Hispanic Black, 84% of non-Hispanic white, and 94% of Hispanic mothers ever breastfeeding.

The Title V Program continued to maintain a breastfeeding support website at www.marylandbreastfeeding.org with resources for women, health professionals, and employers. The statewide Breastfeeding-Friendly Workplace Initiative, launched in February 2008, continued to recognize outstanding workplace lactation support programs with the "Maryland Breastfeeding-Friendly Workplace Award", awarded in August 2010, during International Breastfeeding Week. The Title V Program maintains a lactation support room for breastfeeding employees at DHMH.

Breastfeeding promotion continued in Title V funded Improved Pregnancy Outcome (IPO) Programs in every jurisdiction in the State. Breastfeeding educational materials ("Breastfeeding Know-How" and "Benefits of Breastfeeding" brochures and "Maryland Breastfeeding Law" cards) were updated and continued to be provided free of charge to IPO programs and others.

Lactation support in all Maryland birthing hospitals, as outlined in the Maryland Perinatal System Standards, was promoted through Title V involvement in the statewide Perinatal and Neonatal Learning Networks (continuations of the original collaboratives, established in 2007 and 2009, respectively). Also, the Morbidity, Mortality, and Quality Review Committee was convened in FY 2010. This State-level multidisciplinary, multiagency committee is charged with reviewing the incidence and causes of morbidity and mortality related to pregnancy, childbirth, infancy and early childhood. One specific duty of the Committee is to monitor compliance of Level I and Level II hospitals with the Maryland Perinatal System Standards, including the expectation of lactation support. In FY 2010, plans were begun to carry out site visits to all the level I and level II hospitals in the State.

The WIC Program continued to promote breastfeeding as the preferred method of infant feeding for all clients. WIC maintained a Breastfeeding Coordinator and all WIC staff have received training in advanced lactation support. WIC continued its Peer Counseling Breastfeeding Support Program in several Maryland counties.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Disseminate breastfeeding support materials and provide technical assistance for employers to promote breastfeeding support in the workplace, as now mandated by federal health care reform legislation				X
2. Redesign the "Breastfeeding-Friendly Workplace award" to recognize exemplary support programs and program maintained by small businesses (less than 50 employees)				X
3. Educate the public about the passage of "right to breastfeed" legislation in Maryland			X	
4. Fund and support breastfeeding promotion activities in local health departments				X
5. Educate health care providers about the benefits of breastfeeding and encourage health providers to promote breastfeeding			X	
6. Maintain standards for lactation support in all Maryland's birthing hospitals				X
7. Update and maintain the Maryland breastfeeding website				X
8.				

9.				
10.				

b. Current Activities

Title V continues to maintain its breastfeeding support website at www.marylandbreastfeeding.org and to update and expand resources for women, health professionals, and employers. Title V continues its Maryland Breastfeeding-Friendly Workplace Initiative to recognize exemplary workplace lactation support programs, and to maintain a lactation support room for employees at DHMH.

In FY 2011, the Morbidity, Mortality, and Quality Review Committee began site visits to the level I and level II hospitals in the State to monitor compliance with the Maryland Perinatal System Standards, including the expectation of lactation support. Breastfeeding support materials are being distributed to the hospitals at every site visit. The Title V program is also collaborating with the MD Institute of Emergency Medical Services Systems (MIEMSS) to begin the next 5-year site visit reviews of level III centers in early FY 2012. Breastfeeding support will be reviewed at these site visits as well.

c. Plan for the Coming Year

During the coming year, the Title V Program plans to continue its ongoing activities that support breastfeeding as the norm for infant feeding in Maryland. Plans for FY 2012 include:

- Maintain and expand the Maryland Breastfeeding website.
- Outreach to businesses in the State, including State agencies, with resource materials and technical assistance to help them meet the federal Health Care Reform requirements to support lactating women in the workplace.
- Showcase outstanding workplace lactation support programs by recognizing them with the Maryland Breastfeeding-Friendly Workplace Award.
- Expand awareness in the state of the Maryland law protecting the right to breastfeed.
- Provide outreach and technical assistance to local health departments and other State agencies to implement breastfeeding promotion activities appropriate to their area of responsibility.
- Continue site visits to level I and level II hospitals, reviewing compliance with the Maryland Perinatal System Standards, including the expectation of lactation support.
- Collaborate with MIEMSS on site visit reviews of level III centers, reviewing compliance with the Maryland Perinatal System Standards, including the expectation of lactation support.
- Continue to educate health care providers about the benefits of breastfeeding and encourage their promotion of breastfeeding.
- Promote breastfeeding through the Maryland Perinatal and Neonatal Learning Networks.
- Expand community outreach activities to increase the number of Maryland mothers, of all racial and ethnic groups, who not only initiate breastfeeding but continue breastfeeding for at least 6 months. Examples include activities at health fairs, community events, ethnic street fairs, faith-based organizations, etc.
- Continue to identify other funding sources to address breastfeeding promotion activities.

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	2006	2007	2008	2009	2010

Annual Performance Objective	90	90	90	98	100
Annual Indicator	89.4	92.5	98.8	98.7	98.4
Numerator	64657	68622	74276	70984	69637
Denominator	72345	74196	75210	71917	70782
Data Source			State IH System	State IH System	State IH System (Oz 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	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	100	100	100	100	100

Notes - 2010

Number of occurrent births is from the Maryland Infant Hearing Program's OZ eSP database. Calendar year 2010 marks the first full year that this database was fully functional for the entire reporting period.

Notes - 2009

Number of occurrent births is from MD Vital Statistics and is only provisional at this time. The screening data is primarily from the old state IH system because the new OZ eSP system was not in place for the full year.

While we would like to maintain our progress in screening an increasing percentage of babies before hospital discharge, our historical struggles with databases and providers, make us wary of setting 100% as the measure for satisfactory performance. It may not be realistic.

Notes - 2008

Number of occurrent births is from MD Vital Statistics and is only provisional at this time. The screening data is primarily from the old state IH system because the new OZ eSP system was not in place for the full year.

While we would like to maintain our progress in screening an increasing percentage of babies before hospital discharge, our historical struggles with databases and providers, make us wary of setting 100% as the measure for satisfactory performance. It may not be realistic.

a. Last Year's Accomplishments

The calendar year 2010 Maryland hospital birth population included 70,782 newborns who required hearing screens (birth population less home/maternity center births, infant deaths or hospice releases, infants transferred out of state, and infants whose parent refused screening.) The vast majority (69,367) of those babies underwent newborn hearing screening as inpatients and an additional 1111 were tested as outpatients. This translates to a 99.57% screening rate for Maryland. There were 67,855 infants who passed the birth screen and 2,538 who failed, giving Maryland a 96.39% pass rate.

A total of 2,688 of the 3,781 babies who missed or failed their birth screening returned for outpatient screening and 358 had a diagnostic evaluation in place of a second screening. This total (3,046) equals an 80.56% return rate and shows significant improvement as compared to previous years. Of the remaining 735 babies, 171 were not Maryland residents or moved out of

state following their inpatient screen; their follow-up was transferred to their state of residence. 74 babies expired following the missed or initial screen, 3 refused further testing and the remaining 487 were lost to follow-up.

2,768 of the infants who returned for follow-up passed the second screen (2492) or had a normal diagnostic evaluation (276.) This translates to a 90.87% rescreen pass rate. Of the 182 who failed the second screen, 48 were found to have some type or degree of hearing loss and 29 had incomplete hearing evaluations. Of the 39 who skipped the second screen and went directly to diagnostic eval, 44 were found to have some type or degree of hearing loss and 38 had incomplete hearing evaluations. 72 infants with hearing loss were referred for early intervention services and 20 had transient conductive hearing loss.

The Infant Hearing Program (IHP) accomplished a significant amount of education and training for Early Hearing Detection and Intervention (EHDI) providers. At the start of the fiscal year, the program hosted a day-long meeting for parents and providers covering topics such as Syndromal hearing loss, Early Intervention services in Maryland, and parent experiences during the Early Hearing Detection and Intervention (EHDI) process.

The IHP continued training of hospital staff in the use of the program's new database, OZ Systems' eSP™. Infant Hearing Program staff then monitored the hospitals' daily screening processes to identify problems before they became systemic. This was done by giving priority response to providers, i.e. responding to emails and phone messages within an hour; conducting on-site visits for technical assistance and in-services in addition to annual site visits; and providing monthly compliance reports to hospitals that include quantitative results regarding screening rates, failure rates, and reporting compliance. Hospital providers were also able to access 24/7 technical support from OZ-Systems.

In this year the IHP also initiated training on the eSP™ database for community audiologists. An online virtual training was developed for the audiologist users. A live version of the training was held at 3 different times on 3 different days to accommodate a variety of schedules. The training was recorded and subsequently made available upon request. During FY 10, 69 audiologists underwent training and were granted secure access to eSP™.

Finally, presentations were given to many different EHDI providers including early intervention specialists, graduate Audiology students, and hospital administrators. All presentations focused on educating these providers in methods to optimize the EHDI process.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support hearing screening for all Maryland newborns.	X		X	
2. Provide tracking and follow-up on all screening referrals and not tested infants to confirm hearing status.		X	X	
3. Education materials regarding hearing screening for parents, families and providers developed and available.		X		X
4. Education materials developed and available for parents regarding hearing evaluation and developmental milestones in multiple languages for provider use.		X		X
5. Host EHDI Stakeholders meeting for parents and providers covering pertinent topics				X
6. Continue ongoing training for birthing facilities and audiologists/other providers entering patient data in the web based eSP system.			X	X

7. Monitor hospitals' daily hearing screening processes to identify and rectify problems before they become systemic			X	X
8. Continue the enhancement of the eSP database to add additional features.			X	X
9. Birthing facilities provided with site evaluations.				X
10. Educate EHDI providers including early intervention specialists, graduate Audiology students, and hospital administrators on methods to optimize the EHDI process				X

b. Current Activities

The Infant Hearing Program (IHP) fulfilled the vacancy for a program director and for the voluntary position of American Academy of Pediatrics (AAP) EHDI (Early Hearing Detection and Intervention) Chapter Champion.. The IHP continues to collaborate with OZ Systems, Inc. to enhance the eSP™ database. Database enhancements include the design and build of an Early Intervention module which is in progress, de-duplication tool, and the ability to generate hospital compliance reports on demand. Implementation of an upgraded risk-factors letter has allowed for the increased identification of late onset hearing loss in children in Maryland by increasing the number of risk monitoring appointments scheduled. The database system also automatically adds the NICU risk factor when a patient's nursery status is NICU for greater than 5 days.

The IHP is Collaborating with the Birth Defects Registry Information System (BDRIS) to confirm and/or obtain certain risk factor data and through that program. The IHP also collaborates with the Maryland Vital Statistics Administration (VSA) to confirm reports of infant deaths and to ensure that the IHP receives record of all live occurrent births in hospitals as well as out of hospital births. The IHP is also currently working with the Maryland State Department of Education (MSDE) to promote data matching between the MSDE database and the IHP database.

c. Plan for the Coming Year

Since May 2008, the Infant Hearing Program (IHP) in the Maryland Department of Health and Mental Hygiene (MD DHMH) has been using an online database to track and monitor newborn hearing screenings. Enhancements have been made to the current database that enable the IHP to address many of the data system limitations that contribute to the number of infants who are Lost to Follow-up/Lost to Documentation (LTF/LTD) during the Early Hearing Detection and Intervention (EHDI) process. In addition, the method of enhancement will result in a decreased data entry burden for hospital staff.

Existing linkages with birth hospitals and Maryland's Part C provider will be enhanced. This will be accomplished by implementing automatic data transfer from hospital databases of occurrent births and automatic data transfer from the state Early Intervention program. This Project will also create new electronic data linkages to primary care practices.

With anticipated grant funding, MD EHDI hopes to address many of the data system needs that contribute to LTF/LTD. During FY 12, the focus will be to develop automatic data downloading from the birth hospitals' databases. The download is ultimately a two-tiered process, with the first data transfer occurring at the labor & delivery admission, and the second at infant discharge. In addition to the benefit of obtaining complete and accurate data, automatic downloads will help to alleviate the documentation burden for hospital staff. As part of the auto-download process, the eSP™ database would be modified to capture the birth defects data that hospitals are required to report, which will further decrease the reporting burden for hospital staff. As part of the tier one process, fields would be constructed to capture diagnosis and service information data that is collected post-discharge.

The Infant Hearing Advisory Council will hold its 6th Annual Stakeholders Meeting in August,

2011. The seminar will feature a keynote address by Rachel St. John, M.D. Dr. St. John is a board-certified pediatrician who has specialized in the care of children with hearing loss for many years. Her keynote address is entitled, "Fostering EHDI in the Medical Home." There will be other presentations offered.

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	2006	2007	2008	2009	2010
Annual Performance Objective	9.6	9.6	12.1	10	11
Annual Indicator	12.0	12.0	10.0	10.0	10.0
Numerator	163264	163264	136300	136300	136300
Denominator	1360531	1360531	1363004	1363004	1363004
Data Source			U.S. Census Bureau, CPS, 2008-2009	U.S. Census Bureau, CPS, 2008-2009	U.S. Census Bureau, CPS, 2008-2009
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	9	9	9	9	9

Notes - 2010

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2008-2009 (2-year average of data collected in 2008 and 2009). Children defined as age 18 and under.

Notes - 2009

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2008-2009 (2-year average of data collected in 2008 and 2009). Children defined as age 18 and under.

Notes - 2008

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2008-2009 (2-year average of data collected in 2008 and 2009). Children defined as age 18 and under.

a. Last Year's Accomplishments

In 2008-2009, an estimated 7% of Maryland's children aged 0-18 were uninsured. Medicaid and MCHP are partially credited with a Maryland trend towards decreasing numbers of uninsured children. Among racial/ethnic groups, the uninsured rate is highest for Hispanics (19%). Children living in poor or near poor families (< 200% of the poverty level) are four to five times more likely to be uninsured than children living in wealthier families (> 400% of the poverty level).

Medical Assistance and the Maryland Children's Health Insurance Program (MCHP) continued to provide health insurance coverage for low income children. MCHP, which is administered by the Medicaid Program, provided access to health insurance coverage for significant numbers of uninsured Maryland children in families with incomes up to 400% of the poverty level. MCHP Premium serves children in families with incomes between 200% and 300% of the federal poverty level. Enrolled families pay a monthly contribution. During 2010, enrollment in MCHP exceeded 138,000 while Medicaid provided coverage to over 492,000 children and youth ages 0-10.

The Children's Medical Services Program within the OGCSHCN continued to provide coverage for specialty care for uninsured and underinsured CSHCN in family incomes below 200% of the federal poverty level. Since Medical Assistance also covers this same income group, most of the children served are undocumented.

The MCH Hotline (1-800-456-8900) refers families to local health departments to receive assistance in determining their eligibility for Medicaid and MCHP programs. The Hotline received more than 7,500 calls requesting information about eligibility for Medicaid services in 2010. During Child Health Month and other special observances, the CMCH Outreach Coordinator works closely with local health agencies to distribute pamphlets and other materials that promote Medicaid and MCHP. Resource guides, brochures and fact sheets are periodically distributed by CMCH at health fairs and community events.

Governor O'Malley created the Maryland Health Care Reform Coordinating Council through an Executive Order in 2010 to advise the administration on policies and procedures to implement federal health reform. Lieutenant Governor Anthony Brown and Department of Health and Mental Hygiene Secretary John Colmers co-chaired the Council. The Council released its final report in January 2011.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Refer families to Medicaid and medical services through the MCH hotline		X		
2. Provide health insurance coverage for eligible low income children in families with incomes to 250% of FPL through Medicaid and MCHP		X		
3. Provide coverage for eligible CYSHCN through the Office of Genetics and Children with Special Health Care Needs		X		
4. Provide outreach to enroll children into Medicaid and MCHP. Disseminate resource information including source of financial assistance for health care at health/community health fairs and other outreach events (MCH staff in local health departments)		X		
5. Assess health needs and issues confronting uninsured children and families including geographic and racial/ethnic disparities				X
6.				
7.				

8.				
9.				
10.				

b. Current Activities

In FY 2011, State and local MCH programs will continue to support the Medicaid Program in enrolling eligible children and adolescents. Outreach strategies include distributing MCHP/Medicaid eligibility information to schools, licensed day care centers, Head Start programs, and at community events and health fairs. As funding allows, periodic media campaigns are used to promote the MCH Information and Referral Hotline. The MCH Hotline is continuing to refer pregnant women and families to local health departments and other program sites that determine eligibility for Medical Assistance Programs.

Legislation passed during the 2011 Maryland Legislative Session requires Medicaid, beginning on January 1, 2012, to provide family planning services to all women whose family income is at or below 200% of federal poverty guidelines regardless of how recently a woman has delivered a child. Under Medicaid and the Primary Adult Care Program, eligibility for family planning services is currently limited to women with incomes up to 116% of the federal poverty level. Women with incomes up to 200% of federal poverty guidelines may retain family planning coverage for five years following a birth paid for by Medicaid. Federal funds will pay for the majority of the costs of providing these services, with the general fund share of \$1.2 million derived from existing programs. Medicaid savings from a reduction in unintended pregnancies and births are anticipated.

c. Plan for the Coming Year

Reforming the health care system to reduce the numbers of uninsured in Maryland continues to be a priority of the Governor, Lieutenant Governor and Health Secretary Sharfstein. On April 12, 2011 Governor O'Malley signed into law the Maryland Health Benefit Exchange Act of 2011 to develop Maryland's approach to meeting the Affordable Care Act requirement for states to either establish and operate a Health Insurance Exchange by 2014 or participate in the federal Exchange. Maryland has chosen to operate its own Exchange, rather than join a multi-state Exchange or default to a federal Exchange. The Exchange will allow Marylanders to compare rates, benefits, and quality among plans to help individuals and small employers find an insurance product that best suits their needs. The State applied for and was awarded an Exchange Planning and Establishment Grant. Work on the Exchange will continue in 2012.

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	2006	2007	2008	2009	2010
Annual Performance Objective	32.5	32.5	32.5	32	33
Annual Indicator	33.0	33.0	33.1	33.2	32.2
Numerator	10944	11881	14326	16302	20593
Denominator	33164	36002	43317	49065	63951
Data Source			WIC Program Data for 2008	WIC Program Data for 2009	WIC Program Data for 2010
Check this box if you cannot report the numerator because					

1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2011	2012	2013	2014	2015
Annual Performance Objective	32	32	31	31	31

Notes - 2010

Source: Maryland WIC Program data; Maryland WIC estimates for 2010 based on enrollment and BMI analysis for the period, July-December 2010.

Notes - 2009

Source: Maryland WIC Program data; Maryland WIC estimates for 2009 based on enrollment and BMI analysis for the period, July-December 2009.

Notes - 2008

Source: Maryland WIC Program data; Maryland WIC estimates for 2008 based on enrollment and BMI analysis for the period, July-December 2008.

a. Last Year's Accomplishments

WIC program data continues to be the primary source for overweight and obesity data for children younger than five years of age. WIC Program data for 2010 indicates that one in three two to five years old WIC enrollees were overweight and/or obese. In 2010, the prevalence of obesity in Hispanic children 2-5 years (42.5%) was higher than that of whites (30%) and African Americans (27%).

Surveillance data on overweight and obesity among Maryland children and adolescents is limited, but improving. Data sources continue to include the Maryland Youth Risk Behavior Survey (2005 -- 2009), the Maryland Youth Tobacco survey, BMI data collected by the WIC Program through the Maryland Pediatric Nutrition Surveillance System, and Medicaid data collected from chart reviews.

Childhood overweight/obesity was identified as a priority issue in both the 2005 and 2010 MCH needs assessment. The Office of Chronic Disease Prevention (OCDP) has lead responsibility for addressing overweight/obesity in Maryland. CMCH continues to collaborate with OCDP to address childhood obesity through strategic planning, surveillance, provider education, research translation, and public awareness initiatives. In 2010, OCDP provided technical assistance for childhood obesity interventions in Baltimore City, with the State's implementation of the WIC food package changes, and with the implementation and evaluation of school wellness policies.

Dr. Cheryl DePinto leads childhood obesity prevention activities for CMCH and serves on the American Academy of Pediatrics, Maryland Chapter, Childhood Obesity Committee, which partners with CMCH and the OCDP on obesity prevention strategies, outreach, and education. Additionally, she serves as the liaison to OCDP in implementing the Maryland Nutrition and Physical Activity Plan. CMCH funds also support the work of a full-time childhood obesity coordinator in the Office of Chronic Disease Prevention.

In 2010, the data analysis project, "Childhood Overweight and Obesity Surveillance Among Medicaid EPSDT Enrollees" completed the 6th year of implementation. The project was conducted by Dr. DePinto and Lee Hurt, the senior MCH epidemiologist, in collaboration with the Medicaid EPSDT Program. The success of this project resulted in a strengthened collaborative relationship with Medicaid and has set the foundation for childhood obesity surveillance activities among Medicaid enrollees. Dr. DePinto and Ms. Hurt presented the study results to MCO

medical directors, Local Health Officers, and the Childhood Obesity Committee and conducted CME grand rounds presentations. The results of the study showed that a significant proportion of overweight and obese participants are not diagnosed; and many obese participants are not appropriately screened for complications, but of those screened, a significant proportion have an obesity related complication. In 2010 Dr. DePinto and Ms. Hurt also submitted works for publication in the MMWR and were asked to forward a full manuscript for publication.

With ODCP support, two new local initiatives were implemented in 2010. Through the community-wide Healthy Harford initiative, the Harford County Health Department began modeling the ShapeUp Somerville program by partnering with Harford County Public Schools to provide increased physical activity and improved nutrition opportunities in four Title One schools, and wrap around education for teachers, students, and families. The initiatives in these four pilot schools have provided a framework for nutrition and physical activity policy change throughout the school system. For example, schools are increasing physical activity during the school day by pursuing methods to enhance recess time and establishing school-wide walking programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with the Office of Chronic Disease Prevention (OCDP), WIC and others to plan and implment strategies to reduce childhood overweight and obesity				X
2. Implement child and adolescent health components of the state's most recent Physical Activity Plan				X
3. Work with the MD AAP, Medicaid, and others to improve surveillance				X
4. Promote awareness of childhood overweight and ovesity among health providers, families and the general public through presentations, funding of pilot programs and conducting education sessions			X	
5. Support implementation of referral networks and other services for children who are overweight or obese				X
6. Collaborative efforts with the OCDP to develop policy recommendations for reimbursement for obesity risk assessment, prevention and treatment				X
7.				
8.				
9.				
10.				

b. Current Activities

A new draft State Health Improvement Plan identifies the prevention and control of chronic diseases, including obesity/overweight prevention, as a priority focus area. The State, under the leadership of the Office of Chronic Disease Prevention is applying for a federal Community Transformation Grant to implement strategies to prevent obesity and related chronic conditions. The Maryland State Department of Education Office of Child Care is currently developing a Quality Rating and Improvement System (QRIS) to provide a framework for quality child care, and the Office of Chronic Disease Prevention is working to ensure that policies that promote healthy eating and regular physical activity are included in the QRIS. The current surveillance activities as implemented through the Medicaid surveillance project will identify environmental factors that contribute to obesity. More recent data will be added to expand the dataset for the project, and further analysis on co-morbid conditions such as asthma were added. Data from this project will be used to monitor a new state performance measure - % of Medicaid enrollees ages 5-17 with a BMI => 85th percent

c. Plan for the Coming Year

During 2012, Maryland will continue to promote healthier environments for preschool age children. Multiple stakeholders including MSDE, DHMH, and the Maryland AAP are collaborating to develop a preschool wellness policy, which will include strengthening childcare licensing standards related to nutrition, physical activity, and screen time. CMCH and the OCDP will continue to collaborate with the Maryland State Department of Education on implementation and evaluation of wellness policies, and school-based surveillance recommendations.

CMCH and OCDP will continue to collaborate to promote the implementation of the Committee on Childhood Obesity's recommendations and involve relevant organizations including the Maryland Healthy Eating and Active Lifestyle Coalition. OCDP will continue to support two demonstration projects to implement proven, multi-level interventions (Shape Up Somerville and We Can) in two Maryland counties.

The Maryland Health Quality and Cost Council, which is chaired by the Lt. Governor and co-chaired by the Secretary of Health, has a Wellness and Prevention workgroup which has prioritized childhood obesity. As part of the Governor's health reform initiatives, the Health Quality and Cost Council is charged with identifying actionable strategies to create a culture of wellness in Maryland communities. Strategies under consideration include promoting worksite wellness to enhance the health of parents who are role models for their children's behavior, a campaign to promote the availability of data-driven, evidence-based childhood obesity programs through non-profit hospitals' community benefits, and enhancing access to childhood obesity treatment through third-party reimbursement or convergence grants.

The Council will also champion recommendations of other State agencies and Councils that are working to increase access to healthy food and opportunities for physical activity in communities and schools. This Council recently launched the Healthiest Maryland campaign. Healthiest Maryland is a statewide movement to transform communities into healthy environments for all, particularly population racial, ethnic and economic subgroups experiencing health disparities. Maryland is applying for new federal Community Transformation funding. If successful, beginning in 2012, this opportunity will support funding to local health departments to implement primary prevention efforts under the umbrella of Healthiest Maryland. Specifically, this funding opportunity sees to prevent and control tobacco use, prevent obesity and control hypertension. Strategies selected by applicants should be associated with specific measures to achieve health equity, eliminate health disparities, and improve the health of the population and population subgroups.

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	2006	2007	2008	2009	2010
Annual Performance Objective	10.9	10.7	7.6	9	11
Annual Indicator	7.8	9.3	10.9	9.1	9.1
Numerator	6040	6160	7357	6051	6051
Denominator	77430	66425	67625	66567	66567
Data Source			MD PRAMS 2008	MD PRAMS 2009	MD PRAMS, 2009
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over					

the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	9	8.5	8.5	8.5	8.5

Notes - 2010

Source: Maryland PRAMS 2009; Data for 2010 currently unavailable.

Notes - 2009

Source: Maryland PRAMS 2009

Notes - 2008

Source: Maryland PRAMS 2008

a. Last Year's Accomplishments

Data from the 2009 Maryland Pregnancy Risk Assessment Monitoring System (PRAMS) survey indicates that 9% of women surveyed reported smoking during the last 3 months of pregnancy. Smoking was most prevalent among White non-Hispanic (13%) and younger mothers (24%). Among mothers over the age of 19, those with more than a 12th grade education were much less likely to smoke (3%) than those with a 12th grade education or less (16%). Local health departments, particularly in rural areas of the State, have anecdotally noted increasing rates of smoking among pregnant women.

The Maryland Center for Health Promotion and Education is the lead agency responsible for smoking cessation activities in DHMH. This Center administers three smoking cessation programs that include a focus on pregnant women: (1) the Smoking Cessation in Pregnancy (SCIP) Program; (2) a statewide toll-free telephone quitline that delivers cessation counseling services without charge (Quitline); and (3) in-person smoking cessation counseling conducted through local health departments outside the SCIP program (LHD-C Program).

In the fall of 2010, the Center for Health Promotion conducted a statewide tobacco use survey to track smoking patterns among adolescents attending Maryland middle and high schools. A previously planned tobacco survey of Maryland adults was cancelled due to funding issues.

SCIP Program- SCIP is a multi-component program that trains local health department and Medicaid managed care staff to facilitate smoking cessation among pregnant women and women considering pregnancy. Female smokers meet with public health nurses who counsel them to quit or reduce tobacco use. Along with one-on-one counseling, participants receive self-help materials in the form of a manual and a "Quit Kit." In FY 2010, approximately 750 Quit kits and 1,435 brochures were distributed, as well as over 777 other promotional items for the public. The Center updated its SCIP Booklet in Early 2008 to reflect more current data and information.

Quitline- The statewide quitline (1-800-QUIT-NOW) provides cessation counseling by 'Free & Clear' tailored to the individual needs of callers, including pregnant women. During Fiscal Year 2010, the quitline served 51 pregnant women, 57 women planning to become pregnant during the next 3 months, and 10 women then currently breast feeding.

LHD-C Program- During FY 2010, local health departments provided smoking cessation services to 367 pregnant women. These services included promoting smoking cessation during pregnancy as a part of preconception health counseling during family planning clinic visits. Some clinics supplied nicotine patches and/or Zyban to clients. Educational materials promoting smoking cessation were also offered during home visits and at health fairs and other educational events.

Local health departments continued to partner with groups such as the March of Dimes to educate pregnant women about the health risks linked to smoking during pregnancy.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor trends in smoking rates during pregnancy using several data sources including PRAMS and birth records				X
2. Promote smoking cessation during preconception health counseling in family planning clinics, during local health department prenatal care clinic visits and during prenatal and post partum home visits		X		
3. Refer women of child bearing age who smoke to cessation program including Smoking Cessation in Pregnancy (SCIP) administered by the Office of Health Promotion		X		
4. Promote smoking cessation in schools			X	
5. Enforce MD laws enacted to eliminate smoking in schools				X
6. Support enforcement of Maryland's statewide Clean Indoor Air legislation that prohibits smoking in all indoor worksites including restaurants and bars				
7.				
8.				
9.				
10.				

b. Current Activities

CMCH continues to collaborate with multiple intra and inter-agency groups including the Center for Health Promotion, the American Lung Association, private providers, community-based organizations and the American College of Obstetricians and Gynecologists to promote strategies to reduce smoking during pregnancy.

CMCH used the PRAMS dataset to complete additional analyses on smoking during pregnancy. The analysis showed smoking prevalence was significantly higher among mothers with a delivery paid by Medicaid compared to those with private insurance (14% vs. 7%). Smoking prevalence was especially high among White non-Hispanics with a Medicaid delivery (33%). Delayed initiation of prenatal care and inadequate consumption of preconception vitamin supplements are also associated with smoking. Smokers are significantly more likely to report an unintended pregnancy than nonsmokers. Smokers (especially Black non-Hispanic, heavier smokers) are also significantly more likely to report experiencing such stressful life events as homelessness and physical fights with a partner than nonsmokers. Additional analysis showed that heavier postpartum smokers were significantly more likely to report symptoms of postpartum depression than nonsmokers (28% vs. 13%).

c. Plan for the Coming Year

In 2012, CMCH plans to use the PRAMS dataset to continue assessing prenatal use of tobacco. In addition, pilot programs will be implemented in three family planning clinics to enhance smoking cessation referrals.

Additionally, the SCIP Program will continue to distribute self-help materials in the form of a manual and a "Quit Kit," the Quitline will continue to provide cessation counseling and its' own "Quit Kit" to pregnant callers, and the LHD-C programs will continue to provide in-person

cessation counseling to pregnant women who fall outside of the SCIP framework.

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	2006	2007	2008	2009	2010
Annual Performance Objective	4.7	4.6	4.1	6.6	5
Annual Indicator	4.2	6.6	4.7	7.0	7.0
Numerator	17	27	19	28	28
Denominator	406425	408340	407227	401581	401581
Data Source			MD Vital Statistics Annual Report 2008	MD Vital Statistics, 2009	MD Vital Statistics, 2009
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	7	7	7	7	7

Notes - 2010

Source: MD Vital Statistics Annual Report, 2009; 2010 data is currently unavailable.

Notes - 2009

Source: MD Vital Statistics Annual Report, 2009

Notes - 2008

Source: MD Vital Statistics Annual Report, 2008

a. Last Year's Accomplishments

Suicide and homicide are leading causes of deaths among adolescents in Maryland. The rate (per 100,000 population) of suicide deaths among youths aged 15 through 19 was 7.0 in 2009. This represented an increase over the 2008 rate of 4.7 (per 100,000 population). The actual numbers of suicides in this age range increased from 19 in 2008 to 28 in 2009. The suicide rate remained highest for White male teens in 2009.

The Youth Risk Behavior Survey (YRBS) data for 2009 (the most recent available), helped to define the magnitude of depression and suicide among adolescents in Maryland. These data indicated that:

- 26% of high school students reported feeling sad or hopeless, a proxy measure for depression. Rates were higher for females (33%) than males (19.1%). Overall:
- 13.8% reported seriously considering suicide, while 10.9% indicated making a suicide plan.
- 6.3% reported attempting suicide with females (8.1%) more likely than males, (4.6%), to report

an attempt.

- 1.9% reported requiring medical attention following a suicide attempt.

The Maryland Mental Hygiene Administration (MHA) has lead responsibility for administering programs to prevent adolescent suicide among youth and young adults ages 15-24. Maryland is nationally recognized as a leader in reducing adolescent suicide rates among this age group. For the past 15 years, October has been proclaimed as Youth Suicide Prevention Month in Maryland and MHA sponsors an annual conference on suicide prevention. Funds are also awarded to local school districts to sponsor educational events. A full time Youth Suicide Prevention Coordinator supports these activities.

Maryland was the first State in the nation to offer a toll free decentralized Youth Crisis hotline service to address the needs of troubled youth. The 24-hour toll free Youth Crisis Hotline (1-800-422-0008) is staffed by trained counselors and uses a decentralized system which enables the counselor to access or refer the youth to local agencies for assistance. Throughout its 18 year history, the hotline has been very successful in intervening with youth considering suicide.

Youth suicide prevention activities were supported with a grant from the Garrett Lee Smith Foundation in 2010. These funds were awarded to local jurisdictions to support work that focuses on reaching young people through schools and community based projects, particularly in high risk areas.

The Governor's Commission on Suicide Prevention was created by Executive Order in 2010. The Commission's purpose is to decrease suicide across the life span in Maryland by increasing citizen awareness, use of best practices, training and techniques, and access to life saving resources. The Commission was charged with developing a strategic plan to target suicide prevention, intervention and post-vention. The Title V Program's Child Fatality Review Coordinator, represents the Deputy Secretary for Public Health Services on the Commission.

MCH Program activities continued to focus on child fatality review (CFR) processes to prevent child deaths, data collection and analysis of suicide in annual CFR reports, and education and training around suicide prevention. In the summer of 2010, the MCH Program sponsored a session on youth suicide as part of the State's annual four day School Health Interdisciplinary Program (SHIP) conference. Participants were helped to obtain a greater understanding of the stresses experienced by school aged children that too often lead to suicidal thinking. There will likely be a similar session at the 2011 SHIP conference.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct state and local child fatality review processes that include suicide prevention				X
2. Co-sponsor and participate in planning for the annual statewide youth suicide prevention conference				X
3. Work with the Mental Hygiene Administration (MHA) Youth Suicide Prevention Program to implement the statewide plan and promote school based activities				X
4. Administer a statewide Youth Crisis Hotline		X		
5. Collaborate with other stakeholders to promote positive youth development through initiatives such as Ready by 21				X
6. Assess and monitor data on youth suicide and related factors				X
7. Participate in the grant review and awards process from the Garrett Lee Smith Youth Suicide Prevention grant				X

8. Participate in the Governor's Commission on Suicide Prevention				X
9.				
10.				

b. Current Activities

Planning is proceeding on the 2011 Annual Suicide Prevention Conference. The Coordinator of the State Child Fatality Review Team continues as the DHMH/CMCH Title V representative on the planning committee. The next conference is scheduled for October 5, 2011. Title V funds are used to support this conference.

c. Plan for the Coming Year

The Mental Hygiene Administration, in collaboration with the Governor's Commission and CMCH, will continue to plan and implement the annual statewide suicide prevention conference. Title V funds will continue to be used to help in underwriting conference costs. The Mental Hygiene Administration will continue to administer and support a statewide Youth Crisis Hotline. There is also a plan to implement periodic media campaigns, and school based youth suicide prevention programs.

Title V will continue to provide lead staff support for the State Child Fatality Review Team as well as work in tandem with local teams in every jurisdiction. Child fatality review team processes include working to prevent teen deaths due to suicide. Members of the State and local Child Fatality Review Teams, as well as others, will continue to be encouraged to attend the annual suicide prevention conference to build skills in addressing cases of child and adolescent suicide

The Coordinator of the State Child Fatality Review Team will continue to serve as designee for the Deputy Secretary of Public Health Services on the Governor's Commission on Suicide Prevention. The Commission was established in 2010 to bring partners together to impact policy on suicide prevention.

Finally, the MCH Program will continue to review vital statistics data, YRBS results and data from other sources to gain a better picture of the magnitude of youth suicide and related factors (e.g., depression) in Maryland.

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	2006	2007	2008	2009	2010
Annual Performance Objective	89.5	89.6	89.7	89.8	92
Annual Indicator	87.8	89.3	89.4	90.6	90.6
Numerator	1138	1138	1156	1102	1102
Denominator	1296	1275	1293	1217	1217
Data Source			MD DHMH, Vital Statistics Admin 2008	MD DHMH, Vital Statistics Admin 2009	MD DHMH, Vital Statistics Admin 2009
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	92	92	92	92	92

Notes - 2010

Source: MD DHMH Vital Statistics Administration, 2009
 Data for 2010 is currently unavailable

Notes - 2009

Source: MD DHMH Vital Statistics Administration, 2009

Notes - 2008

Source: MD DHMH Vital Statistics Administration, 2008

a. Last Year's Accomplishments

The Center for Maternal and Child Health (CMCH) continued to work to improve hospital-specific birth outcomes and to lower neonatal mortality rates by promoting the standard that all very low birth weight (VLBW) infants should be born at Level III perinatal centers. Level I and Level II hospitals should make every effort to keep the number of VLBW births at those hospitals as close to zero as possible. In 2009, more than 90% of very low birth weight infants born in Maryland were delivered at Level III facilities.

In FY 2010, CMCH and MD Vital Statistics Administration (VSA) again provided hospital-specific data on VLBW births and deaths to all birthing hospitals in the State. Data are presented by encoded hospital of birth, and hospitals are grouped into 3 levels of perinatal care, as outlined in the Maryland Perinatal System Standards. The Standards were most recently updated in October 2008 and are available at http://fha.maryland.gov/mch/perinatal_standards.cfm , The Standards were initially developed in 1995 as voluntary standards for Maryland hospitals providing obstetric and neonatal services. The Standards have been incorporated into the regulations for perinatal referral centers (Level III) by the Maryland Institute of Emergency Medical Services Systems (MIEMSS), and into the Maryland Health Care Commission's State Plan regulations for obstetric units and neonatal intensive care units. The goal of providing hospital-specific data is to improve compliance with the Standards, to reduce the number of VLBW births outside of Level III facilities, and to improve the quality of obstetric and neonatal care in Maryland hospitals.

In FY 2010, the Morbidity, Mortality, and Quality Review Committee was convened. This State-level multidisciplinary, multiagency committee, established in regulation (36:19 Md R. 1436), is charged with reviewing the incidence and causes of morbidity and mortality related to pregnancy, childbirth, infancy and early childhood. One specific duty of the Committee is to monitor compliance of Level I and Level II hospitals with the Maryland Perinatal System Standards, including the standard that all VLBW infants should be born at Level III perinatal centers. In FY 2010, plans were begun to carry out site visits to all the level I and level II hospitals in the State.

Title V funding continued to support the Maryland Advanced Perinatal Support Services (MAPSS), a statewide program of telemedicine and on-site high-risk consultation services provided by the State's two academic medical centers to obstetric provider. This service provides outreach education as well as clinical consultations that allow rural patients to remain in their communities rather than traveling to metropolitan areas of the State for specialty consultations.

With the Maryland Patient Safety Center, Title V continued to support a Perinatal Learning

Network, a continuation of the Perinatal Collaborative begun in 2006. The Network includes 32 member hospitals, with the goal of improving patient safety in labor and delivery units. Focus areas include improving communication, team building, standardizing electronic fetal monitoring, reducing nosocomial infections, and reducing elective deliveries prior to 39 weeks gestation. CMCH is also participating in a Neonatal Collaborative, initiated in FY 2009 by the Maryland Patient Safety Center. Members include 28 hospitals in Maryland, the District of Columbia and Northern Virginia. The goal of this Collaborative is to improve patient safety in neonatal intensive care units. Focus areas include improving communication, team building, reducing central line-associated bloodstream infections, and standardizing initial resuscitation and stabilization of VLBW infants. With the National Perinatal Information Center, the Collaborative is collecting pre and post-intervention data.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide hospital specific data on VLBW births and deaths to Maryland hospitals				X
2. Collect and analyze perinatal data				X
3. Review, update and disseminate the MD Perinatal System Standards				X
4. Provide technical assistance to improve compliance with Standards				X
5. Support and expand statewide program of telemedicine and on-site high-risk consultation services				X
6. Work with the Maryland Patient Safety Center to improve quality of care in hospital settings				X
7.				
8.				
9.				
10.				

b. Current Activities

In FY 2011, CMCH with VSA again provided hospital-specific data on VLBW births and deaths to all birthing hospitals in the State.

The Morbidity, Mortality, and Quality Review (MMQR) Committee began site visits to all level I and level II hospitals in Maryland to monitor compliance with the Maryland Perinatal System Standards. At each site visit, all VLBW births occurring at the hospital in the prior two year reporting period are reviewed to look for systems issues preventing maternal transport to a level III facility for delivery, and opportunities to improve hospital compliance with the Standards.

As part of the GDU project, CMCH has supported expansion of the MAPSS program of telemedicine and on-site high-risk obstetric consultation services provided by the State's two academic medical centers. CMCH continues to support and participate in the Maryland Patient Safety Center's Perinatal and Neonatal Learning Networks.

c. Plan for the Coming Year

CMCH, with VSA, will continue to provide Maryland hospitals with hospital-specific data on VLBW births and deaths, and to monitor perinatal outcomes in the State. These activities will be enhanced by the statewide Morbidity, Mortality, and Quality Review (MMQR) Committee, which will continue to carry out site visits to all level I and level II hospitals in Maryland to monitor

hospital compliance with the Maryland Perinatal System Standards, including the standard that all VLBW infants should be born at Level III perinatal centers. CMCH will also begin planning with the Maryland Institute of Emergency Medical Services Systems (MIEMSS) for the next round of site visits of Level III centers.

CMCH will continue work with the Governor's Delivery Unit (GDU) on the Governor's Strategic Goal to reduce infant mortality in Maryland by 10% by 2012. Work will continue on the three specific focus areas of the project: 1.) healthier women before conception, 2.) earlier entry into prenatal care, and 3.) improved perinatal and neonatal care.

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	2006	2007	2008	2009	2010
Annual Performance Objective	82.3	82.4	81	80	83
Annual Indicator	81.7	79.5	80.2	80.2	80.2
Numerator	62261	62068	62003	60129	60129
Denominator	76248	78057	77268	74999	74999
Data Source			MD Vital Statistics Annual Report 2008	MD Vital Statistics, 2009 Annual Report	MD Vital Statistics, 2009 Annual Report
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
	2011	2012	2013	2014	2015
Annual Performance Objective	83	83	83	85	85

Notes - 2010

Source: MD Vital Statistics Administration, 2009 Annual Report; 2010 data currently unavailable

Notes - 2009

Source: MD Vital Statistics Administration, 2009 Annual Report

Notes - 2008

Source: MD Vital Statistics Administration, 2008 Annual Report

a. Last Year's Accomplishments

In 2009, the percentage of Maryland women accessing first trimester prenatal care increased slightly to 80.2%, after more than a decade of decline. According to Maryland Vital Statistics Administration (VSA), first trimester prenatal care rates in 2009 varied by race and ethnicity.

Since 2005, the greatest percentage increase was among Hispanic women at 68.1% (?7.9%). The 2009 rates were 83.9% among non-Hispanic White women, and 73.7% (?0.4%) among African American women.

More than 3,500 women received late or no prenatal care in 2009. One in four were African American women living in Prince George's County.

The Healthy People 2020 goal is 77.9% of women initiating prenatal care within the first trimester. In 2009, 21 of 24 Maryland jurisdictions met the 2020 goal. The exceptions were Baltimore City (77.3%), Charles County (74%) and Prince George's County (65.7%).

Maryland PRAMS Data for 2009 continued to show that the leading reasons why women do not begin prenatal care in the first trimester relate to lack of health care coverage and availability of obstetric services.

Title V funds continued to support the limited prenatal care clinical services in selected local health departments and home visiting services in other jurisdictions. In Baltimore City, Title V helped to support a team of home visiting nurses and social workers who worked with pregnant and postpartum women facing the most extreme medical and social hardships. In several outlying rural areas with limited obstetric capacity, the local health department, either directly or in partnership with a local hospital, supported the provision of direct prenatal care services. The Maryland Maternal and Child Health Hotline continued to make referrals to prenatal care services in 2010. In State fiscal year 2010, 730 Marylanders contacted the Hotline to receive Medicaid enrollment forms to support pregnancy and childbirth, while 33 women requested a referral for prenatal care services.

The Babies Born Healthy Initiative continued to provide a comprehensive approach to improving perinatal health in 2010. Babies Born Healthy focuses on prevention services and quality improvement. Activities included increasing access to family planning and preconception services; Perinatal and Neonatal Learning Networks advancing patient safety for mothers and infants in Maryland hospitals; strengthening provider capacity and expertise with high-risk obstetric consultation via telemedicine and on-site services through a partnership with the State's two academic medical institutions; and establishing standards for obstetric and neonatal care in Maryland's birthing hospitals.

A state-of-the-art web-based electronic birth certificate was implemented in January 2010, partially with Babies Born Healthy support. This has allowed more timelier and complete reporting of data on prenatal care status and birth outcomes.

In FY 2010, CMCH continued work with the Governor's Delivery Unit (GDU) to develop a plan to achieve the Governor's Strategic Goal of reducing infant mortality in Maryland by 10% by 2012. The GDU Plan builds on the Babies Born Healthy Initiative by expanding prevention services, improving infrastructure, and building new models and systems of care. Initially, 3 jurisdictions (Baltimore City, Prince George's and Somerset Counties) with high infant mortality rates and racial disparities were targeted. The plan has 3 specific focus areas: 1.) healthier women before conception, 2.) earlier entry into prenatal care, and 3.) improved perinatal and neonatal care. The second focus area directly addresses this performance measure.

Also with a goal of earlier entry into prenatal care, Medicaid applications for pregnant women in Maryland have been expedited through a process called "accelerated certification of eligibility" beginning Dec. 1, 2009. If a pregnant woman's application can not be completed within 10 days, she is presumptively enrolled in Medicaid (with a SSN and oral declaration of income) and provided up to 90 days of coverage while the full application is being processed. Services provided during that period will be reimbursed.

These activities are being enhanced by the state level Morbidity, Mortality, and Quality Review (MMQR) Committee, established in regulation, and convened in late FY 2010.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assess and monitor trends in the use of prenatal care		X		
2. Refer women to prenatal care services through the MCH Hotline		X		
3. Fund local health department-based prenatal care services for low-income uninsured pregnant women		X		
4. Support fetal and infant mortality review processes in every jurisdiction to promote perinatal system improvements	X			
5. Promote the importance of early prenatal care in home visiting and care coordination programs	X	X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In FY 2011, Babies Born Healthy Initiative programs and the Governor's Development Unit Initiative continue to focus on prevention services, quality improvement, and data systems development. Dorchester County, a rural jurisdiction on Maryland's Eastern Shore, became a GDU county in 2011 as a result of data demonstrating the need to improve birth outcomes, including large racial disparities.

CMCH began the application process to receive funding under the new federal Maternal, Infant and Early Childhood Home Visiting Program. Maryland plans to fund implementation of evidence based home visiting programs in the State's highest need communities. Goals include reducing infant mortality and improving prenatal care usage rates. Funds will be awarded to local communities later in 2011.

CMCH began conducting site visits at Maryland Level I and II hospitals FY 2011, and began planning with the Maryland Institute of Emergency Medical Services Systems (MIEMSS) for the next round of site visits of Level III centers.

A revised State Infant Mortality Reduction Plan and a new State Health Improvement Plan are currently being finalized. Both plans call for the promotion of strategies to improve rates of early entry into prenatal care.

c. Plan for the Coming Year

Ongoing activities will continue in 2012.

CMCH, with VSA, will continue to monitor the percent of women in Maryland receiving first trimester prenatal care. The Babies Born Healthy and GDU Initiatives will continue to focus on prevention services, quality improvement, and data systems development.

CMCH will work with partners to implement activities and strategies in the State Health Improvement Plan as well the State Infant Mortality Reduction Plan to improve access to quality, comprehensive and timely prenatal care services, particularly for women most at risk. A major focus will be on addressing worsening racial/ethnic disparities in infant mortality and related risk factors. The GDU goal of reducing infant mortality by 10% was met for the overall population in 2009; however, vital statistics data show a worsening of the disparity by race with African

American babies now dying at more than three times the rate of White babies. A new goal was set for the GDU Initiative -- to maintain or further improve the overall infant mortality rate and also to reduce the African American rate by 10% by 2012.

D. State Performance Measures

State Performance Measure 1: *Percent of pregnancies that are unintended*

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance	58.9	60	60	60	60.5
Objective					
Annual Indicator	59.7	56.7	42.4	45.5	45.5
Numerator	46226	44258	28967	30359	30359
Denominator	77430	78057	68252	66756	66756
Data Source			MD PRAMS Report 2007	MD PRAMS Report, 2009	MD PRAMS Report, 2009
Is the Data Provisional or Final?				Final	Provisional
	2011	2012	2013	2014	2015
Annual Performance	60	60	60	60	60
Objective					

Notes - 2010

Source: MD PRAMS Report, 2009; Data for 2010 currently unavailable

Notes - 2009

Source: MD PRAMS Report, 2009

Notes - 2008

Source: MD PRAMS Report, 2008

a. Last Year's Accomplishments

Pregnancy intendedness: In 2009, there was a decrease in intended pregnancies to 54.5%, down from 57.6% in 2008. The U.S. Healthy People 2010 goal was for no less than 70% of pregnancies to be intended.

The Title X Maryland Family Planning Program subsidizes family planning, preconception health, teen pregnancy prevention and colposcopy services provided to women and families in every jurisdiction in the State. The Title X Maryland Family Planning Program serves approximately 70,000 clients annually at 80 sites. Adolescents represent one fourth of persons served. Title V funds continued to partially support the provision of services in 12 jurisdictions in 2010.

The Center began working with family planning programs in three jurisdictions: Baltimore City, Prince George's and Somerset counties, as part of a pilot to expand their scope of services to become Comprehensive Women's Health Centers under the Governor's Delivery Unit (GDU) initiative to reduce infant mortality. These programs promote preconception health, screen for chronic disease conditions, and provide mental health and substance abuse prevention counseling for women seen in the clinics. Program staff began working on development of a comprehensive Reproductive Health Life Plan form specific to the Maryland Family Planning Program based on a review of the existing literature and guidance from related programs. Clinic

staff in the GDU jurisdictions pilot tested and refined the form. In the targeted GDU jurisdictions, the Center worked with Medicaid, WIC/Nutrition Services, Mental Health, and other referral sources to insure prompt referral to/from family planning services to maximize women's health before pregnancy. Changes were implemented in Maryland Family Planning Program Data System (Ahlers System) to track Comprehensive Women's Health services in the targeted jurisdictions and referrals to/from other services.

Programs promote strategies to insure earlier entry into prenatal care for women found to be pregnant, and referral for any conditions, which could negatively affect the health of the woman and their babies. Through collaboration with the Office of Minority Health and Health Disparities, the Program will support culturally competent outreach and education efforts in the community to target hard to reach families and address minority health needs.

The Medicaid Program continued to provide coverage for family planning services to enrollees. In addition, a federal waiver continued to allow the Program to continue coverage for women no longer eligible for Medicaid following pregnancy. Eligible women may receive comprehensive family planning and reproductive health services including contraceptives. However, less than one in three eligible women are receiving services according to Medicaid claims files. Family planning program staff in several jurisdictions, including Baltimore City indicate that many women are still not aware of their eligibility for Medicaid waiver services. This continued to serve as a barrier to care.

The Center for Maternal and Child health continued to support the Babies Born Healthy and the Early Childhood Health Plans. Both initiatives promote strategies to improve access to family planning and preconception health services. Babies Born Healthy is a response to a worsening in the State's perinatal health indicators. This Initiative expanded access to preconception care, prenatal care and postpartum family services for uninsured and uninsurable pregnant women in local health departments and other safety net provider sites.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Subsidize family planning and reproductive health clinical services to promote access to care in every jurisdiction in the state	X			
2. Distribute family planning brochures to all residents requesting a marriage license and insure availability of the brochure for distribution at community events and through other departments				X
3. Analyze and disseminate PRAMS data on pregnancy intendedness in Maryland				X
4. Refer Marylanders to family planning services through the MCH hotline				X
5. Continually update and disseminate family planning program administrative and clinical guidelines				X
6. Identify and implement strategies to reduce teen and unintended pregnancies				X
7.				
8.				
9.				
10.				

b. Current Activities

CMCH was awarded a three-year (July 1, 2008 -- June 30, 2011) Title X Family Planning Supplemental Expansion grant to expand family planning clinical service delivery. Activities are continuing under this grant to provide additional clinical services to populations in need in underserved areas of the State. Strategies include adding new service providers, linking with other community-based entities, and employing clinic efficiency strategies to enhance the ability to serve additional clients. Reproductive health expansion services are targeted to low income clients, with a focus on teen and Hispanic clients, in the Prince George's County/Greenbelt area. Service delivery partners include a federally qualified health center and the Maryland WIC Program.

c. Plan for the Coming Year

Ongoing activities will continue in FY 2012. The Family Planning Program will continue to operate, and focus on a critical assessment of family planning activities and needs both at state and local program levels, as part of a strategic planning process that will take the Program into the future. The MCH Program has prepared a budget initiative seeking additional funding for family planning services. According to the Guttmacher Institute, the Program is currently only able to serve less than half of the 200,000 Maryland women estimated to be in need of subsidized family planning services.

Legislation (the Family Planning Works Act) passed in 2011 will expand eligibility for family planning services in the Medicaid program to all women whose family incomes are at or below 250% of the federal poverty level. Approximately 34,000 Maryland women are expected to be eligible for this expanded program which will begin enrolling women on January 1, 2012. This expansion of family planning services to uninsured women with incomes between 116% and 250% of the federal poverty level is expected to result in savings to the Medicaid Program due to anticipated reductions in the number of Medicaid births, pregnancy and labor complications, low birth weight babies, infant mortality and sexually transmitted infections. The Title V Program will provide technical assistance as needed to assist with program development and implementation.

State Performance Measure 2: *Percent of women reporting alcohol use 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	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator				9.9	9.9
Numerator				6592	6592
Denominator				66378	66378
Data Source			MD PRAMS Report	MD PRAMS Report, 2009 births	MD PRAMS Report, 2009 births
Is the Data Provisional or Final?				Final	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	10	10	10	10	10

Notes - 2010

Source: MD PRAMS Report, 2009. Data for 2010 is currently unavailable

Notes - 2009

Source: MD PRAMS Report, 2009.

a. Last Year's Accomplishments

Prenatal alcohol exposure is the leading known cause of mental retardation. Alcohol exposure at any point during fetal development may cause permanent, lifelong disabilities. Fetal Alcohol Spectrum Disorder (FASD), the term given to disorders caused by prenatal alcohol exposure, was identified as a continuing priority during the 2010 Title V needs assessment. It is estimated that 700 to 750 new cases of FASD occur in Maryland each year.

In 2009, 10% of Maryland PRAMS mothers reported alcohol use during their last trimester. A smaller percentage (2%) reported binge drinking, defined as four or more drinks in one sitting, during the last three months of pregnancy. Alcohol use rates were highest for White women, women 35-39 years of age, and women with a more than a high school education. One in four (26%) women reported binge drinking and 55% reported alcohol use before pregnancy. Local health department staff (particularly those in rural areas) surveyed for the Title V needs assessment indicated that they were seeing increasing evidence of alcohol addiction among pregnant women and women of childbearing age.

In 2006, a statewide FASD Coalition was formed. The Coalition met quarterly in 2010 and included representatives from State agencies (e.g., Education, Juvenile Services, Disabilities), DHMH agencies (e.g., Mental Health, Medicaid), universities and community groups. CMCH provides leadership and staffing for the Coalition and appointed a State FASD Coordinator in 2006. One major Coalition goal is to develop a long range plan for increasing awareness of FASD among all sectors -- health care, substance abuse treatment, social services, education, juvenile services, the faith community, business and industry as well as families and individuals. The Coalition has developed Work Groups to accomplish its tasks. Educational materials (e.g., posters, brochures) and a website have been developed for a public information campaign as mandated by Legislation passed in 2006.

In 2010, the Maryland FASD Coalition sponsored a Social Workers Conference on FASD in cooperation with the University of Maryland, School of Social Work-Continuing Education Department. As a result of this successful conference, the School of Social Work has agreed to develop a curriculum on FASD for the School; to be taught by Kathy Mitchell, President of NOFAS and Co Chair of the Maryland FASD Coalition. At the SAMSHA FASD National Conference in May 2010 the MD FASD Coordinator conducted a presentation entitled: "Developing a State Coordinator Position." In May 2010, a new FASD State Plan was drafted. The FASD Coalition participated in numerous outreach events and health fairs statewide and hosted several events during FASD Month in September.

CMCH and the FASD Coalition held the State's first FASD conference in September 2007. The conference featured both local and national experts and was geared towards professionals serving families affected by FASD. Over 150 professionals attended. The FASD Coordinator also collaborated with the Early Childhood Health Team to develop and implement a CME unit to increase provider awareness of the need to screen patients to prevent and/or address FASD. The target group for training is psychiatrists, psychologists, OB/GYNs, and pediatricians.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide administrative and staff support for a statewide coalition to address Fetal Alcohol Spectrum Disorders (FASD)				X
2. Implement a state mandated outreach and education program to raise awareness about FASD. Develop and disseminate			X	

outreach materials				
3. Maintain a FASD website				X
4. Hold a statewide FASD conference to educate providers and other stakeholders about FASD				X
5. Analyze data and publish issue briefs and reports on the problem of FASD in Maryland				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activities this year have focused on continuing to promote awareness of FASD to professionals, women, teens and the general public. The FASD Coalition and its sub-committees are developing a web based FASD toolkit as a resource for providers who work with women of childbearing age. The Coalition is sponsoring an educational meeting for professionals and service providers. The State Coordinator along with other committee members has been working with the Girls Scouts of Central Maryland to develop a Service Project to promote awareness of FASD among adolescent girls.

An abstract titled, "Partnering to Prevent Fetal Alcohol Spectrum Disorder in Maryland" was accepted for poster presentation at the biannual June 2011 Office on Women's Health Meeting in Alexandria VA. Analysis of Pregnancy Risk Assessment Monitoring (PRAMS) has resulted in two publications from CMCH:

- . Cheng D, Kettinger L, D'Agati D, Lockhart PJ, Hurt L. Alcohol Use Pre-and Late-Pregnancy: Epidemiology and Comments from Postpartum Surveys. In: Pregnancy and Alcohol Consumption. Hauppauge: Nova Science Publishers, 2011
- . Cheng D, Kettinger L., Uduhiri K, Hurt L. Alcohol use during pregnancy: prevalence and provider assessment. *Obstet Gynecol* 2011;116 (2):212-217.

c. Plan for the Coming Year

In the coming year, CMCH along with the FASD Coalition will focus on:

- .Finalizing and widely disseminating a comprehensive five year action plan for the prevention of FASD and improving the system of care for families and individuals affected by FASD.
- .Continuing a five year public information campaign based on recommendations in the FASD plan.
- .Continuing to conduct continuing education seminars on FASD for physicians, health educators, school health personnel, foster care workers and juvenile justice staff.
- .Collaborating with the Department of Juvenile Services to provide a workshop for front line case managers.
- .Organizing a curricula on FASD for the University of Maryland, School of Social Work.
- .Developing three webinars on FASD for educators and consumers.
- .Organizing and hosting a 2nd statewide FASD conference in the fall of 2011.
- .Analyzing available data on alcohol use during pregnancy.
- .Identifying funding to sustain activities.

State Performance Measure 3: *Percent of children enrolled in evidence based home visiting programs in Maryland*

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator			6.0	6.0	6.0
Numerator			2590	2590	2590
Denominator			43000	43000	43000
Data Source			Center for Maternal and Child Health	Center for Maternal and Child Health	Center for Maternal and Child Helth
Is the Data Provisional or Final?				Provisional	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	6	7	7	8	8

Notes - 2010

Denominator - Approximate number of low income children in the State

Notes - 2009

New Performance Measure, data not available

Notes - 2008

New Performance Measure, data not available

a. Last Year's Accomplishments

Federal funding from HRSA was received to support a coordinated system of early childhood home visiting that has the capacity and commitment to provide infrastructure and supports to assure high-quality, evidence-based practices. These funds will enable Maryland to utilize what is known about effective home visiting services and provide evidence-based programs to promote: improvements in maternal and prenatal health, infant health, and child health and development; increased school readiness; reductions in the incidence of child maltreatment; improved parenting related to child development outcomes; improved family socio-economic status; greater coordination of referrals to community resources and supports; and reductions in crime and domestic violence. In FY 2010, CMCH estimates that 2,590 Maryland children under the age of five were receiving services from one of the seven evidenced based home visiting programs approved for funding under the new home visiting initiative. This represents 6% of the 43,000 poor children under the age of five in the State who are potentially in need of evidence based home visiting services.

In FY 2010, Maryland began preparing to meet federal requirements for new federal Maternal, Infant and Early Childhood Home Visiting (MIECHV) funds. These requirements included submission of an initial plan, a comprehensive needs assessment and an Updated State Plan.

During 2010, Maryland submitted the initial plan and was awarded \$500,000 of the \$1.0 million allocated to the State through formula funding. In September 2010, the State completed the statewide home visiting needs assessment which indicated areas of the State most at risk for poor early childhood health outcomes and began work on the Updated State Plan. The Maryland MIECHV Program was created to oversee development and implementation of this work. The Program is initially being staffed by a program administrator and an epidemiologist with support from other key staff in the Title V Program as well as other important partners.

For the needs assessment, Maryland looked at 15 indicators that put children and families at-risk: including infant mortality, premature birth, unemployment, poverty, and crime rates. Maryland collected information about current home visiting programs and substance abuse services throughout the State. Maryland has used a systematic approach for looking at data and capacity in the State and communities. Communities were identified as highest risk based on the number of elevated indicators. Census tract level data was used whenever possible. Communities identified as most at risk located in parts of Baltimore City, and Dorchester Prince George's, Somerset, Wicomico and Washington counties.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct needs assessment and planning activities to identify areas most at risk in the State				X
2. Fund, monitor and provide technical assistance to evidence based home visiting programs in at risk areas of the State				X
3. Collect and analyze data for benchmarking and reporting.				X
4. Hold quarterly meetings with the State Home Visiting Advisory Group				X
5. Conduct process and outcome evaluation				X
6. Identify funding sources and submit funding applications				X
7.				
8.				
9.				
10.				

b. Current Activities

CMCH submitted the required Updated State Plan in May 2011. The State Plan identifies two of the State's at-risk communities in Baltimore City and the City of Cambridge in Dorchester County for initial funding, and outlines program goals and objectives for the State Home Visiting Program. A State Planning Team was convened to provide guidance on plan development.

This year, Maryland also saw an opportunity to improve the wellness of families and young children by applying for competitive funding through a federal HRSA/ACF home visiting initiative. CMCH is seeking these funds to enhance the State's evidence based infrastructure and further support the jurisdictions most at risk. If funded, the grant will allow the State to further create a seamless system of care for young children and their parents/caregivers through a central intake system and expansion of evidence based programming that will allow additional families to receive services.

Title V is also represented on the planning team that is developing Maryland's Race to the Top-Early Learning Challenge Grant application.

c. Plan for the Coming Year

In 2012, Maryland's MIECHV Program plans to:

- . Continue needs assessment and planning activities in "hot and warm spot" communities to position them to implement evidence based programs once funding becomes available.
- . Monitor and provide technical assistance to local groups awarded federal funds to expand evidence based home visiting services.
- . Conduct process and outcome evaluations. The State will require local home visiting programs

who are awarded funds to collect and report a number of benchmark measures on program participants and program inputs.

- . Increase early identification and treatment of mothers for whom nurturing and early attachment to the newborn is impaired. Home visitors will be trained to use a maternal depression screen tool and to assess parental capacity to respond appropriately to the nurturing needs of a newborn.
- . Improve parenting skills. Identify and promote development and replication of parenting curricula that is most effective in teaching parenting at all stages of child development and to families of diverse cultural, ethnic and educational levels.
- . Apply for competitive home visiting funds if the State's 2011 application is unsuccessful.
- . Hold quarterly Home Visiting Program Advisory Group meetings and other stakeholder meetings as needed.
- . Continue Title V representation on numerous inter-agency groups addressing home visiting and early childhood issues. These include the Maryland Home Visiting Consortium, the Home Visiting Alliance, and the State Early Childhood Advisory Council.

The overall goal will be to increase the availability of evidenced-based home visiting services in communities at highest risk. Home visiting programs and home visitors will be trained, supervised and supported in meeting the training and performance standards required by the national accrediting organization for their Home Visiting model.

State Performance Measure 4: *Rate of emergency department visits for asthma per 10,000 children, ages 0-4*

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator			188.1	195.2	195.2
Numerator			7117	7428	7428
Denominator			378334	380606	380606
Data Source			HSCRC, Population U.S. Census	HSCRC, Population U.S. Census	HSCRC, Population U.S. Census
Is the Data Provisional or Final?				Final	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	180	180	180	180	180

Notes - 2010

Source: HSCRC, 2009; Population Data from U.S. Census; Data for 2010 currently unavailable

Notes - 2009

Source: HSCRC, 2009; Population Data from U.S. Census

Notes - 2008

Source: HSCRC, 2008; Population Data from U.S. Census

a. Last Year's Accomplishments

The 2008 Maryland Asthma Surveillance Report (most recent report available) indicates that statewide, an estimated 190,000 children have been diagnosed with asthma at some point in their

lifetime. This represents 13.6% of children. Between 2007 and 2009 and estimated 10.3% of children ages 0-11 had asthma. Emergency department (ED) visits, hospitalizations and mortality suggest a failure to manage asthma properly. Children under the age of five have the highest ED visit of any age group in Maryland. While the Healthy People 2010 goal was for 80 visits per 10,000 population, Maryland's youngest children had 194.9 visits per 10,000 in 2009.

The Maryland Asthma Control Program or MACP addresses both pediatric and adult asthma and is administratively housed in CMCH. The Maryland Legislature mandated establishment of the MACP in 2002 and charged the Program to develop a statewide asthma surveillance system and an asthma control program. Maryland has received a CDC asthma grant since 2001 that supports staff salaries (i.e., an asthma epidemiologist, administrator and evaluator) and funds sub-grantees. Title V partially supports the costs of administrative staff, program printing and the purchase of educational materials.

MACP continued to implement select interventions to reduce asthma morbidity and mortality in 2009. The seventh edition of the Asthma Surveillance Report was completed. Chapters address asthma among Medicaid enrollees, emergency room and hospitalization usage and racial/ethnic disparities in asthma morbidity and mortality. The Program maintains a Website that includes a Maryland Asthma Resource Guide, the most recent asthma surveillance report and other educational materials is available at www.marylandasthmacontrol.org.

An Asthma Action Plan has been developed for use by families and providers to ensure that appropriate actions are taken to control asthma. Health care providers from across the State participated in educational programs focused on adherence to the NHLBI Guidelines and the importance of the Asthma Action Plan. The Asthma Action Plan is available through the MACP to individuals, families, schools and communities.

Asthma continues to disproportionately affect African American children in Maryland, particularly those living in Baltimore City. Title V funding to the Baltimore City Health Department supported the Childhood Asthma Program. This Program provides outreach, education and home-based case management to families of young children (ages < 6) affected by asthma. Parents/caregivers are educated about the importance of eliminating environmental triggers and proper asthma medical management.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administer the Maryland Asthma Control Program				X
2. Continue asthma surveillance activities including annual publication of surveillance reports and briefs				X
3. Revise the State's Asthma Control Plan. Refine and implement a statewide plan to address disparities in asthma outcomes				X
4. Fund local health department based asthma interventions including support to local and regional asthma coalitions				X
5. Co-chair and provide staff support for the MD Asthma Coalition				X
6. Provide staff support for the Children's Environmental Health Advisory Council				X
7. Collaborate with state and local healthy homes initiatives				X
8.				
9.				

b. Current Activities

Throughout 2009 and 2010, MACP has worked diligently with the Maryland Department of Education, local departments of education and local health departments to implement the Asthma Friendly Schools program. Thus far, over 40 schools have been designated as an Asthma Friendly with over 20 more applications pending for school year 2010-2011. In addition, MACP will expand the program to include child care centers and family based programs as designated Asthma Friendly Child Care Centers. In addition, the MSDE is currently developing a Quality Improvement Ratings Scale (QRIS) to provide a framework for Quality Child Care. The MACP is working with MSDE to assure the criteria for AFCC designation will be included in the QRIS. MACP works collaboratively with a variety of stakeholders on the MACP Executive Committee and Maryland Asthma Coalition to ensure the burden of asthma is addressed in all populations and particular focus on disparate populations including children ages 0-4 and the elderly. Research shows that asthma can be effectively managed with medication and quality medical care delivered based on NAEPP guidelines. Reduction in the hospitalization rate is being addressed by provider education, promotion of appropriate medication use, and outreach to disparate populations. Medicaid data on pharmacy claims, provider visits and hospitalization rates will be used to target outreach and education efforts in 2012.

c. Plan for the Coming Year

Proposed asthma activities for 2012 will include:

- Maintaining and expanding the asthma surveillance system. MACP anticipates continued participation in the BRFSS Asthma Call Back Survey. This Survey will provide data on the frequency and severity of asthma episodes, treatment and management practices, environmental controls and exposure, cost, etc. MACP has published five annual comprehensive surveillance reports (2002- 2007), In addition, MACP anticipates an in-depth analysis of Medicaid and MCHP claim/encounter data, particularly assessing prescription drug utilization among children and adults with asthma.

- Educating parents/caregivers, patients and the public about asthma prevalence, treatment and best practices management. The University of Maryland Breathmobile will continue to receive support to conduct education and case management for asthmatic children in Baltimore City. Activities and outreach will take place to educate providers and health officials concerning the updated NAEPP Guidelines.

- Educating providers, nurses and pharmacists in underserved locations (Eastern Shore, Western Maryland, Baltimore City) regarding proper asthma diagnosis and adherence to the NAEPP Guidelines.

- Continuing to support and maintain the Maryland Asthma Coalition and Executive Committee. The Executive Committee serves as an advisory group to MACP staff and guides the Coalition in creation and implementation of asthma specific outreach programs.

- Promoting healthy environments to lessen the impact of asthma. MACP will continue its partnership with a national coalition to educate child care providers concerning the effects of the indoor environment on asthmatic children. This Healthy Homes approach includes in-home education and home assessment for asthma triggers within Prince George's County and in Dorchester County.

- Developing an "action plan" to address disparities in outcomes.

- Implement and expand the AFCC initiative.

State Performance Measure 5: *Percent of children ages 5-17 enrolled in the Maryland Medicaid Program whose BMI >= 85% of normal weight for height*

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator				40.3	40.3
Numerator				110096	110096
Denominator				273190	273190
Data Source				Healthy Kids Study 2009; CHPMD enroll data	Healthy Kids Study 2009; CHPMD enroll data
Is the Data Provisional or Final?				Final	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	39	39	38	38	38

Notes - 2010

MD Medicaid, Healthy Kids Study, 2009 dataset
 Enrollement data from Maryland Medicaid eHealth Statistics, June 2009; data for 2010 currently unavailable

Notes - 2009

MD Medicaid, Healthy Kids Study, 2009 dataset
 Enrollement data from Maryland Medicaid eHealth Statistics, June 2009

a. Last Year's Accomplishments

WIC program data continues to be the primary source for overweight and obesity data for children younger than five years of age. WIC Program data for 2010 indicates that one in three two to five years old WIC enrollees were overweight and/or obese. In 2010, the prevalence of obesity in Hispanic children 2-5 years (42.5%) was higher than that of whites (30%) and African Americans (27%).

Surveillance data on overweight and obesity among Maryland children and adolescents is limited, but improving. Data sources continue to include the Maryland Youth Risk Behavior Survey (2005 -- 2009), the Maryland Youth Tobacco survey, BMI data collected by the WIC Program through the Maryland Pediatric Nutrition Surveillance System, and Medicaid data collected from chart reviews.

Childhood overweight/obesity was identified as a priority issue in both the 2005 and 2010 MCH needs assessment. The Office of Chronic Disease Prevention (OCDP) has lead responsibility for addressing overweight/obesity in Maryland. CMCH continues to collaborate with OCDP to address childhood obesity through strategic planning, surveillance, provider education, research translation, and public awareness initiatives. In 2010, OCDP provided technical assistance for childhood obesity interventions in Baltimore City, with the State's implementation of the WIC food package changes, and with the implementation and evaluation of school wellness policies.

Dr. Cheryl DePinto leads childhood obesity prevention activities for CMCH and serves on the

American Academy of Pediatrics, Maryland Chapter, Childhood Obesity Committee, which partners with CMCH and the OCDP on obesity prevention strategies, outreach, and education. Additionally, she serves as the liaison to OCDP in implementing the Maryland Nutrition and Physical Activity Plan.

In 2010, the data analysis project, "Childhood Overweight and Obesity Surveillance Among Medicaid EPSDT Enrollees" completed the 6th year of implementation. The project was conducted by Dr. DePinto and Lee Hurt, the senior MCH epidemiologist, in collaboration with the Medicaid EPSDT Program. The success of this project resulted in a strengthened collaborative relationship with Medicaid and has set the foundation for childhood obesity surveillance activities among Medicaid enrollees. Dr. DePinto and Ms. Hurt presented the study results to MCO medical directors, Local Health Officers, and the Childhood Obesity Committee and conducted CME grand rounds presentations. The results of the study showed that a significant proportion of overweight and obese participants are not diagnosed; and many obese participants are not appropriately screened for complications, but of those screened, a significant proportion have an obesity related complication. In 2010 Dr. DePinto and Ms. Hurt also submitted works for publication at MMWR and requested they send a full manuscript.

With ODCP support, two new local initiatives were implemented in 2010. Through the community-wide Healthy Harford initiative, the Harford County Health Department began modeling the ShapeUp Somerville program by partnering with Harford County Public Schools to provide increased physical activity and improved nutrition opportunities in four Title One schools, and wrap around education for teachers, students, and families. The initiatives in these four pilot schools have provided a framework for nutrition and physical activity policy change throughout the school system. For example, schools are increasing physical activity during the school day by pursuing methods to enhance recess time and establishing school-wide walking programs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with the Office of Chronic Disease Prevention (OCDP), WIC and others to plan and implement strategies to reduce childhood overweight and obesity				
2. Implement child and adolescent health components of the state's most recent Physical Activity Plan				
3. Work with the MD AAP, Medicaid, and others to improve surveillance				
4. Promote awareness of childhood overweight and obesity among health providers, families and the general public through presentations, funding of pilot programs and conducting education sessions				
5. Support implementation of referral networks and other services for children who are overweight or obese				
6. Collaborative efforts with the OCDP to develop policy recommendations for reimbursement for obesity risk assessment, prevention and treatment				
7.				
8.				
9.				
10.				

b. Current Activities

A new draft State Health Improvement Plan identifies the prevention and control of chronic diseases, including obesity/overweight prevention, as a priority focus area. The State, under the

leadership of the Office of Chronic Disease Prevention is applying for a federal Community Transformation Grant to implement strategies to prevent obesity and related chronic conditions. The Maryland State Department of Education Office of Child Care is currently developing a Quality Rating and Improvement System (QRIS) to provide a framework for quality child care, and the Office of Chronic Disease Prevention is working to ensure that policies that promote healthy eating and regular physical activity are included in the QRIS. The current surveillance activities as implemented through the Medicaid surveillance project will identify environmental factors that contribute to obesity. More recent data will be added to expand the dataset for the project, and further analysis on co-morbid conditions such as asthma were added. Data from this project will be used to monitor a new state performance measure - % of Medicaid enrollees ages 5-17 with a BMI => 85th percent

c. Plan for the Coming Year

During 2012, Maryland will continue to promote healthier environments for preschool age children. Multiple stakeholders including MSDE, DHMH, and the Maryland AAP are collaborating to develop a preschool wellness policy, which will include strengthening childcare licensing standards related to nutrition, physical activity, and screen time. CMCH and the OCDP will continue to collaborate with the Maryland State Department of Education on implementation and evaluation of wellness policies, and school-based surveillance recommendations.

CMCH and OCDP will continue to collaborate to promote the implementation of the Committee on Childhood Obesity's recommendations and involve relevant organizations including the Maryland Healthy Eating and Active Lifestyle Coalition. OCDP will continue to support two demonstration projects to implement proven, multi-level interventions (Shape Up Somerville and We Can) in two Maryland counties.

The Maryland Health Quality and Cost Council, which is chaired by the Lt. Governor and co-chaired by the Secretary of Health, has a Wellness and Prevention workgroup which has prioritized childhood obesity. As part of the Governor's health reform initiatives, the Health Quality and Cost Council is charged with identifying actionable strategies to create a culture of wellness in Maryland communities. Strategies under consideration include promoting worksite wellness to enhance the health of parents who are role models for their children's behavior, a campaign to promote the availability of data-driven, evidence-based childhood obesity programs through non-profit hospitals' community benefits, and enhancing access to childhood obesity treatment through third-party reimbursement or convergence grants.

The Council will also champion recommendations of other State agencies and Councils that are working to increase access to healthy food and opportunities for physical activity in communities and schools. This Council recently launched the Healthiest Maryland campaign. Healthiest Maryland is a statewide movement to transform communities into healthy environments for all, particularly population racial, ethnic and economic subgroups experiencing health disparities. Maryland is applying for new federal Community Transformation funding. If successful, beginning in 2012, this opportunity will support funding to local health departments to implement primary prevention efforts under the umbrella of Healthiest Maryland. Specifically, this funding opportunity sees to prevent and control tobacco use, prevent obesity and control hypertension. Strategies selected by applicants should be associated with specific measures to achieve health equity, eliminate health disparities, and improve the health of the population and population subgroups.

State Performance Measure 6: *The percent of youth with special health care needs (YSHCN) families who participate in transition planning for their child.*

Tracking Performance Measures

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

Annual Objective and Performance	2006	2007	2008	2009	2010
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Data					
Annual Performance Objective					
Annual Indicator					36.8
Numerator					161
Denominator					438
Data Source					2010 Maryland Parent Survey
Is the Data Provisional or Final?					Final
	2011	2012	2013	2014	2015
Annual Performance Objective	40	40	45	45	50

Notes - 2010

This is baseline data for this performance measure, and it comes from the 2010 Maryland Parent Survey for the 2010 Title V Needs Assessment. Subsequent years' data will come from annual surveys of Maryland parents about transition issues, to be conducted through the Parents' Place of Maryland with assistance from Maryland Title V program for CYSHCN.

The rate is calculated by taking the number of respondents who report having a child with special health care needs aged 13 to 21 years (the denominator, n=438), and who answered 'yes' to having participated in the development of a transition plan for their child (the numerator, n=161.) It is important to note that 163 of the 438 respondents did not answer this question; 99 respondents answered "no"; and 15 answered "don't know." If this measure was calculated using only those respondents who answered this particular question (161/275), the rate would be 58.5%.

a. Last Year's Accomplishments

Youth transition to adulthood is one of the six core outcomes identified by the federal Maternal and Child Health Bureau for children and youth with special health care needs (CYSHCN). Please see the 'Last Year's Accomplishments' section under National Performance Measure 6 for a full discussion of Title V activities around transition in FY10. Both quantitative and qualitative data collected for Maryland's 2010 Title V Needs Assessment indicate that Maryland is struggling to ensure that all YSHCN receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. According to the 2005-06 National Survey of Children with Special Health Care Needs (NS-CSHCN), Maryland ranked 42nd in the nation on achieving this core outcome; less than 38% of Maryland families of YSHCN aged 12 to 17 reported that their child received the services necessary to make appropriate transitions to adult life. During FY10, Youth Transition to Adulthood was identified as a state-level priority for Title V programs in Maryland. The needs assessment process began with a population based assessment for children with special health care needs. This assessment included a review of available quantitative data and several sources of qualitative data including a parent survey, a web-based MCH stakeholder survey, and key informant interviews. On the stakeholder survey, a total of 130 respondents including state and local agency staff, local health department staff, advocacy groups, and community based groups and parents ranked their top 5 out of 17 listed priority areas for Maryland CYSHCN and their families. Transition did not rank within the top ten CYSHCN priorities overall; only 31% of respondents ranked it as a top five priority and only 10% ranked it as a number one or two priority. Despite this, youth transition to adulthood emerged as a top priority at the Maryland MCH Needs Assessment Stakeholder Meeting in March 2010. More than 100 MCH stakeholders were invited to attend this meeting to review data and to help determine MCH priority needs for 2011-2015. The 80 attendees included representatives from state and local government agencies, local health departments, advocacy groups, health provider groups, parents, and community-based organizations. After reviewing available quantitative and qualitative data on youth transition to adulthood and other CYSHCN priority areas, and small group discussions between Title V staff and key CYSHCN stakeholders including parents, it was agreed that improving supports for the successful transition of all Maryland youth needed to be a priority focus area for the state. Upon further discussion, it was also agreed that because

participation in transition planning is an important step for families and YSHCN, and increasing the proportion of parents of YSHCN who report engaging in transition planning from pediatric to adult health care has been identified as a Healthy People 2020 objective, that transition planning should be the focus for the performance measure for this priority. Existing state data as of FY10 revealed a low rate of transition planning among families of YSHCN: only 27% of respondents on the 2006 Maryland Medical Home Survey reported that a plan for addressing their child's changing needs had been developed with the child's primary care doctor; and the 2010 Maryland Parent Survey indicated that, among respondents who have a YSHCN aged 14 to 21 years with an IEP, approximately 48% have participated in the development of a transition plan for their child. Further analysis of the 2010 parent survey revealed that, among all respondents with a YSHCN aged 13 years or older only 36.8% reported participation in transition planning for their child. Maryland's Office for Genetics and Children with Special Health Care Needs (OGCSHCN) is the Title V CSHCN program for the state and will be directing many of the activities around youth transition for YSHCN over the next five years.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support The Parents' Place of Maryland in providing individual assistance and training to families and providers around transition issues including transition planning information.		X		
2. Support The Parents' Place of Maryland in the dissemination of transition planning training guides for families and providers.		X		X
3. In partnership with The Parents' Place of Maryland, conduct a survey of Maryland parents of YSHCN including several questions about participation in transition planning for their youth.				X
4. Partner with The Parents' Place of Maryland and the Center for Maternal and Child Health to analyze data gathered from Maryland families of YSHCN on parent participation in transition planning				X
5. Support monthly Transition Lecture Series for youth, families and providers hosted by Kennedy Krieger		X		
6. Support transition clinic activities including clinics for youth with sickle cell disease and youth with diabetes		X		
7. Identify youth transition to adulthood as a state-level priority for Maryland YSHCN and begin more intensive strategic planning to improve this outcome.				X
8.				
9.				
10.				

b. Current Activities

The FY11 OGCSHCN reorganization has allowed for the creation of a Transition Coordinator who developed a transition webpage and an informational brochure for families. OGCSHCN funded transition clinics and the transition lecture series at Maryland Centers of Excellence. OGCSHCN developed and piloted the Parent Survey for Transitioning Youth (the data source for this performance measure for FY11-15.) The Maryland Consortium for CSHCN (CoC), supported by OGCSHCN, conducted quarterly meetings at which transition issues were discussed and questions for the Transition survey were developed. OGCSHCN resumed the staffing of the Statewide Steering Committee on Services for Adults with Sickle Cell Disease (established in 2007 under Maryland HB 793.) The committee had not met in over two years, but is now active again. OGCSHCN hopes to use its involvement to raise general awareness of health care transition issues as well as to ensure that there are appropriate systems of primary and specialty

care for CYSHCN with SCD to transition into as adults. Health care transition materials were submitted to the Maryland State Department of Education (MSDE) for the annual update of their Transition Planning Guide which is provided to students with an IEP at their transition planning meeting. OGCSCHN also staffed a table on health care transition at a recent Baltimore City School System Transition fair, and is active in the planning of an Interagency Transition Council conference this fall.

c. Plan for the Coming Year

The above activities will continue. The OGCSHCN Transition Coordinator is working with PPMD on planning three regional health care transition conferences to take place during FY12. These will be held each year for the next five years. An action plan will be developed to include partnering with MSDE's school health division to provide outreach and education to school nurses and to families regarding health care transition for CYSHCN. Support and technical assistance will also be offered to OGCSHCN grantees who are involved in transition activities. Groundwork has been laid for the formation of a Family and Youth Advisory Council. OGCSHCN now has access to key stakeholders and partners to create such a council and has adequate staff to do so, and the first meeting should occur in the first quarter of FY12.

The data pertaining to transition from the 2010 parent survey continues to be analyzed and OGCSHCN plans to work with PPMD to prepare several issue-specific analyses of gathered data. One such issue is youth transition to adulthood. Plans for analyses include looking for patterns of responses among caregivers who report having participated in transition planning for their YSHCN versus those who report no participation. Findings will be disseminated to stakeholders through the CoC and other OGCSHCN partners.

The CoC, through the D70 grant, will continue to look for opportunities to positively impact this core outcome. At a quarterly meeting, attendees reviewed strategies developed at the 2008 Summit to increase the achievement of successful youth transition to adulthood in Maryland. Progress on strategies was reviewed and next steps and appropriate partners to pursue strategies were identified. A strong focus, along with other initiatives, should be on youth involvement and family training around transition planning, while at the same time consolidating transition resources and information in a user/family-friendly accessible database. OGCSHCN has plans to enhance its statewide resource database to include a comprehensive catalogue of transition resources for families. Families and providers will have access to this database through OGCSHCN's Children's Resource Line. Additionally, the transition webpage will be updated to incorporate information about this resource database. There are plans for an online portal through which Marylanders can access the CYSHCN resource database via the web.

The Parent Survey for Transitioning Youth will be administered during FY12-15 (add youth-answered section); PPMD will conduct the survey each year using their network of parents of YSHCN. Results will be analyzed to inform planning and for reporting for this performance measure.

PPMD will continue to conduct parent trainings around transition during FY12. There are plans to make KKI's Transition Lecture series more widely available throughout the state through posting videos of lectures on websites and enabling web and audio conferencing during live lectures.

State Performance Measure 7: *The percent of Maryland Community of Care Consortium for CSHCN (CoC) members who report 5 or more collaborative activities with Consortium partners in the previous 12 months.*

Tracking Performance Measures

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

Annual Objective and	2006	2007	2008	2009	2010
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Performance Data					
Annual Performance Objective					
Annual Indicator					51.8
Numerator					29
Denominator					56
Data Source					2008 Maryland Community of Care Partnership Profil
Is the Data Provisional or Final?					Final
	2011	2012	2013	2014	2015
Annual Performance Objective	53	54	55	55	57

Notes - 2010

This baseline measurement comes from the 2008 “Maryland Community of Care Partnership Profile,” a survey conducted yearly every two years by the Maryland Community of Care Consortium. Respondents (members of the Consortium) report on the number and types of collaborations they have had in the past year with other Consortium member organizations.

a. Last Year's Accomplishments

Supporting the development and implementation of comprehensive, culturally competent, coordinated systems of care for CSHCN has been identified as a critical objective for states by the federal Maternal and Child Health Bureau. State Title V programs have been asked to work with family advocates, providers, and other partners to achieve success on the six core outcomes for CSHCN. At the March 2010 MCH Stakeholder Meeting for Maryland's Title V Needs Assessment, key Title V CSHCN staff and parent advocates, working together as a group, identified ongoing stakeholder partnerships as the primary method through which several core outcomes for CSHCN in Maryland should be addressed. Earlier in the meeting, a broad collection of stakeholders from across Maryland had selected those core outcomes as top priority needs for the CSHCN population in the state, including medical home, that families receive needed services through easy-to-use, community-based systems of care, and adequate health insurance and financing. Stakeholders agreed that the improvement of CYSHCN outcomes requires a system-oriented, partnership-based approach that incorporates infrastructure, population-based services, enabling services, and direct services. There was further agreement that strong, ongoing partnerships and collaborations in the design and implementation of services for CYSHCN and their families, as well as leadership at the state level have become critical in Maryland.

In 2008, a key partner of the State's Title V program for CSHCN (the Office for Genetics and Children with Special Health Care Needs, or OGCSHCN) - the Parents' Place of Maryland (PPMD) - was awarded a federal "State Implementation Grant for Integrated Community Systems for Children and Youth with Special Health Care Needs" in partnership with OGCSHCN, the Maryland Chapter of the American Academy of Pediatrics, and the Women's and Children's Health Policy Center at the Johns Hopkins Bloomberg School of Public Health. Through the grant and partnerships, PPMD developed the Maryland Community of Care Consortium for CSHCN (or CoC.) Since its inception in Fall 2008, the CoC Consortium has created a broad alliance of diverse stakeholders in collaborative efforts to improve systems of care for Maryland CSHCN and their families. They oversee and spread the use of evidence-based and best practice strategies both at the state and local levels, using mini-grants to support implementation. Much of the CoC's work is aligned with the Healthy People 2020 objective to increase the proportion of CSHCN who receive their care in family-centered, comprehensive, coordinated systems (MICH HP2020-14.)

The CoC has been a leader in building and sustaining partnerships among members while successfully advancing the goals of Title V programs in Maryland since its inception in 2008.

Stakeholders at the aforementioned MCH meeting also concurred that the role of the CoC is essential to the health of Maryland's Title V program.

The CoC conducted research at the 2008 Summit to determine the extent of collaboration among CSHCN stakeholders in Maryland. A survey of CoC participants ("Maryland Community of Care Partnership Profile") regarding the intensity of interaction of agencies/programs on behalf of CYSHCN was designed to document how and to what degree the consortium activities are influencing meaningful working relations among the partners -- parents, providers, advocates, administrators, consumers, and professionals from public, private, and non profit sectors at both the state and community levels. Summit participants were asked to complete a chart indicating whether or not their organization interacted with listed agencies/programs specifically on behalf of CYSHCN in the past 2 years (baseline) and if so, which activities they engaged in. Approximately 57% of COC participants at the initial consortium meeting reported between 5 or more collaborative activities. It was agreed that this composite measure of partnerships among CYSHCN stakeholders should be the performance measure for this priority area.

During FY10, there were 4 quarterly meetings of the CoC with a total of 151 attendees; 27% of attendees were from local, state, or federal government agencies; 29% were parents of CYSHCN; 20% were from parent or non-profit organizations; 11% were from universities or hospitals, 9% were from insurance providers; and 4% were from professional organizations.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Act as a key partner and member of the leadership team for the Maryland Community of Care (CoC) Consortium for CSHCN.				X
2. Educate CoC members about Title V CSHCN Maryland programs and responsibilities, engage them in the needs assessment process, and solicit CoC input for program priorities.				X
3. Identify the building and strengthening of strategic partnerships as a state-level priority for Maryland CYSHCN and begin more intensive strategic planning around this priority.				X
4. Identify maintaining the CoC as a priority and take steps to sustain its existence past its current period of funding (federal funding officially ends in FY12.)				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CoC has been funded since 2008 by a HRSA D70 grant. PPMD, the fiscal agent for the grant, was awarded a no-cost extension with remaining funds to continue to CoC through FY12. PPMD is the main partner of the OGCSHCN in building the infrastructure for a comprehensive, community based, culturally competent, family centered, user-friendly system of care for CYSHCN. During FY11, the CoC held 4 quarterly meetings with a total of over 150 attendees; approximately 34% of attendees were from local, state, or federal government agencies; 10% were parents of CYSHCN; 28% were from parent or non-profit organizations; 8% were from universities or hospitals, 12% were from insurance providers; and 8% were from professional organizations. Each year, the CoC gives out several mini-grants with the purpose of supporting community-based efforts to build infrastructure to improve the system of care for CYSHCN and their families. Awards for FY11 included support for an asthma education program, development

of medical home materials for Prince George's County through the One World Center for Autism, a grant to the Abilities Network for improving systems for children with epilepsy, and an award to COMMHAT, an innovative mental health telehealth project in Western Maryland. The CoC meetings in FY10 and FY11 incorporated trainings for CoC members on Title V CSHCN and the Needs Assessment process, and CoC meeting attendees were regular contributors to the Needs Assessment process.

c. Plan for the Coming Year

Federal funding of the CoC through HRSA's D70 grant ends after FY12. In FY12, quarterly meetings of the CoC will be held and the mini-grants program will continue. One such grant will support a regional CoC Consortium in the mid-eastern shore region of the state, an area with high rates of unmet needs for or delayed receipt of needed health care and related services for CYSHCN and their families. OGCSHCN hopes to move to a regional center model for the service system for CYSHCN and their families, in which each region of the state has a regional center with a hub. The hub will consist, minimally, of a care coordination/case management position, a parent navigator position, and will have a phone number and website that can be used by families of CSHCN and YSHCN in finding assistance and services related to their special health needs. Ideally, the regional hubs will also house a resource/training room for parents and providers with computers, scanners, printers, and a library available for families' use. The hubs will be a connection center for local health departments, primary care pediatricians and specialty providers, providers of related services, mental health and oral health providers, child care providers, etc. within each region that provide or are interested in providing services to CYSHCN and families. The regional consortium on the eastern shore will explore existing relationships among these groups/providers and identify strengths and barriers to the establishment of a regional hub on the eastern shore.

In FY12 the CoC also plans to continue its subcontracts in support of developmental screening and medical home initiatives in the state (see the description of the Baltimore Medical Homes project under the discussion of National Performance Measure 3.)

In FY13 and in future years, the CoC will be funded through OGCSHCN's Systems grant to PPMD, to ensure sustainability of this important work around partnerships and collaboration among Maryland CYSHCN stakeholders. In addition to the partnerships formed and strengthened through the CoC, OGCSHCN works to build and strengthen partnerships outside of the CoC. OGCSHCN has working relationships with the following agencies/offices within DHMH: the Center for Maternal and Child Health, the Laboratories Administration, Environmental Health Protection and Tracking Program, the Office of Oral Health, Vital Statistics Administration (VSA), the Developmental Disabilities Administration, the Mental Hygiene Administration, and Medicaid. Other state agencies that OGCSHCN works with include the Department of Disabilities, the Interagency Transition Council, the Maryland State Department of Education (MSDE), 22 of the 24 Local Health Departments in Maryland, and the Maryland Center of Excellence for Developmental Disabilities. In addition to these government entities, OGCSHCN works with numerous community organizations on a regular basis.

State Performance Measure 8: *Percent of performance measure benchmarks Maryland has reached in implementing a Data Sharing plan among its Title V programs and other government and non-government agencies and organizations.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator					0.0

Numerator					0
Denominator					6
Data Source					Maryland Title V Program Data
Is the Data Provisional or Final?					Final
	2011	2012	2013	2014	2015
Annual Performance Objective	16	33	50	67	100

Notes - 2010

This measure is based on how many (numerator) of 6 (denominator) benchmarks have been reached: Performance measure benchmarks toward implementing an effective data sharing plan for increased data integration are as follows: 1. Assess data sharing needs 2. Identify barriers to data sharing and propose recommendations to overcome them 3. Develop an implementation plan 4. Obtain feedback from stakeholders on implementation plan and make necessary adjustments 5. Pilot test the implementation plan 6. Implement the plan.

As 2010 was the year the measure was developed, no progress was made during that year, so the measure for 2010 is zero.

a. Last Year's Accomplishments

Consistent state level data that indicates the well-being of Maryland's CYSHCN population is crucial to measuring the state's progress on the six core outcomes for this population. However, availability of this data is limited due to agency silo issues and fragmentation among government and non-government agencies and organizations serving the CYSHCN population in Maryland. The data most commonly used to measure Maryland's performance around the six core outcomes is national data from two surveys, the National Survey of Children's Health (NSCH) and the National Survey of Children with Special Health Care Needs (NS-CSHCN.) While these surveys provide valuable information every five years and allows state to state and state to nation comparisons of critical data points and outcomes, they do not provide yearly, statewide, or jurisdiction level data that would help Maryland target resources within the state to improve outcomes for CYSHCN. At a needs assessment stakeholder meeting in March, key Title V CSHCN staff and parent advocates, working together as a group, identified the lack of data sharing among agencies as one of the most significant barriers in planning and implementing strategies to improve core outcomes for CYSHCN in Maryland.

Maryland collects state and jurisdiction level data that would be useful to analyze and evaluate on behalf of CYSHCN and other maternal and child health populations, however in many instances this information is either not made available to or easily accessed by the state's Title V CSHCN program, the Office for Genetics and Children with Special Health Care Needs (OGCSHCN). Examples from the aforementioned stakeholder meeting include: Infants and Toddlers program data (through Maryland State Department of Education); Maryland Head Start program data; Medicaid/Managed Care Organizations; SSDI; and EPSDT.

Even when the data is available or easily accessible, it is not always integrated in such a way as to make analysis or evaluation feasible in a timely manner. Examples include: Infant Hearing Screening (or EHDI) program data; Birth Defects (BDRIS); long-term follow-up for metabolic disorders and sickle-cell disease; Maryland Assessment Tool for Community Health (MATCH); Maryland Pregnancy Risk Assessment Monitoring System (PRAMS); and Children's Medical Services (CMS) for CYSHCN.

The need for data sharing and integration in support of MCH populations is recognized in the Healthy People 2020 Public Health Infrastructure objective PHI-11.2: Integrated data management. Greater data sharing, systems development, and integration of current databases would enable state agencies to improve state and local capacity to collect, analyze, share, translate and disseminate MCH data and evaluate programs. This would result in a more comprehensive assessment of Maryland's achievement and progress for each of the six core

outcomes for CYSHCN. This could lead to a more efficient use of state and partner resources, resulting in better health outcomes for CSHCN in Maryland. To this end, a primary focus of Title V in Maryland for the next five years will be to enhance data sharing among Maryland's Title V CSHCN program, the Center for Maternal and Child Health, and other state and local government and non-government agencies and organizations in order to better target state efforts to improve systems of care for CYSHCN and to provide timely information to stakeholders. The performance measure for this priority is the percentage of performance measure benchmarks Maryland has reached toward implementing a Data Sharing plan. The benchmarks are as follows: 1. Assess data sharing needs; 2. Identify barriers to data sharing and propose recommendations to overcome them; 3. Develop an implementation plan; 4. Obtain feedback from stakeholders on implementation plan and make necessary adjustments; 5. Pilot test the implementation plan; 6. Implement the plan.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct a population based needs assessment of Maryland CYSHCN and their families in support of the Title V 2010 Needs Assessment.				X
2. In partnership with The Parents' Place of Maryland, conduct a survey of Maryland parents of CYSHCN in order to gather more detailed data about the population of CYSHCN and their families in Maryland.				X
3. Begin analyses of the data gathered from the 2010 Maryland Parent Survey.				X
4. Identify Data Systems and Sharing as a state-level priority for Maryland CYSHCN and begin more intensive strategic planning around this priority.				X
5. Begin to assess data systems and sharing needs in OGCSHCN.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In FY11, through the SSDI grant, a consultant was hired to convene and lead a Data Work Group among the programs in Maryland's Family Health Administration (FHA) within the Department of Health and Mental Hygiene. OGCSHCN is part of FHA, as is the Center for Maternal and Child Health. This work group identified data needs among all participating programs in FHA and is focused on 3 main areas- Access, Support, and Standards. Through this data work group, OGCSHCN is completing much of the needed work around benchmarks one and two of this performance measure with its FHA partners, including CMCH. OGCSHCN has also assessed data sharing needs and begun identifying barriers to sharing with external partners- projects include data collaboration activities with the Vital Statistics Administration and Maryland State Department of Education. The infant hearing screening program has initiated and integrated a statewide online data management system for the Maryland Early Hearing Detection and Intervention Program. The online data base allows for virtually real time data sharing which facilitates more timely and accurate follow up and improved continuity of hearing health care. OGCSHCN also worked with Maryland's Community of Care Consortium (CoC) for CSHCN in developing an action plan for this state priority.

c. Plan for the Coming Year

During FY12, OGCSHCN will continue to identify barriers to data sharing (assessing data needs and barriers to sharing will be continual throughout this Needs Assessment cycle.)

Implementation plans will also be formulated- there will most likely be multiple plans, one with internal FHA and other DHMH partners through SSDI activities, and one or more with external partners. An implementation plan has been developed with external partners, the Maryland Center for Developmental Disabilities (MCDD) and the Women and Children's Health Policy Center at Johns Hopkins Bloomberg School of Public Health, through a joint application for funding to the Robert Wood Johnson Foundation. Whether or not this funding is received, the plan, which focuses on developing and implementing a continuous quality improvement information system for children with special health care needs in Maryland, will move forward.

The FHA Data group will continue, with a focus on ensuring linkages between OGCSHCN, CMCH, and other FHA partners. OGCSHCN will continue to strengthen and expand data linkages within its own programs and with partners. OGCSHCN houses a powerful database for tracking infants in its Infant Hearing Program (IHP.) The data system, called the eSP™ database, is administered and maintained by OZ Systems and managed by IHP staff to track the hearing screening of all newborn infants in Maryland and to facilitate follow-up with families and primary care physicians of infants who have risk factors or who fail hearing screens. There are no direct links between the eSP™ database and other State health department databases. This type of linkage, if forged, would prove invaluable both in coordination of follow up and evaluation of prevalence and incidence, socio-economic and demographic impacts, service delivery needs, and care coordination. In Maryland, development and integration of databases has occurred in isolation, which makes after-the-fact data sharing linkage costly and labor intensive. A file sharing relationship is being developed with the Vital Statistics Administration, and there are also plans to enact direct file sharing with with the state's Part C provider, the Infants and Toddlers program (ITP.) Maryland has applied for funding from the Centers for Disease Control and Prevention (CDC) for funding to finance these enhancements to the eSP™ database. These enhancements will improve the state's ability to capture complete and accurate demographic data on all infants born in a hospital. The CDC funding would also create direct electronic links with hospitals and doctors and with the ITP. Maintaining the eSP™ database is crucial to the operability of OGCSHCN's follow-up programs for CSHCN and the database could provide a powerful platform to create linkages between OGCSHCN, CMCH, and other databases.

OGCSHCN also intends to continue building its resource database for families and providers and will focus on the creation of a web portal to access this database.

E. Health Status Indicators

Introduction

Health status indicator data is collected from several sources including Vital Statistics, the Injury and Sexually Transmitted Infections surveillance systems, and State program databases. Form 21 provides important data on the socio-demographic and socio-economic characteristics of children in Maryland. Social factors are important determinants of health. These data are used to monitor trends in social factors that may have either a negative or positive effect on the health of Maryland children. The data are distributed to MCH staff at the State and local levels to assist with program planning and policy development.

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

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	9.4	9.1	9.3	9.2	9.2
Numerator	7294	7133	7163	6865	6865
Denominator	77430	78057	77268	74999	74999
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010

Source: Vital Statistic Report data for 2009. 2010 data is not yet available.

Notes - 2009

Source: 2009 data is currently unavailable; Percent of births <2,500 grams provided by Vital Statistics Report, 2008. Total number of live births from Vital Statistics Report, 2008.

Notes - 2008

Source: Percent of births <2,500 grams provided by Vital Statistics Report, 2008. Total number of live births from Vital Statistics Report, 2008.

Narrative:

According to the Maryland Vital Statistics Administration and the National Center for Health Statistics, low birthweight (LBW) births have increased over the past decade, both nationally and in Maryland. Comparing 1999 and 2009 data, LBW births are up 7.9% nationally, but up only 2.2% in MD. Over this period, LBW births in MD increased by 7.5% among white infants, but fell by 3.6% among Black infants. Among Hispanic infants, LBW births have increased by 9.2% from 2000 when data were first collected. From 2007 to 2008, LBW births in MD increased slightly. There was no change in the national percentage at 8.2%, according to preliminary data.

The MD percent LBW remains above the national average (9.2% in MD (2009) vs 8.2% in the U.S. for 2008 births). Although MD's overall percent LBW is higher than the national average, race and ethnic specific percentages in MD are generally at or below the US rates. In 2009, 7.2% of white infants, 13.2% of Black infants, and 7.1% of Hispanic infants were LBW in MD, compared with 7.2% white, 13.7% Black, and 7.0% Hispanic nationally. The higher overall percent of LBW in MD is the result of demographics in the State.

CMCH is involved in many initiatives to reduce LBW births. In FY 2010, Babies Born Healthy Initiative programs continued to focus on prevention services, quality improvement, and data systems development. A state-of-the-art web-based electronic birth certificate was implemented in January 2010, and will allow timelier and more complete reporting of data on birth outcomes. Other ongoing activities included increasing access to family planning and preconception services, perinatal and neonatal Collaboratives advancing patient safety for mothers and infants in Maryland hospitals, establishing standards for obstetric and neonatal care in Maryland's birthing hospitals, and strengthening provider capacity and expertise with high-risk obstetric consultation via telemedicine and on-site services through a partnership (the MD Advanced Perinatal Support Services [MAPSS]) with the State's two academic medical institutions. In FY 2009, CMCH completed regulations for House Bill 535, passed by the MD Legislature in 2008. The regulations codify the State's FIMR Program, and establish a Morbidity, Mortality and Quality Review Committee to review statewide outcomes related to pregnancy, childbirth, infancy and early childhood. This Committee convened in late FY 2010.

The new Governor's Delivery Unit (GDU) Plan addresses the Governor's strategic goal to reduce

infant mortality by 10% by 2012. The GDU Plan builds on the Babies Born Healthy Initiative by expanding prevention services, improving infrastructure, and building new models and systems of care. 3 jurisdictions (Baltimore City, Prince George's and Somerset Counties) with high infant mortality rates and racial disparities have been targeted. CMCH is the lead agency with collaboration from various state agencies.

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

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	7.3	7.2	7.2	7.2	7.2
Numerator	5441	5373	5318	5235	5235
Denominator	74295	75083	74109	72251	72251
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010

Source: Vital Statistic Report data for 2009. 2010 data is not yet available.

Notes - 2009

Source: 2009 data is currently unavailable; Vital Statistics Administration, 2008

Notes - 2008

Source: Vital Statistics Administration, 2008

Narrative:

According to the Maryland Vital Statistics Administration and the National Center for Health Statistics, low birthweight (LBW) births have increased over the past decade, both nationally and in Maryland. Comparing 1999 and 2009 data, LBW births are up 7.9% nationally, but up only 2.2% in MD. Over this period, LBW births in MD increased by 7.5% among white infants, but fell by 3.6% among Black infants. Among Hispanic infants, LBW births have increased by 9.2% from 2000 when data were first collected. From 2007 to 2009 slightly. There was no change in the national percentage at 8.2%, according to preliminary data.

The Center for Maternal and Child Health (CMCH) is involved in many initiatives to reduce LBW births. In FY 2010, Babies Born Healthy Initiative programs continued to focus on prevention services, quality improvement, and data systems development. A state-of-the-art web-based electronic birth certificate was implemented in January 2010, and will allow timelier and more complete reporting of data on birth outcomes. Other ongoing activities included increasing access to family planning and preconception services, perinatal and neonatal Collaboratives advancing patient safety for mothers and infants in Maryland hospitals, establishing standards for obstetric and neonatal care in Maryland's birthing hospitals, and strengthening provider capacity and expertise with high-risk obstetric consultation via telemedicine and on-site services through a partnership (the MD Advanced Perinatal Support Services [MAPSS]) with the State's two academic medical institutions. In FY 2009, CMCH completed regulations for House Bill 535,

passed by the MD Legislature in 2008. The regulations codify the State's FIMR Program, and establish a Morbidity, Mortality and Quality Review Committee to review statewide outcomes related to pregnancy, childbirth, infancy and early childhood. This Committee convened in late FY 2010.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	1.9	1.9	1.9	1.8	1.8
Numerator	1473	1474	1462	1373	1373
Denominator	77430	78057	77268	74999	74999
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010

Source: Vital Statistic Report data for 2009. 2010 data is not yet available.

Notes - 2009

Source: Vital Statistics Administration, 2008 Report
2009 data is currently unavailable

Notes - 2008

Source: Vital Statistics Administration, 2008 Report

Narrative:

The new Governor's Delivery Unit (GDU) Plan addresses the Governor's strategic goal to reduce infant mortality by 10% by 2012. The GDU Plan builds on the Babies Born Healthy Initiative by expanding prevention services, improving infrastructure, and building new models and systems of care. Initially, 3 jurisdictions (Baltimore City, Prince George's and Somerset Counties) with high infant mortality rates and racial disparities have been targeted. CMCH is the lead agency with collaboration from the Office of Minority Health & Health Disparities, Medicaid, Alcohol & Drug Abuse Administration, Mental Hygiene Administration, WIC, and local health departments in the 3 target jurisdictions, as well as the Department of Human Resources and the Governor's Office for Children. Programs and strategies focus on the three critical periods before, during, and following pregnancy, and include:

- . Family planning service expansion to a broader Comprehensive Women's Health model, with the goal of healthier women at the time of conception and planned pregnancies.
- . Implementation of a Medicaid Accelerated Certification of Eligibility (ACE) process, providing coverage for pregnant women beginning within 48 hours of an abbreviated application process and continuing up to 90 days while a full Medicaid application is completed, with a goal of earlier entry into prenatal care.
- . "Quickstart" prenatal care services at the three local health departments, with expanded screening and referral services, and deployment of community outreach workers, with a goal of risk-appropriate early prenatal care.
- . A standardized post-partum discharge referral process for birthing hospitals statewide, piloted in the three target jurisdiction, assuring coordination between hospitals, providers, local health

departments and community services, with a goal of risk-appropriate follow-up services for mothers and infants. Promoting "Safe Sleep" will be a key component. CMCH will also conduct site visits at all MD Level I and II hospitals to promote compliance with the Perinatal Standards. In 2010, CMCH will begin planning with the MD Institute of Emergency Medical Services Systems (MIEMSS) for the next 5-year site visit reviews of Level III centers.

/2012/Above narrative was updated//2012//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	1.5	1.5	1.5	1.5	1.5
Numerator	1095	1090	1089	1084	1084
Denominator	74283	75083	74109	72251	72251
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010

Source: Vital Statistic Report data for 2009. 2010 data is not yet available.

Notes - 2009

Source: Vital Statistics Administration, 2008
2009 data is currently unavailable

Notes - 2008

Source: Vital Statistics Administration, 2008

Narrative:

The new Governor's Delivery Unit (GDU) Plan addresses the Governor's strategic goal to reduce infant mortality by 10% by 2012. The GDU Plan builds on the Babies Born Healthy Initiative by expanding prevention services, improving infrastructure, and building new models and systems of care. Initially, 3 jurisdictions (Baltimore City, Prince George's and Somerset Counties) with high infant mortality rates and racial disparities have been targeted. CMCH is the lead agency with collaboration from the Office of Minority Health & Health Disparities, Medicaid, Alcohol & Drug Abuse Administration, Mental Hygiene Administration, WIC, and local health departments in the 3 target jurisdictions, as well as the Department of Human Resources and the Governor's Office for Children. Programs and strategies focus on the three critical periods before, during, and following pregnancy, and include:

- . Family planning service expansion to a broader Comprehensive Women's Health model, with the goal of healthier women at the time of conception and planned pregnancies.
- . Implementation of a Medicaid Accelerated Certification of Eligibility (ACE) process, providing coverage for pregnant women beginning within 48 hours of an abbreviated application process and continuing up to 90 days while a full Medicaid application is completed, with a goal of earlier entry into prenatal care.
- . "Quickstart" prenatal care services at the three local health departments, with expanded screening and referral services, and deployment of community outreach workers, with a goal of

risk-appropriate early prenatal care.

. A standardized post-partum discharge referral process for birthing hospitals statewide, piloted in the three target jurisdiction, assuring coordination between hospitals, providers, local health departments and community services, with a goal of risk-appropriate follow-up services for mothers and infants. Promoting "Safe Sleep" will be a key component. CMCH will also conduct site visits at all MD Level I and II hospitals to promote compliance with the Perinatal Standards. In 2010, CMCH will begin planning with the MD Institute of Emergency Medical Services Systems (MIEMSS) for the next 5-year site visit reviews of Level III centers.

/2012/Above narrative was updated//2012//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	5.2	6.5	5.5	4.7	4.7
Numerator	58	72	60	53	53
Denominator	1112945	1113284	1099652	1115865	1115865
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010

Source: Vital Statistic Report data for 2009. 2010 data is not yet available.

Notes - 2009

Source: MD Vital Statistics Administration, 2008
Data for 2009 is currently unavailable

Notes - 2008

Source: MD Vital Statistics Admin, 2008

Narrative:

Strategies to maintain and/or improve the death rate due to intentional injuries among children aged 14 and younger include the assessment of deaths by the Child Fatality Review Teams (CFRT) that exist in every jurisdiction in Maryland. The teams review and analyze each death and report any community/systems issues that impacted or contributed to the death. Recommendations are made to the community to prevent any recurrences. These recommendations may include the need for policy changes, community education and resource development.

The Center for Maternal and Child Health provides administrative support to the CFRT. The CFRT receives reports on child deaths from the Office of the State Medical Examiner and these reports form the foundation of the case reviews.

In 2009 the State CFR focused on amending the law to allow local CFR teams to participate in a

system of electronic data entry offered free to states by the National Center for Child Death Review. Over time, participation in this system will improve state data and allow for better understanding of child deaths and improve planning to address them. Additionally, there has been on-going focus on injury prevention in relation to MVC's. Also, Safe Sleep remains an area of great concern and teams are encouraged to use and promote the trainings offered by the Center for Infant and Child Loss which focuses its efforts on safe sleep. Likewise, CMCH staff participate in meetings and trainings offered by the Partnership for a Safer Maryland and Safe Kids, two organizations dedicated to injury prevention.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	2.5	2.8	2.3	1.7	1.7
Numerator	28	31	25	19	19
Denominator	1112945	1113284	1099652	1115865	1115865
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010

Source: Vital Statistic Report data for 2009. 2010 data is not yet available.

Notes - 2009

Source: MD Vital Statistics Administration, 2008 Report
Data for 2009 is currently unavailable.

Notes - 2008

Source: MD Vital Statistics Administration, 2008 Report

Narrative:

In 2009, the death rate per 100,000 for unintentional injuries among children 14 years and younger due to motor vehicle accidents was 1.7. This is a decrease from the 2008 rate of 2.3 per 100,000.

Strategies to maintain and/or improve the death rate due to intentional injuries among children age 14 and under due to motor vehicle crashes (MVCs) include the assessment of deaths by the Child Fatality Review Teams (CFRT) operating in each jurisdiction in Maryland. These teams review and analyze each death and report any community/systems issues that impacted the death. Recommendations are made to prevent recurrences. These recommendations may include the need for policy changes, changes to laws, community education, resource development or actual physical changes at the site of the accident.

The Center for Maternal and Child Health provides administrative support to Child Fatality Review teams. The State Child Fatality Review Team supports the local CFR teams in Maryland and

receives feedback from local teams. Local CFR teams receive monthly reports from the Office of the Chief Medical Examiner (OCME) listing the children who died the previous month from unusual or unexpected causes. These reports form the foundation of the CFR case review and enable local CFR teams to seek more information for the case review.

Collaboration exists with the Partnership for a Safer Maryland and the Children's Safety Network which provide networking meetings, training programs, webinars, etc., to prevent MVCs (and other injuries) among children 14 years and younger, as well as older individuals. Additionally, a program promoting use and training regarding child safety seats is a very active in Maryland. It is implemented under the Center for Health Promotion and Education within the Family Health Administration at the Maryland Department of Health and Mental Hygiene.

Finally, a law was passed in 2009 that enabled Maryland child fatality review teams to participate in a free system of electronic data collection supported by the National Center for Child Death Review. The standard use of this electronic system for data collection began in earnest in 2010, when all local CFR teams began to be required to use it. Ultimately, this electronic data collection will improve data collection and over time will allow for better understanding and assessment of child fatalities in Maryland.

/2012/ The narrative above was updated. /2012//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	21.6	22.0	17.1	15.2	15.2
Numerator	169	173	134	119	119
Denominator	780609	786990	784401	783608	783608
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010

Source: MD Vital Statistics Administration, 2009 Report
2010 data is currently unavailable.

Notes - 2009

Source: MD Vital Statistics Administration, 2009 Report

Notes - 2008

Source: MD Vital Statistics Administration, 2008 Report

Narrative:

/2012/ In 2009, the death rate due to motor vehicle crashes in ages 15- through 24 years was 15.2 per 100,000. This is a decrease from the 2008 rate of 17.1. /2012//

Influences to maintain and/or improve the death rate due to intentional injuries among teens and young adults aged 15 to 24 year olds due to motor vehicle crashes (MVCs) include the

assessment of deaths by Child Fatality Review Teams (CFRT) that operate in every jurisdiction in Maryland and the subsequent systems changes that are implemented. The teams review and analyze each death (through age 17 required, and above voluntarily) and report any community/systems issues that impacted the death, to prevent recurrences. Recommendations are made to the community that may include the need for policy changes or changes to laws, community education, resource development, or actual physical changes to the site of the crash.

The Center for Maternal and Child Health provides administrative support to Child Fatality Review teams. There is a part-time Child Fatality Review Coordinator. The State Child Fatality Review Team supports the local teams and receives feedback from them. The CFRT's in Maryland receive reports on child deaths from the Office of the State Medical Examiner, and these reports are used to set in motion the process of case review. Via CFRT, CMCH addresses MVC deaths up to the age of 18, while the Center for Health Promotion and Injury Prevention addresses the older age limits. Teen MVCs have been an ongoing focus in Maryland, with safe teen driving education and auto safety provided in a variety of venues and for a variety of audiences. Issues of attention, distracted driving, interaction with friends and speed affect these age groups at a much higher rate than older adults.

The Partnership for a Safer Maryland and Safe Kids Program are two of the other groups addressing the issue of teen driving and deaths. CMCH staff participates in both these programs.

Finally, during the 2009 legislative session, a law was passed that enabled Maryland CFR teams to participate in a free system of electronic data collection supported by the National Center for Child Death Review. The standard use of this system became mandatory for all local CFR teams in 2010. This will improve data collection and analysis and will allow for better understanding and assessment of child fatalities in Maryland.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	191.5	201.5	201.2	201.0	201.0
Numerator	2131	2232	2212	2243	2243
Denominator	1112945	1107687	1099652	1115865	1115865
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010

Source: HSCRC hospital discharge data, 2009; data for 2010 not currently available

Notes - 2009

Source: HSCRC hospital discharge data, 2009

Notes - 2008

Source: HSCRC hospital discharge data, 2008

Narrative:

//2012/ In 2009, the rate of non-fatal injuries among children aged 14 and younger was 201.1 per 100,000. This is similar to the 2008 rate. //2012//

The Maryland State Child Fatality Review Team (SCFRT) oversees local review cases of unusual and unexpected child fatality (to age 18) to learn how such deaths might be prevented in the future. Several years ago the State Team developed a definition of "near fatality", to assist local child fatality teams, particularly low-death counties, in reviewing non-fatal incidents. While only a few teams have yet ventured into this area, it is anticipated that in time there will be more reviews of non-fatal cases. This will take development of a system of notification from the emergency rooms of hospitals, so teams can learn about near fatalities occurring in their jurisdiction. The current system in place notifies only of fatalities. Notice comes through the Office of the Chief Medical Examiner (OCME) and, of course, the OCME only knows about fatalities, not near fatalities.

Local child fatality review teams currently enter data from case reviews into a national data system sponsored and funded by the National Center for Child Death Review. Over time this system will improve state and national data analysis and eventually may assist with the assessment of near fatalities.

Some members of the State and child fatality review teams also attend the meetings of "Safe Kids Maryland", which looks at all areas of injury risk to develop reduction strategies.

The Partnership for a Safer Maryland (PSM) is an organization started by the DHMH Center for Health Promotion and Education. Public and private organizations from across the State participate in PSM meetings and trainings, to identify risk areas and strategies for injury prevention. The PSM provides a monthly newsletter, technical assistance for data needs and networking with other injury prevention professionals.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	23.1	21.8	15.6	18.3	18.3
Numerator	257	241	171	204	204
Denominator	1112945	1107687	1099652	1115865	1115865

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

Notes - 2010

Source: HSCRC hospital discharge data, 2009; data for 2010 not currently available

Notes - 2009

Source: HSCRC hospital discharge data, 2009

Notes - 2008

Source: HSCRC hospital discharge data, 2008
Data for 2009 is currently unavailable

Narrative:

//2012/ In 2009, the rate of non fatal injuries due to motor vehicle accidents for children aged 14 years and younger was 18.3 per 100,000. This is an increase from the 2008 rate of 15.6 per 100,000. //2012//

The Maryland State Child Fatality Review Team (SCFRT) oversees local review of cases of unusual and unexpected child fatalities under age 18; (including MVCs) to learn how such deaths might be prevented in the future. Several years ago, the SCFRT developed a definition of "near fatality" to assist local child fatality teams, particularly low-death counties, in reviewing non-fatal incidents. While only a few teams have yet ventured into this area, it is anticipated that in time there will be more reviews of non-fatal MVC's and other injuries. This will take development of a system of notification from the emergency rooms of hospitals, to allow teams to learn about near fatalities occurring in their jurisdiction. The current system in place notifies of fatalities only. Notice comes through the Office of the Chief Medical Examiner (OCME) and, of course, the OCME only knows about fatalities, not near fatalities.

In 2009, the State Child Fatality Review Team worked to change state law, to enable local child fatality review teams to enter fatality data from case reviews into a national data system sponsored and funded by the National Center for Child Death Review. This system will improve overall data collection and assessment of near fatalities, including MVCs in children aged 14 and under.

Some members of State and child fatality review teams attend the meetings of "Safe Kids Maryland", which addresses all areas of injury risk to develop reduction strategies. Safe Kids even has a special "Occupant Protection Task Force" to address the needs of children in vehicles.

The Partnership for a Safer Maryland (PSM) is a group started several years ago under the auspices of the DHMH Center for Health Promotion and Education. Public and private organizations from all areas of the State participate in PSM meetings and trainings, to identify risk areas and strategies for injury prevention. The PSM has had a sub-committee on MVCs and also provides an electronic newsletter, technical assistance for data, and networking with other injury prevention professionals.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	230.7	213.0	186.5	174.2	174.2
Numerator	1801	1676	1463	1365	1365
Denominator	780609	786789	784401	783608	783608
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010

Source: HSCRC hospital discharge data, 2009; data for 2010 not currently available

Notes - 2009

Source: HSCRC hospital discharge data, 2009

Notes - 2008

Source: HSCRC, hospital discharge data, 2008

Narrative:

In 2008, the rate of non-fatal injuries due to motor vehicle accidents for youth aged 15-24 years was 186.5 per 100,000.

The Maryland State Child Fatality Review Team (SCFRT) oversees local review of cases of unusual and unexpected child fatality under age 18, to learn how such deaths might be prevented in the future. Motor vehicle crashes (MVCs) claim many lives in the 15 to 24 age group and cause even more injuries. Several years ago, the SCFRT developed a definition of "near fatality" to assist local child fatality teams, particularly low-death counties, in reviewing non-fatal incidents. While only a few teams have yet ventured into reviewing near-fatalities, it is anticipated that in time there will be more reviews of non-fatal MVC's and other injuries. This will take development of a system of notification from the emergency rooms of hospitals, to allow teams to learn about near fatalities occurring in their jurisdiction. The current system in place notifies child fatality review teams of fatalities only. Notice comes through the Office of the Chief Medical Examiner (OCME) and, of course, the OCME only knows about fatalities, not near fatalities.

The State Child Fatality Review Team worked in recent years to change State law so local teams may enter data from case reviews into a national data entry system sponsored and funded by the National Center for Child Death Review. This system will eventually also help with data collection and assessment of near fatalities as well as fatalities, including MVCs, but only in children under 18.

Some members and staff of state and child fatality review teams attend the meetings of "Safe Kids Maryland", which examines all areas of injury risk to develop reduction strategies. Safe Kids does take a special interest in MVCs and even has a special "Occupant Protection Task Force" to address the needs of children and teens in vehicles.

The Partnership for a Safer Maryland (PSM) is a group started several years ago under the auspices of the Center for Health Promotion and Education. Its efforts are not limited to children,

so it covers the age range in this health status indicator. Public and private organizations from all areas of the State participate in PSM meetings and trainings, to identify risk areas and strategies for injury prevention. The PSM has had a sub-committee on MVC's and also provides a monthly electronic newsletter, technical assistance for data, and networking with other injury prevention professionals. The Coordinator of the State Child Fatality Review Team and members of local teams attend the PSM meetings, finding them very valuable.

/2012/ In 2009, the rate of non-fatal injuries due to motor vehicle accidents for youth aged 15-24 years was 174.2 per 100,000. This is a decrease from the 2008 rate of 186.5 per 100,000. //2012//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	35.1	39.1	40.2	47.8	47.8
Numerator	7163	7827	8033	9384	9384
Denominator	204122	200269	199714	196289	196289
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010

Source: Division of Sexually Transmitted Diseases, Epidemiology and Disease Control Program, MD DHMH, 2009

Data for 2010 not currently available

Notes - 2009

Source: Division of Sexually Transmitted Diseases, Epidemiology and Disease Control Program, MD DHMH, 2009

Notes - 2008

Source: Division of Sexually Transmitted Diseases, Epidemiology and Disease Control Program, MD DHMH, 2008

Narrative:

Modest increases in Chlamydia rates for teens reflect both trends of concern in prevention messages and positive activities in screening. Repeat infections among teens also are a public health issue, coupled with difficulties in accessing care for this age group. Cuts in public health spending affect expanding screening programs, or even maintaining services in the face of increasing health costs. On the positive side, detection rates increase when screening is increased, and when more sensitive tests are used, and when simpler testing is done via urine screening. These enhance the ability to treat cases and prevent serious sequelae.

Screening and treatment services for sexually transmitted infections are provided by the state STD Program and the Maryland Family Planning Program.

Influences on maintaining/improving HSIs include fiscal issues that affect testing supply costs and screening/prevention programs, availability of more sensitive (but more costly) detection tests, current evidence-based guidelines on routine and targeted screening, availability of urine screening, and abstinence-only messages vs. comprehensive sex education.

The Family Planning Program, State STD Program and State Laboratories Administration meet frequently internally and with regional IPP partners to discuss ways to improve screening, increase detection rates, promote prevention messages, and insure prompt treatment to reduce complications. Program guidelines stress the importance of screening the under 25 population, assessing those clients at highest risk, and providing prevention messages, including abstinence and correct use of condoms for those who are sexually active. The program provides condoms to local family planning/std programs as a means of promoting safer sex messages. In addition, program testing for Chlamydia is transitioning quickly to the more sensitive and accurate Nucleic Acid Amplification Test from the EIA test to further improve detection rates. Clinic sites are moving toward urine-based testing, which allows screening of young women who come for pregnancy tests or emergency contraception and do not receive a pelvic exam. Urine testing has a high level of acceptance and results in the ability to screen populations not previously screened but who are clearly sexually active.

Program activities include a close monitoring of treatment activities to insure positive cases get prompt treatment and partner evaluation. A pilot project in Baltimore City is testing Expedited Partner Therapy as another means to reduce Chlamydia rates by facilitating ease of treating partners of known cases. In addition, program clinic sites participate in providing treatment to positive testing clients who have requested and received test kits online.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	9.8	10.0	10.8	13.8	13.8
Numerator	9719	9889	10604	13527	13527
Denominator	987698	989922	981479	979707	979707
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010

Source: Division of Sexually Transmitted Diseases, Epidemiology and Disease Control Program, MD DHMH, 2009

2010 data is currently unavailable

Notes - 2009

Source: Division of Sexually Transmitted Diseases, Epidemiology and Disease Control Program, MD DHMH, 2009

Notes - 2008

Source: Division of Sexually Transmitted Diseases, Epidemiology and Disease Control Program, MD DHMH, 2008

Narrative:

Modest increases in Chlamydia rates for women ages 20-44 have been occurring. Cuts in public health spending affect expanding screening programs, or even maintaining services in the face of increasing health costs. Many of the STD and Family Planning Clinics have combined services or offer services on the same day. Costs associated with testing require focusing screening on populations most at risk, and targeting testing according to specific risk criteria. At the Annual STD Program Update it was noted that the detection rates increased. The program intends to follow this closely to ensure that the most vulnerable 20-25 age group is being targeted and tested appropriately to assist in determining if the rise is due to an increase in the prevalence of Chlamydia.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
TOTAL POPULATION BY RACE								
Infants 0 to 1	76511	43009	25389	401	4575	100	3037	0
Children 1 through 4	304095	168633	102496	1325	17989	603	13049	0
Children 5 through 9	370292	217643	116356	1595	20053	455	14190	0
Children 10 through 14	364967	214803	119316	1416	17723	271	11438	0
Children 15 through 19	401581	237312	135858	1466	17310	315	9320	0
Children 20 through 24	382027	230404	124846	1546	17595	357	7279	0
Children 0 through 24	1899473	1111804	624261	7749	95245	2101	58313	0

Notes - 2012

Maryland Dept. of Planning, U.S. Census, 2009 Population Data

Maryland Dept. of Planning, U.S. Census, 2009 Population Data

Maryland Dept. of Planning, U.S. Census, 2009 Population Data

Maryland Dept. of Planning, U.S. Census, 2009 Population Data

Maryland Dept. of Planning, U.S. Census, 2009 Population Data

Maryland Dept. of Planning, U.S. Census, 2009 Population Data

Narrative:

CMCH supports and participates in many programs to address the needs of children, and to address disparities. Patient safety for mothers and infants in MD hospitals is enhanced through a Perinatal Collaborative, and a newly formed Neonatal Collaborative, in partnership with the MD Patient Safety Center. Standards for obstetric and neonatal care in MD hospitals were updated in 2008. High-risk obstetric services are provided by the MD Advanced Perinatal Support Services (MAPSS), a statewide program of telemedicine and on-site consultation provided by the State's academic medical centers. The Office for Genetics and Children with Special Health Care Needs also supports programs for children with metabolic diseases, hemoglobinopathies and birth defects.

Other programs include the MD Asthma Control Program; MD Asthma Coalition; Teen Pregnancy Prevention; Lead Poisoning Prevention Commission; Fetal Alcohol Spectrum Disorders Coalition; Fetal and Infant Mortality Review; Child Fatality Review; Maternal Mortality Review; and a legislatively mandated Morbidity, Mortality and Quality Review Committee to review statewide outcomes related to pregnancy, childbirth, infancy and early childhood that convened in early FY 2010 and the results incorporated into the Title V needs assessment.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
TOTAL POPULATION BY HISPANIC ETHNICITY			
Infants 0 to 1	66033	10478	0
Children 1 through 4	259317	44778	0
Children 5 through 9	330448	39844	0
Children 10 through 14	335374	29593	0
Children 15 through 19	372847	28734	0
Children 20 through 24	350813	31214	0
Children 0 through 24	1714832	184641	0

Notes - 2012

Maryland Dept. of Planning, U.S. Census, 2009 Population Data

Maryland Dept. of Planning, U.S. Census, 2009 Population Data

Maryland Dept. of Planning, U.S. Census, 2009 Population Data

Maryland Dept. of Planning, U.S. Census, 2009 Population Data

Maryland Dept. of Planning, U.S. Census, 2009 Population Data

Maryland Dept. of Planning, U.S. Census, 2009 Population Data

Narrative:

CMCH supports and participates in many programs to address the needs of children, and to address disparities. Patient safety for mothers and infants in MD hospitals is enhanced through a Perinatal Collaborative, and a newly formed Neonatal Collaborative, in partnership with the MD Patient Safety Center. Standards for obstetric and neonatal care in MD hospitals were updated in 2008. High-risk obstetric services are provided by the MD Advanced Perinatal Support Services (MAPSS), a statewide program of telemedicine and on-site consultation provided by the State's

academic medical centers. The Office for Genetics and Children with Special Health Care Needs also supports programs for children with metabolic diseases, hemoglobinopathies and birth defects.

Other programs include the MD Asthma Control Program; MD Asthma Coalition; Teen Pregnancy Prevention; Lead Poisoning Prevention Commission; Fetal Alcohol Spectrum Disorders Coalition; Fetal and Infant Mortality Review; Child Fatality Review; Maternal Mortality Review; and a legislatively mandated Morbidity, Mortality and Quality Review Committee to review statewide outcomes related to pregnancy, childbirth, infancy and early childhood that convened in early FY 2010 and the results incorporated into the Title V needs assessment.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Women < 15	86	33	47	0	3	3	0	0
Women 15 through 17	1902	783	1035	3	36	23	0	22
Women 18 through 19	4294	1908	2241	11	67	39	0	28
Women 20 through 34	55855	32321	18059	125	4419	655	0	276
Women 35 or older	13674	8202	3835	25	1467	100	0	45
Women of all ages	75811	43247	25217	164	5992	820	0	371

Notes - 2012

MD Vital Statistics Administration, 2009 Report

Narrative:

Maryland had 77,261 births in 2008, with 2,155 born to mothers <18 years old. The racial / ethnic breakdown was 59% white, 34% Black.

CMCH has many initiatives to improve birth outcomes and reduce disparities. Patient safety for mothers and infants in MD hospitals is enhanced through a Perinatal Collaborative, and a newly formed Neonatal Collaborative, in partnership with the MD Patient Safety Center. Standards for obstetric and neonatal care in MD hospitals were updated in Oct. 2008. High-risk obstetric services are enhanced by the MD Advanced Perinatal Support Services, a statewide program of telemedicine and on-site consultation provided by the State's academic medical centers. CMCH

supports FIMR, Child Fatality and Maternal Mortality Review programs throughout the State. A legislatively mandated Morbidity, Mortality and Quality Review Committee to review statewide outcomes related to pregnancy, childbirth, infancy and early childhood will convene in early FY 2010. CMCH has also begun work with the Governor's Delivery Unit on the Strategic Goal to reduce infant mortality in MD by 10% by 2012. Focus areas are healthier women before conception, earlier entry into prenatal care, and improved perinatal neonatal care.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Total live births			
Women < 15	66	17	0
Women 15 through 17	1560	315	4
Women 18 through 19	3645	601	9
Women 20 through 34	47826	7307	67
Women 35 or older	12293	1262	19
Women of all ages	65390	9502	99

Notes - 2012

MD Vital Statistics Administration, 2009 Report

Narrative:

For 2008, the birth rate among Hispanic women was substantially higher than among non-Hispanic women for all age groups. The birth rate among Hispanic adolescents has risen significantly since 2000, while the teen birth rate among non-Hispanic teens has declined. While infant mortality among older Hispanic mothers is lower than their White non-Hispanic counterparts, infant mortality among Hispanic teens is higher than among White non-Hispanic teens 15-17 years old.

//2012/ In 2009, the Hispanic birht rate was still substantially higher than among non-Hispanic women for all age groups. //2012//

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

HSI #08A - Demographics (Total deaths)

CATEGORY	Total All	White	Black or African American	American Indian or Native	Asian	Native Hawaiian or Other	More than one race reported	Other and Unknown
Total deaths								

	Races			Alaskan		Pacific Islander		
Infants 0 to 1	541	175	343	0	7	12	0	4
Children 1 through 4	67	35	29	0	1	1	0	1
Children 5 through 9	38	21	15	0	2	0	0	0
Children 10 through 14	62	34	24	0	2	2	0	0
Children 15 through 19	198	93	94	0	2	4	0	5
Children 20 through 24	376	190	174	2	1	5	0	4
Children 0 through 24	1282	548	679	2	15	24	0	14

Notes - 2012

MD Vital Statistics Administration, 2009 Report

Narrative:

The all race infant mortality rate was 8.0 per 1,000 live births in 2008. There were large disparities by race, with the Black infant mortality rate 2.6 times higher than the rate among White rates.

In Maryland deaths of infants are reviewed in the Fetal and Infant Mortality Review Programs in all of Maryland's 24 jurisdictions to determine possible systems changes that could prevent a recurrence of the deaths reviewed. These reviews include gathering information from hospital records, face to face interviews with the mothers and final review by a group of experts to assess what happened and if there was anything that could have prevented the loss.

The leading causes of death among children 1 through 17 continue to be unintentional injuries and homicides. Deaths of children 0 through 17 years are reviewed by the local Child Fatality Review Teams. A State Child Fatality Review (CFR) Team includes a diverse group of experts (see website at http://fha.maryland.gov/mch/cfr_home.cfm). Legislation passed in the 2009 legislative session will permit the sharing of CFR data with the National Center for Child Death Reporting and result in improved data assessment and program implementation.

Local CFR Initiatives include a Teen Driving Task Force, articles in the local newspapers to promote water safety and drowning prevention, a Pediatric Window Falls Task Force, collaboration with the Department of Juvenile Justice to address juvenile crimes, trainings for the local law enforcement on juvenile crime investigation and infant death scene investigation, prevention of shaken baby syndrome (see brochure developed at <http://fha.maryland.gov/mch/publications.cfm> entitled "When Your Baby Won't Stop Crying") and safe sleep initiatives. The Center for Maternal and Child Health provides funding to the Maryland Center for Infant and Child Loss at the University of Maryland School of Medicine to help them

provide bereavement interventions and counseling to families who have experienced a loss.

//2012/ In 2009, the infant mortality in Maryland was 7.2 per 1,000 live births. This is a decrease from the 2008 rate of 8.0 per 1,00 live births. The infant mortality rate for black infants (13.6) is more than three times that of white infants (4.1).//2012//

Health Status Indicators 08B: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)

HSI #08B - Demographics (Total deaths)

CATEGORY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Total deaths			
Infants 0 to 1	512	29	0
Children 1 through 4	57	10	0
Children 5 through 9	36	2	0
Children 10 through 14	60	2	0
Children 15 through 19	183	14	1
Children 20 through 24	359	17	0
Children 0 through 24	1207	74	1

Notes - 2012

MD Vital Statistics Administration, 2009 Report

Narrative:

There are many issues related to age and race reflected in Maryland disparities. The incidence of low birth weight (<2500 grams) was 9.1% in 2007. This figure was 7.18% for white infants, 12.9% for black infants and 7.3% for Hispanic infants. The incidence of very low birth weight (<1500 grams) was 1.9% overall, 1.2% for whites, 3.2% for blacks and 1.3% for Hispanics. The infant mortality rate, likewise, was 8.0 per 1000 live births in 2007 with the rate of 4.6 among whites, 14.0 among blacks and 3.8 among Hispanics.

Additionally, the overall age-adjusted death rate for blacks was 1.2 times higher than the rate for whites. Rates were higher among blacks than whites for six of the ten leading causes of death. The largest race differential by cause of death was the HIV disease, with the death rate 23.9 times higher among blacks than whites.

In Maryland deaths of infants children aged 0 through 24 years are reviewed in the Fetal and Infant Mortality Review Programs in all of Maryland's 24 jurisdictions to determine possible

systems changes that could prevent a recurrence of the deaths reviewed. These reviews include gathering of information from hospital records, face to face interviews with the mothers and final review by a group of experts to assess what happened and if there was anything that could have prevented the loss.

Additionally, deaths of children age one year or older are reviewed by the local Child Fatality Review Teams. A State Child Fatality Review (CFR) Team includes a diverse group of experts (see website at http://fha.maryland.gov/mch/cfr_home.cfm). Legislation passed in the 2009 legislative session will permit the sharing of CFR data with the National Center for Child Death Reporting and result in improved data assessment and program implementation.

Local CFR Initiatives include a Teen Driving Task Force, articles in the local newspapers to promote water safety and drowning prevention, a Pediatric Window Falls Task Force, collaboration with the Department of Juvenile Justice to address juvenile crimes, trainings for the local law enforcement on juvenile crime investigation and infant death scene investigation, prevention of shaken baby syndrome (see brochure developed at <http://fha.maryland.gov/mch/publications.cfm> entitled "When Your Baby Won't Stop Crying") and safe sleep initiatives. The Center for Maternal and Child Health provides \$137,799 per state fiscal year for a total of \$413,397 to the Maryland Center for Infant and Child Loss at the University of Maryland School of Medicine to help them provide bereavement interventions and counseling to families who have experienced a loss.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown	Specific Reporting Year
All children 0 through 19	1517446	881400	499415	6203	77650	1744	51034	0	2009
Percent in household headed by single parent	34.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2009
Percent in TANF (Grant) families	7.5	3.2	15.7	5.4	2.3	4.2		12.9	2010
Number enrolled in Medicaid	492350	127107	249929	846	13383	272	68827	31986	2010
Number enrolled in SCHIP	139923	38851	55618	219	6605	87	31347	7196	2010
Number living in foster home care	17172	4336	11408	27	76	4	421	900	2010
Number enrolled in food stamp program	285283	0	0	0	0	0	0	285283	2010
Number enrolled in WIC	110865	45935	48813	4572	3111	1866	6568	0	2010
Rate (per 100,000) of	3088.0	209.0	5660.0	322.0	342.0	0.0	0.0	0.0	2009

juvenile crime arrests									
Percentage of high school drop-outs (grade 9 through 12)	2.5	1.9	3.2	3.1	0.8	0.0	0.0	0.0	2010

Notes - 2012

MD. Dept of Planning, 2009 Population Estimates - These numbers represent Total All Races population

Annie E. Casey Foundation, KIDS COUNT Report, 2009.
 437,000 = total number of children in Maryland in single family homes
 Data is not broken down by race/ethnicity

The Hilltop Institute, Maryland Medicaid, Reporting CY 2010
 Population data is 2009 Maryland Dept. of Planning Estimates
 Population denominator for race calculations do not include Hispanic

The Hilltop Institute, Maryland Medicaid data, CY 2010
 Totals include Hispanic. The Hispanic number has been included in the More than One Race Reported Section entry

The Hilltop Institute, Maryland Medicaid data, CY 2010
 Totals include Hispanic. The Hispanic number has been included in the More than One Race Reported Section entry

Maryland Dept of Human Resources
 Race/ ethnicity data not available

CDC, WIC program data, 2010

Maryland State Police Department, juvenile crime arrests ages <18 years
 Population from Dept of Planning estimates 2009, ages 0-17

Maryland Report Card, 2010, Maryland State Dept. of Education

The Hilltop Institute, Maryland Medicaid data, CY 2010
 Totals include Hispanic. The Hispanic number has been included in the More than One Race Reported Section entry

Narrative:

In today's failing economy families are in crisis from lost jobs and the loss of health insurance that may have been provided by these jobs. The unemployment rate in Maryland in 2009 was 7% and the rate continues to increase. Federal, state and local programs have been called on to meet the need for increasing services while facing cuts of their own. Adverse outcomes disproportionately affect infants and children in foster care (over 17,000 children) or in single parent homes. Single adult women are nearly twice as likely to be uninsured as married women. Children less than 19 years of age comprise 18% of the uninsured.

Additionally, when families are in crisis it follows that there is an increase in family violence and abuse and neglect of children. The Department of Human Resources is spearheading a three

year effort to bolster 1000 new foster families by 2010 so that children can live in closer proximity to family members and their communities. Crime increased in Maryland by 2% in 2008, although violent crime decreased by 2%. Leaving high school before graduation can lead to continued poverty and higher incidence of juvenile arrests. In Maryland the graduation rate is 85%, slightly higher than the national average.

Many infants and children eligible for Medicaid and other State programs are not enrolled. Outreach efforts are underway at both the state and local levels to meet this challenge.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity.*
(Demographics)

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported	Specific Reporting Year
All children 0 through 19	1364019	153427	0	2009
Percent in household headed by single parent	0.0	0.0	0.0	2009
Percent in TANF (Grant) families	7.5	3.8	0.0	2010
Number enrolled in Medicaid	391537	68827	0	2010
Number enrolled in SCHIP	101380	31347	0	2010
Number living in foster home care	15851	421	0	2010
Number enrolled in food stamp program	0	0	0	2010
Number enrolled in WIC	78950	31915	0	2010
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	0.0	2010
Percentage of high school drop- outs (grade 9 through 12)	0.0	4.0	0.0	2010

Notes - 2012

MD. Dept of Planning, 2009 Population Estimates

Annie E. Casey Foundation, KIDS COUNT Report, 2009.
437,000 = total number of children in Maryland in single family homes
Data is not broken down by race/ethnicity

The Hilltop Institute, Maryland Medicaid, Reporting CY 2010
Population data is 2009 Maryland Dept. of Planning Estimates

The Hilltop Institute, Maryland Medicaid data, CY 2010

The Hilltop Institute, Maryland Medicaid data, CY 2010

Maryland Dept of Human Resources
Race/ ethnicity data not available

CDC, WIC program data, 2010

Maryland State Police Department, juvenile crime arrests ages <18 years
Population from Dept of Planning estimates 2009, ages 0-17

Maryland Report Card, 2010, Maryland State Dept. of Education

The Hilltop Institute, Maryland Medicaid data, CY 2010

Narrative:

In today's failing economy families are in crisis from lost jobs and the health insurance that may have been provided by these jobs. The unemployment rate in Maryland is at 7.2% and the future continues to look bleak. Federal, state and local programs have been called on to meet the need for increasing services that are just not able to provide while facing cuts of their own. Adverse outcomes disproportionately affect infants and children in foster care (some 9600 children) or in single parent homes. Among women ages 19-44 and 45-64, single women are about twice as likely to be uninsured as married women in the same age group. Adults without dependent children younger than age 19 comprises the majority (58%) of Maryland's uninsured, and most of them are single. Children are 20% of the uninsured, and young adults (single or married) are 42%.

Additionally, when families are in crisis it follows that there is an increase in family violence and abuse and neglect of children. The Department of Human Resources is spearheading a three year effort to bolster 1000 new foster families by 2010 so that children can live in closer proximity to family members and their communities. Crime, too, is on the increase in metropolitan areas like Baltimore City and the greater metropolitan areas surrounding Washington, DC. Leaving high school before graduation can lead to continued poverty and higher incidence of juvenile arrests. In Maryland the graduation rate is 73%, slightly higher than the national average.

Many infants and children eligible for Medicaid and other State programs are not enrolled. Outreach efforts are underway at both the state and local levels to meet this challenge.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	907284
Living in urban areas	165063
Living in rural areas	445099
Living in frontier areas	0
Total - all children 0 through 19	610162

Notes - 2012

Classification of metropolitan areas based on Maryland Annotated Code. Metro areas in Maryland include: Anne Arundel, Baltimore, Howard, Montgomery, and Prince George's counties.

Population data 0-19, 2009

Classification of urban areas based on Maryland Annotated Code. Urban areas in Maryland include: Baltimore City

Population data 0-19, 2009

Classification of metropolitan areas based on Maryland Annotated Code. Rural areas in Maryland include: Allegany, Calvert, Caroline, Carroll, Cecil, Charles, Dorchester, Frederick, Garrett, Harford, Kent, Queen Anne's Somerset, St. Mary's, Talbot, Washington, Wicomico and Worcester counties.

Population data 0-19, 2009

N/A

Narrative:

In today's failing economy families are in crisis from lost jobs and the health insurance than may have been provided by these jobs. The unemployment rate in Maryland is at 7.2% and the future continues to look bleak. Federal, state and local programs have been called on the meet the need for increasing services that are just not able to provide while facing cuts of their own. Adverse outcomes disproportionately affect infants and children in foster care (some 9600 children) or in single parent homes. Among women ages 19-44 and 45064, single women are about twice as likely to be uninsured as married women in the same age group. Adults without dependent children younger than age 19 comprises the majority (58%) of Maryland's uninsured, and most of them are single. Children are 20% of the uninsured, and you adults (single or married) are 42%.

Additionally, when families are in crisis it follows that there is an increase in family violence and abuse and neglect of children. The Department of Human Resources is spearheading a three year effort to bolster 1000 new foster families by 2010 so that children can live in closer proximity to family members and their communities. Crime, too, is on the increase in metropolitan areas like Baltimore City and the greater metropolitan areas surrounding Washington, DC. Leaving high school before graduation can lead to continued poverty and higher incidence of juvenile arrests. In Maryland the graduation rate is 73%, slightly higher than the national average.

Many infants and children eligible for Medicaid and other State programs are not enrolled. Outreach efforts are underway at both the state and local levels to meet this challenge.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	5699478.0
Percent Below: 50% of poverty	0.0
100% of poverty	9.1
200% of poverty	23.7

Notes - 2012

MD Dept. of Planning, population estimates July 2009

U.S. Census, Current Population Survey, 2010 Annual Social and Economic Supplement, 2009 data

Below 50% of federal poverty level is not available

U.S. Census, Current Population Survey, 2010 Annual Social and Economic Supplement, 2009 data

U.S. Census, Current Population Survey, 2010 Annual Social and Economic Supplement, 2009 data

Narrative:

Title V funds do not directly affect the geographic location of children whether rural, Metropolitan or urban. However, barrier and access to care may be influenced by geographic location. The provision of programs including outreach clinics and telemedicine would positively influence the health of those living in areas of limited access.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	1517446.0
Percent Below: 50% of poverty	0.0
100% of poverty	11.1
200% of poverty	28.3

Notes - 2012

MD. Dept of Planning, Population estimates July 2009

U.S. Census, Current Population Survey, 2010 Annual Social and Economic Supplement, 2009 data

Census reports persons below 18 years old

Data for below 50% poverty level is not available

U.S. Census, Current Population Survey, 2010 Annual Social and Economic Supplement, 2009 data

Census reports persons below 18 years old

U.S. Census, Current Population Survey, 2010 Annual Social and Economic Supplement, 2009 data

Census reports persons below 18 years old

Narrative:

Title V funds do not directly affect the poverty level of the population. Poverty has been shown to impact the health of a population. The availability of health insurance is important to allow access to care for those living in poverty. During the 2007 Special Legislative Session, Senate Bill 6 was passed, which provides for Medical Assistance to parents and other family members caring for children with incomes up to 116% of the Federal Poverty Level. In Fiscal Year 2009, the Medical Assistance for Families initiative was launched. On July 1, 2008, Medical Assistance benefits expanded to include comprehensive health care coverage for many more parents and other family members caring for children. Eligibility depends on family size and income. The income limit is about \$21,200 for a family of three. There is no asset limit when applying, no face-to-face interview is required and there are options to apply online, by mail or by fax. The number of families now on the new program has exceeded 45,000.

F. Other Program Activities

MCH Hotline/Children's Resource Line: The MCH/Medicaid Programs operate an 800 number telephone line for MCH outreach, information and referral (1-800-456-8900). This line is located and operated by the Medical Assistance Program and is used to provide information and education about the Medical Assistance Program as well as to refer callers to MCH providers.

Web Sites: Both the Center for Maternal and Child Health (www.fha.state.md.us/mch) and the Office for Genetics and Children with Special Health Care Needs (www.fha.state.md.us/genetics) provide functional Websites. These web sites include information about all programs funded or

provided, as well as information about the Title V program, including linkage to a copy of the complete Title V report for the most recent fiscal year.

Child Abuse and Neglect: The Legislature charged DHMH to establish a Child Abuse and Neglect Center of Excellence Initiative within DHMH. Responsibility for administering this Initiative was placed within CMCH. The Center of Excellence trains providers in each region of the State to diagnose and treat child abuse and neglect. Legislation passed in 2006 establishes the Children's Trust Fund under DHMH to fund the Child Abuse and Neglect Centers of Excellence using funds derived from the sale of commemorative birth certificates. CMCH recently revised and updated the Commemorative Birth Certificate brochure promotes the Children's Trust Fund.

Emergency Preparedness: Emergency preparedness is an important priority concern for DHMH. DHMH recently consolidated the Office of Public Health Response and the Office of Emergency Response into a single unit reporting directly to the Deputy Secretary for Public Health. This was done to ensure that activities are coordinated. CMCH has also begun to prepare for a range of emergency situations that would benefit from a coordinated MCH approach. A CMCH protocol has been developed and staff are continuing to meet to discuss the role of MCH within the DHMH emergency preparedness program. Title V will continue to take an active role in promoting H1N1 vaccinations.

Conferences and Training: The MCH Program recognizes the importance of enhancing public health competency through ongoing training and education. It achieves this activity by providing training opportunities to LHD public health personnel in important MCH domains such as home visiting, school and adolescent health, screenings and surveillance and asthma education. Several conferences are annually supported by the MCH Program. These include the annual reproductive health update, the annual school health institute, an asthma summit, a perinatal health conference, and technical assistance workshops for local health departments.

//2012/ Stakeholder meetings are planned as the new Affordable Care Act programs (e.g., home visiting, PREP) are implemented. //2012//

Women's Health: An Office of Women's Health was established within CMCH in 2001 with the goal of promoting wellness for Maryland women throughout the lifespan. Activities of this Office include the publication and dissemination of reports (e.g., chartbook on the health status of Maryland women; postpartum depression); promotion of inter and intra-agency coordination on women's health issues, and implementation of a statewide model for integrating preventive health screening into family planning programs.

//2012/ CMCH hosted the annual Women's Health Steering Committee meeting in May 2011. Findings from the 2009 PRAMS report were highlighted. A revised Women's Health Chartbook will be published in 2011. //2012//

Sudden Infant Death Syndrome: Title V monies will continue to support the Maryland SIDS Project at the Center for Infant and Child Loss, University of Maryland School of Medicine. This Center provides SIDS outreach and education as well as counseling to support families experiencing the death of a child.

Environmental Health Tracking System: The Community Health Administration continued to work with the Environmental Public Health Tracking Program's network implementation grant from the CDC. The Family Health Administration, including CMCH and OGCSHCN, will be involved in grant development. The grant references the need for collaboration with a variety of data sources important to Title V including the birth defects registry, hospital discharge data, vital statistics and the childhood lead registry. CMCH provides staff support for the Children's Environmental Health Advisory Council and worked to complete a Children's Environmental Health Indicator Report.

The OGCSHCN is working with the Environmental Public Health Tracking Program' to post data on birth defects for public uses on the web as per the CDC protocol. The Maryland Tracking

Network went live and displays birth defects data. The Environmental Public Health Tracking Program and OGCSHCN also worked together in FY11 to create and print a Providers' Manual for the BDRIS program to be distributed to hospitals and facilities. The manual educates providers on reporting information requirements and guidelines to assist them in ensuring that their institutions are compliant with the State of Maryland Birth Defects Reporting mandate. In addition, the manual provides an overview of Maryland's BDRIS and can serve as a training tool for new employees responsible for the reporting requirements for institutions. A Care Notebook for families has also been created and will be provided in paper or electronically to all newly identified families in OGCSHCN follow up programs.

Autism Spectrum Disorders (ASD): During the 2005 session, legislation was passed requiring the Maryland Dept of Education, in collaboration with the Maryland Dept of Health and Mental Hygiene, to establish a pilot program to study and improve screening practices for Autism Spectrum Disorders. Title V has participated in several meetings focused on Autism Spectrum Disorders. In FY11 OGCSHCN partnered with The Parents' Place of Maryland (PPMD) in applying for a HRSA State Planning Grant to improve systems of care for children with ASD and other developmental disorders. If awarded, this funding would allow for (1) development of a project leadership team to guide planning activities; (2) completion of a comprehensive regional and statewide needs assessment of the target population; (3) incorporation of input from diverse stakeholders and establishment of advisory councils from each region of the state in developing the needs assessment and state plan; and (4) evaluation and documentation of strengths and needs of current developmental screening and medical home initiatives.

OGCSHCN is also funding Baltimore City and The Harriet Lane Clinic in a quality improvement initiative for developmental screening in pediatric practices. This project improves the rates with which pediatric primary care providers in Baltimore City effectively screen young children for developmental delays. An article describing the findings was published in a peer-reviewed journal in FY10. The project has expanded into practices outside of Baltimore City and over 25 practices have now been trained.

G. Technical Assistance

Maryland's Office for Genetics and Children with Special Health Care Needs is requesting Technical Assistance around National Performance Measure # 5- 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. We have distinct regional disparities in Maryland where families in certain regions of the state (Eastern Shore, Western Maryland, and Southern Maryland) do not have adequate access to needed primary and specialty medical care, mental health services, oral health services, and related services such as speech, occupational, and physical therapies, as well as other types of services. We are considering a regional center model similar to states like Pennsylvania and Virginia.

OGCSHCN hopes to move to a regional center model for the service system for CYSHCN and their families, in which each region of the state has a regional center with a hub. The hub will consist, minimally, of a care coordination/case management position, a parent navigator position, and will have a phone number and website that can be used by families of CSHCN and YSHCN in finding assistance and services related to their special health needs. Ideally, the regional hubs will also house a resource/training room for parents and providers with computers, scanners, printers, and a library available for families' use. The hubs will be a connection center for local health departments, primary care pediatricians and specialty providers, providers of related services, mental health and oral health providers, child care providers, etc. within each region that provide or are interested in providing services to CYSHCN and families.

OGCSHCN would like assistance in organizing conference calls or meetings with other state CSHCN programs who have regional centers, as it would be beneficial to learn from their experiences and expertise. Virginia and Pennsylvania have regional models, any if there are any

other states that HRSA/MCHB Title V know of, OGCSHCN would like to consult with those states as well.

Other technical assistance needs may be discussed at the August review meeting with the Maternal and Child Health Bureau.

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 2010		FY 2011		FY 2012	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line1, Form 2)</i>	11955050	11940135	11953971		11863538	
2. Unobligated Balance <i>(Line2, Form 2)</i>	0	0	0		0	
3. State Funds <i>(Line3, Form 2)</i>	8966288	8955101	8965479		8897654	
4. Local MCH Funds <i>(Line4, Form 2)</i>	0	0	0		0	
5. Other Funds <i>(Line5, Form 2)</i>	0	0	0		0	
6. Program Income <i>(Line6, Form 2)</i>	0	0	0		0	
7. Subtotal	20921338	20895236	20919450		20761192	
8. Other Federal Funds <i>(Line10, Form 2)</i>	113707133	113707133	129454241		131150864	
9. Total <i>(Line11, Form 2)</i>	134628471	134602369	150373691		151912056	

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

	FY 2010		FY 2011		FY 2012	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	2971107	2546333	2586320		2698788	
b. Infants < 1 year old	2830478	2307113	2802689		2293249	

c. Children 1 to 22 years old	8936427	9085195	8577383		8920381	
d. Children with Special Healthcare Needs	5805320	5829652	5589845		5638784	
e. Others	0	783177	1003213		771297	
f. Administration	378006	343766	360000		438693	
g. SUBTOTAL	20921338	20895236	20919450		20761192	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	224511		437274		2380865	
b. SSDI	94644		93713		93737	
c. CISS	0		0		0	
d. Abstinence Education	0		0		486550	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	96900831		112043869		109561818	
h. AIDS	0		0		0	
i. CDC	8283512		8546040		9986860	
j. Education	0		0		0	
k. Other						
Family Planning	0		4307837		4573336	
Injury Prevention	0		0		1342988	
PHHS	0		0		1966786	
Primary Care/Rural H	0		0		757924	
Injury Preventive Health S	0		1387061		0	
Primary Care/Rura	0		2032809		0	
FP/Injury	0		605638		0	
FP/Injury	5632822		0		0	
PCR/PHHS	2570813		0		0	

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

	FY 2010		FY 2011		FY 2012	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	1571270	3482667	2529026		3766140	
II. Enabling Services	6524185	6209917	7839371		6174671	
III. Population-Based Services	4862982	5545388	2850823		5236577	
IV. Infrastructure Building Services	7962901	5657264	7700230		5583804	
V. Federal-State Title V Block Grant Partnership	20921338	20895236	20919450		20761192	

Total						
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A. Expenditures

This section describes Title V expenditures for FFY 2010 and notes any trends and shifts in expenditures as compared to previous years. During FFY 2010, the Maryland joint federal-state Title V Program expended \$20,895,236 for services and activities to promote the health of women, infants, and children including those with special health care needs. With the federal funds, the state met the 30-30-10 budgeting requirement, with 38% of federal funds allocated for children with special health care needs and 47% allocated for preventive and primary care services for children. Less than 10% of federal funds were used for administration.

By level of the MCH pyramid, the majority of Title V -- State partnership funds supported activities at the infrastructure (27%) and enabling levels (29.7%). Direct services represented 16.8% of expenditures and included direct medical care for children with special health care needs in tertiary medical and medical day care centers. Direct care services were also provided by family planning clinical providers in several jurisdictions as well as prenatal care and well child care clinical services that continued to be offered by a very limited number of local health departments.

The first notable shift in funding allocation occurs in FY 1999 with the advent of MCHP making children in families with incomes up to 200% FPL eligible for Medicaid services. Direct expenditures went from 61% to 28% in one year. This continued to decrease as Maryland's Medical Assistance Program assumed a greater fiscal role, including covering more CSHCN unique services.

During this same time period, the percentage of expenditures for enabling services also increased. This was due to more local health departments providing care coordination services in lieu of direct services. Most of the current funding for these services has been in prenatal and early infant home visiting of the families most at risk for poor maternal and birth outcomes. This shift also occurred as the State Title V Agency educated and notified local health departments that combined, the majority of Title V dollars, should be allocated for enabling, population-based services and infrastructure development.

Population based services represented 26.5% of expenditures. These services included newborn screening for metabolic disorders, screening for blood lead exposure, immunizations, and vision and hearing screening in the schools.

/FY2012/OGCSHCN

During the past year, OGCSHCN underwent an administrative and structural realignment to better meet the needs of Maryland's CYSHCN population as identified through the 2010 Needs Assessment. The OGCSHCN was re-engineered to increase effectiveness and efficiency, and strategies were developed to create a focus on collaboration and teamwork both internally and with external partners.

As part of this structural realignment, OGCSHCN worked with internal and external stakeholders, including families and grantees, to review the MCH Funding and Services pyramid and evaluate how it categorizes its programs, services, grants, and other activities by pyramid level. This resulted in a large shift in categorizations between what constitutes infrastructure building and direct services. Several large OGCSHCN grants had been classified as infrastructure building prior to the OGCSHCN reorganization. After the evaluation, the services provided through these grants were reclassified, mostly as direct services, to be in alignment with the MCHB pyramid definitions.

This redefinition also helped to drive the direction of strategic planning, including budgets, for FY13 (the first year significant programmatic and budgeting changes can be implemented.)

B. Budget

Maryland's Maternal and Child Health Block Grant supports vital programs and services for women and children in Maryland, including those with special health care needs. The Title V MCH Program is jointly administered by the Center for Maternal and Child Health (CMCH) and the Office for Genetics and Children with Special Health Care Needs (OGCSHCN) under the auspices of the Family Health Administration. The Department of Health and Mental Hygiene has a strong commitment to core public health functions and essential public health services to Maryland's families and children.

The Maternal and Child Health Program budgets and functions reflect an evolving public health responsibility that complements and enhances the current health delivery system, recognizes recent legislative changes in health and mandated public health functions, the uniqueness of the populations being served, and emerging research and standards of care affecting the health status of MCH populations. Maryland's Title V budget for FY 2012 totals \$20,761,192 including \$11,863,538 in federal funds and \$8,897,654 in State funds and reflects a decrease in federal block grant funding since 2006. The State share in MCH services meets the requirements for the State match. Maryland meets the maintenance of effort requirement of Sec. 505 (a)(4).

Maryland continues to allocate Maternal and Child Health Block Grant funds using criteria that include: (1) MCH priority needs based on statewide and community assessments, (2) local health department fiscal shortfalls within the identified core categories, (3) poverty rates and estimated size of the maternal and child population (birth-21 years of age), (4) performance measures and outcome measures and (5) the availability of other funding sources. An example of this is the MCHP expansion which enabled funds to be reallocated from direct services for CSHCN to other population groups ineligible for MCHP. Funds may be reallocated throughout the year when unexpected needs are identified. (Budgets are developed two years prior to authorized spending. For example during the summer of 2010, the MCH Budgets for FY 2011 were developed. During the 2011 Legislative Session, the FY 2012 budget was approved).

Throughout the two-year budget process, but particularly during the budget development and the revision phase (based on legislative authorized budget), the MCH Offices evaluate the MCH Service Pyramid fiscal allocation to ensure that it reflects the spirit and intent of MCHB. Throughout the year, quarterly meetings are held between the MCH Offices and the Budget Personnel to determine current expenditure levels and expected expenditure for the remainder of the year. It is during these meetings that budget shortfalls and funds to be reallocated are identified. Throughout the year, all contracts including LHD grants are tracked through the procurement process and subsequently monitored for appropriate and timely expenditures, and adherence to DHMH fiscal procedures.

During the development and subsequent expenditure of the MCH budget, the grant is fiscally and programmatically monitored to ensure that the funding levels adhere to the "30-30-10" Title V requirement. For FFY 2012, it is proposed that funding for each Title V population will be distributed accordingly: preventive and primary care for children -- 48.6%, CSHCN --40.3% and Administration -- 3.3%. The other category at 7.8% refers to the maternal and infant health population. By level of the MCH pyramid, it proposed that funding will be distributed as follows: direct services - \$3,766,140 or 18.1%; enabling services - \$6,174,671 or 29.8%; population based -- \$25,236,577 or 25.2% and infrastructure building services - \$5,583,804 or 26.9%.

In FFY 2012, a total of \$8,920,381 in State and federal funds are budgeted to support programs and services for children and adolescents. These funds will support activities that promote and protect the health of Maryland's 1.7 million children and adolescents, ages 0-21, by assuring that

comprehensive, quality preventive and primary services are accessible. Activities and strategies will include:

- . Early Childhood Initiatives, including home visiting, early childhood mental health and promotion of access to a medical home;
- . Childhood Lead Screening Program, which promotes increased blood lead testing, particularly in "at risk" areas;
- . The Maryland Asthma Control Program, which includes partnership building and implementation of interventions, planning, and surveillance;
- . School health programs, including medical consultation and development of guidelines related to issues such as childhood nutrition and obesity; and provision of screening services; and;
- . Child Fatality Review, the goal of which is to prevent child deaths by developing an understanding of the causes and incidence of child deaths.

In FY 2012, a total of \$4,992,037 is budgeted for programs and services to prevent maternal and infant deaths and improve the health care system for women of childbearing age and the 75,000+ babies born each year in Maryland. Activities and strategies will include:

- . Statewide Perinatal Standards, and perinatal systems building activities in each jurisdiction, including maternal, fetal and infant mortality reviews, and perinatal center review and designation;
- . Sudden Infant Death Syndrome (SIDS) educational and family support activities;
- . Statewide initiatives (Babies Born Healthy and the Governor's Delivery Unit) to reduce infant mortality and eliminate racial disparities in birth outcomes;
- . A statewide survey to improve pregnancy outcomes (PRAMS);
- . Promotion of infant breastfeeding;
- . Care coordination services and home visiting for pregnant women and infants;
- . Fetal alcohol spectrum disorder (FASD) prevention activities; and
- . Family planning/reproductive health clinical services.

In FY 2012, a total of \$4,777,381 (federal) is budgeted for programs and services to address children with special health care needs. Activities and strategies will include:

- . **Payment for Medical/Clinical Services**

Through the Children's Medical Services Program, payment for direct specialty care and related services is made to providers for uninsured and underinsured children who meet the medical and financial eligibility criteria for the program.

- . **Genetic Services**

Funding is also provided for a statewide system of clinical genetic services, including infrastructure support for 3 Genetics Centers, 7 Outreach Clinics, the Comprehensive Hemophilia Treatment Center, pediatric and transition (adolescent/young adult) Sickle Cell Disease Clinics and specialized biochemical genetics laboratory services.

- . **Birth Defects Program**

The Birth Defects Reporting and Information System (BDRIS) collects data on birth defects to estimate birth defects prevalence, track trends and conduct surveillance for changes in trends that could be related to environmental hazards. BDRIS also uses the full resources of the OGCSHCN to provide families with information and referrals.

- . **Medical Day Care for CSHCN**

Two medical day care programs designed specifically for medically fragile infants and young children are funded by the Program. These unique centers provide skilled nursing services in a child care setting for children ages 6 weeks to 5 years who have complex medical conditions and whose needs cannot be met in traditional child care programs.

- . **Local Health Department Grants**

In addition to funding local health departments for core public health activities, funds are also provided specifically for CSHCN services and programs. Outreach specialty clinics are still funded in some jurisdictions, but most jurisdictions have replaced actual clinics with gap-filling care coordination, outreach, information/referral, dissemination of resource information, and needs assessment activities. The local health departments also administer the respite care funds provided through the local health department grants.

. Respite Programs and Special Camps

Enabling services are growing in Maryland. In addition to the PKU and Sickle Cell Disease camps that have been funded for many years, specialty camps for children with neurofibromatosis and spina bifida are now being supported. Local health departments are now funding a variety of respite services as well as increasing community capacity for providing them with grant funds provided by the OGCSHCN.

. Parent Involvement Activities

Parental involvement in policy and program development is supported through a grant to Parent's Place of Maryland (PPMD), a non-profit, family-directed and staffed center serving parents of children with disabilities and special health care needs. PPMD also houses the Maryland chapter of Family Voices. PPMD and OGCSHCN have an ongoing partnership in a number of activities. These include the Family-to-Family Health Education and Information Center, which provides families of CYSHCN with a central source of information and education about the health care system as well as direct family support and referrals as well as the Maryland Community of Care Consortium for CSHCN. The Consortium is funded by a grant from the federal Maternal and Child Health Bureau and offers a forum for information exchange, problem solving, consensus building, and collaborative action to address gaps and barriers in services for children with special health care needs (CSHCN) and their families.

. CSHCN Systems-Building Activities

System-building activities include grants to four Centers of Excellence (Johns Hopkins, University of Maryland, Children's National Medical Center, and Kennedy Krieger Institute) to support a Resource Liaison at each center whose function is to assist families of CYSHCN to find needed resources both within the centers and within the community. In some centers, these individuals may work directly with particular clinics and play a greater role in coordinating the care of CYSHCN. During FY11, the Improving Medical Home Partnerships for Specialty Access through Coordination and Training (IMPACT) program was initiated by OGCSHCN. Through an MOU between OGCSHCN and the University of Maryland, this project is developing specialty modules to prepare medical home providers to better handle common specialty concerns in their offices. A collaborative care agreement is also being developed for use by practices that participate in the specialty module training. In FY12 an evaluation component will be added to determine system impact on health outcomes.

. Youth Transition to Adulthood

The OGCSHCN Transition Coordinator is working on planning three regional health care transition conferences to take place during FY12. These will be held each year for the next five years. An action plan will be developed to include partnering with MSDE's school health division to provide outreach and education to school nurses and to families regarding health care transition for CYSHCN. Support and technical assistance will also be offered to OGCSHCN grantees who are involved in transition activities. Groundwork has been laid for the formation of a Family and Youth Advisory Council. OGCSHCN now has access to key stakeholders and partners to create such a council and has adequate staff to do so, and the first meeting should occur in the first quarter of FY12.

. Data Development

Projects include data collaboration activities with the Vital Statistics Administration and Maryland State Department of Education. The infant hearing screening program has initiated and integrated a statewide online data management system for the Maryland Early Hearing Detection and

Intervention Program. The online data base allows for virtually real time data sharing which facilitates more timely and accurate follow up and improved continuity of hearing health care.

In FY 2012, \$438,693 is budgeted for administrative costs to include indirect costs applied to salaries, travel and supplies.

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.