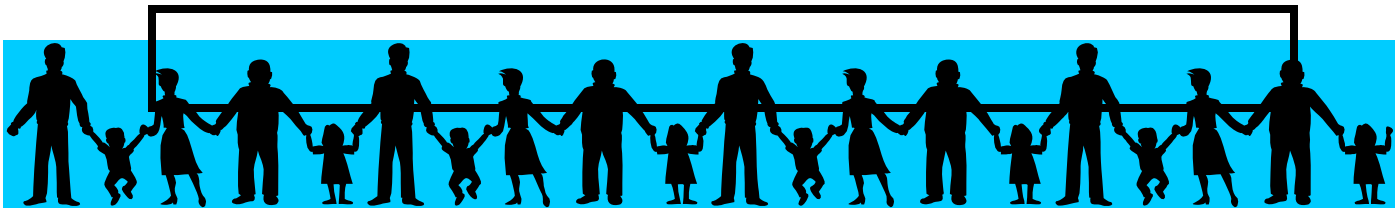


Colorado

County Nursing Service Guidelines for Maternal and Child Health Services

Colorado Department of Public Health and Environment

Prevention Services Division
Center for Healthy Families and Communities
4300 Cherry Creek Drive South
Denver, CO 80246

Colorado County Nursing Service
Guidelines for Maternal Child Health Services

TABLE OF CONTENTS

Introduction

Welcome to the Colorado County Nursing Service (CNS) Guidelines for Maternal Child Health (MCH) Services.

- **MCH Background**

This provides background information about Maternal and Child Health and the Maternal and Child Health Services Block Grant (Title V).

The CNS Guidelines for MCH Services are posted online at www.mchcolorado.org. The hyperlinks in the CNS Guidelines link to companion documents (such as forms, instructions, and guides) posted on the website.

MCH BACKGROUND

A. Maternal and Child Health[1]

Maternal and Child Health (MCH) is "the professional and academic field that focuses on the determinants, mechanisms and systems that promote and maintain the health, safety, well-being and appropriate development of children and their families in communities and societies in order to enhance the future health and welfare of society and subsequent generations" (Alexander, 2004).

MCH public health is distinctive among the public health professions for its lifecycle approach. This approach integrates theory and knowledge from multiple fields including human development, as well as women's, child and adolescent health. MCH professionals are from diverse backgrounds and disciplines, but are united in their commitment to improving the health of women and children. However, to meet this ambitious goal, it is essential that MCH professionals work with a broad group of other professionals and organizations.

1. MCH Funding

The Maternal and Child Health Bureau (MCHB) administers the Maternal and Child Health Services Block Grant (Title V). Since 1935, Title V has been the primary, continuous mechanism that supports national efforts to improve maternal and child health including children with special health care needs. Maternal and Child Health Services Block Grant funds are used for: State Formula Block Grants; Special Projects of Regional and National Significance (SPRANS) grants; and Community Integrated Service Systems (CISS) grants.

The purpose of the Title V MCH Block Grant Program is to create federal-state partnerships in development and enhancements of service systems that:

- Significantly reduce infant mortality
- Provide comprehensive care for women before, during, and after pregnancy
- Provide preventive and primary care services for infants, children, and adolescents
- Provide comprehensive care and build a comprehensive system of supports for children and adolescents with special health care needs
- Immunize all children
- Reduce adolescent pregnancy
- Prevent injury and violence
- Implement national standards and guidelines for prenatal care, for healthy and safe child care, and for the health supervision of infants, children, and adolescents
- Assure access to care for all mothers and children
- Meet the nutritional and developmental needs of mothers, children and families.

[1] Adapted from the Introduction to MCH 101 in-depth module at the HRSA MCH Timeline Retrieve November 2006 at http://www.mchb.hrsa.gov/timeline/

2. Colorado MCH

Every five years, Colorado completes an in-depth needs assessment and prepares a grant to receive federal Title V funding. For the next four years, annual grants are submitted to MCHB providing an update on progress and plans for the coming year.

In Colorado, Title V funds are primarily distributed to county health departments. The amount is dictated by a funding formula. The recipient health departments complete a plan that indicates how they will use the funding to address documented MCH needs within their community.

To assist agencies in the planning process, the state provides county specific MCH data reports and analysis (http://www.cdphe.state.co.us/ps/mch/data-reports.html). State consultants with expertise in various aspects of MCH are available to provide technical assistance as needed.

3. MCH Accountability[2]

Background and History
Accountability to the public has long been a component of Title V. However, by the 1990s both public and private health care systems were facing rapidly rising health care costs. Calls for health care reform were coupled with an increased emphasis on results that impacted the allocation of health care funding. Both public and private purchasers of health care, along with consumers and policymakers, require that health care programs achieve intended goals.

Within the public health sphere, accountability efforts focused on conducting thorough needs assessments to target programs to areas of greatest need, and developing a plan for improving health status. Documenting health care outcomes and measuring public health systems change were paramount. For the private sector, greater emphasis was placed on purchasing high quality services while controlling health care costs.

Some landmark efforts to improve accountability include:

- In 1979, Surgeon General Julius Richmond led an effort to develop the first quantitative public health objectives for the nation. These efforts resulted in **Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention.** www.healthypeople.gov

- In 1981, Congress consolidated several categorical grants into one **MCH Block Grant**. The purpose was to create greater flexibility to address existing and emerging MCH issues. Concurrently, the federal MCH program began to require annual performance reporting about performance and outcome measures for the MCH Block Grant.

- In 1988, the Institute of Medicine released **The Future of Public Health**, a report that outlined the crisis in public health in the U.S. and established a framework of accountability for public health agencies focused on the three core public health functions—assessment, policy development, and assurance. http://fermat.nap.edu/books/0309038308/html

[2] Adapted from the MCH Timeline: History, Legacy, and Resources for Education and Practice. MCH Performance and Accountability in-depth module http://mchb.hrsa.gov/timeline/. Retrieved 11/06.

- In 1989, Congress, through the **Omnibus Budget Reconciliation Act** (OBRA), linked greater MCH Block Grant flexibility with increased accountability. OBRA 89 required states to conduct a needs assessment every 5 years and submit annual progress reports.

- By 1994, the Centers for Disease Control and Prevention (CDC) took the lead in further refining the services outlined in the Future of Public Health report. A steering committee developed the **Ten Essential Public Health Services**, which describe key public health activities that should be undertaken in all communities. The Essential Services provide a working definition of public health and a guiding framework for the responsibilities of local public health systems. www.trainingfinder.org/competencies/background.htm

- The 1993 **Government Performance and Results Act** (GPRA), Public Law 103-62, required that "…each Federal program establish performance measures that can be reported as part of the budgetary process, thus linking funding decisions with performance and reviewing related outcome measures to see if there were improved outcomes for the target population." GPRA also linked budgets to strategic plans and the achievement of stated performance indicators. Following the federal lead, many states developed similar requirements. http://govinfo.library.unt.edu/npr/initiati/mfr/

- **Program Assessment Rating Tool** (PART) was developed in 2002 to assess the performance of every government program in order to improve program operations and inform budget decisions. Funding is directly linked with performance and every federal program is held accountable for improvement. Each program is assessed once every five years and rated according to the following categories: effective, moderately effective, adequate, ineffective, or results not demonstrated. Programs without performance measures are rated as "results not demonstrated," regardless of their score. www.expectmore.gov

MCH Performance and Accountability

MCH Programs are accountable for continually assessing needs, assuring that services are provided to the MCH population, and developing policies consistent with needs. MCH public health professionals are accountable to the public and to policymakers to assure that public dollars are being spent in a way that is aligned with priorities. Some of the factors for which MCH is accountable include: the core public health functions outlined in the 1988 Future of Public Health report; collecting and analyzing health data; developing comprehensive policies to serve the MCH population; and assuring that services are accessible to all.

There is general agreement that the quality of health care systems will improve through better performance measurement and expanded accountability. However, performance measurement has limitations. Priorities that are more easily measured may be more frequently chosen as it can be difficult to measure complex, community-based, or systems-building interventions. Performance measures only provide a snapshot, and must be combined with other data and evaluations to provide a fuller picture of what is occurring within an MCH program. Moreover, the measures tend to be driven by the available databases, and new databases can be expensive to initiate, which can hinder performance monitoring.

Legislative priorities, which are not always based on the best available evidence, must also be taken into account. Also, it can be difficult to change priorities, especially once a program is established and a constituency is developed. Additionally, when new priorities emerge, resources must be reallocated. Building accountable systems requires further development and refinement of tools and databases, which will allow better measurement.

Performance measurement and accountability are and will continue to be fundamental to MCH. The need for MCH to document accomplishments and prioritize future initiatives based on rigorous scientific evidence will not change. A comprehensive approach to program assessment that takes into account the challenges associated with measuring complex systems-based approaches is likely to emerge, but emphasis on performance measurement will remain.

B. MCH Performance Measures

A number of tools and measures have been developed to measure performance and document accountability. The Maternal and Child Health Bureau (MCHB) uses performance measurement and other program evaluation to assess progress in attaining goals, implementing strategies, and addressing priorities. Evaluation is critical to MCHB policy and program development, program management, and funding. Findings from program evaluations and performance measurement are part of the ongoing needs assessment activities of the Bureau.

At the state level, the MCHB performance and accountability cycle begins with a needs assessment that includes reporting on health status indicators. Analysis of these data and other information leads to the identification of priority needs. MCH performance and outcome measures are developed to address those needs, and resources are allocated. Program implementation, ongoing monitoring, and evaluation follow.

Currently the MCH Program has 18 National Performance Measures, 10 State Performance Measures, 6 Outcome Measures, Health Status Indicators, and 36 Discretionary Grant Performance Measures. Federal MCH Program staff, states, and other grantees jointly developed these consensus measures. In addition to the national performance measures, states develop and report on state priority needs and performance measures.

1. Criteria for MCHB Performance Measures

MCH Performance measures must meet the following criteria:

1. The measure should be relevant to major MCHB priorities, activities, programs, and dollars.
2. The measure should be important and understandable to MCH partners, policymakers, and the public.
3. Data are available across states.
4. A logical linkage can be made from the measure and the desired outcome.
5. Measurable change should be detectable within 5 years.
6. A potential for change in the measure should be realistic.
7. Process or capacity measures should logically lead to improved outcomes.
8. Measures should be prevention focused.

Performance measures help to quantify whether:

1. Capacity was built or strengthened;
2. Processes or interventions were accomplished;
3. Risk factors were reduced; and
4. Health status was improved.

2. 18 National Performance Measures (2006)

1. 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.
2. The percent of children with special health care needs age 0 to 18 whose families partner in decision-making at all levels and are satisfied with the services they receive. (CSHCN Survey)
3. 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)

4. The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)
5. The percent of children with special health care needs age 0 to 18 whose families report community-based service systems are organized so they can use them easily. (CSHCN Survey)
6. 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. (CSHCN Survey)
7. Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.
8. The rate of birth (per 1,000) for teenagers aged 15 through 17 years.
9. Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
10. The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.
11. The percent of mothers who breastfeed their infants at 6 months of age.
12. Percent of newborns who have been screened for hearing before hospital discharge.
13. Percent of children without health insurance.
14. Percent of children, ages 2 to 5 years, receiving WIC services that have a Body Mass Index (BMI) at or above the 85th percentile.
15. Percent of women who smoke in the last three months of pregnancy.
16. The rate (per 100,000) of suicide deaths among youths 15-19.
17. Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
18. Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

3. 6 MCH Outcome Measures

1. The infant mortality rate per 1,000 live births.
2. The ratio of the black infant mortality rate to the white infant mortality rate.
3. The neonatal mortality rate per 1,000 live births.
4. The postneonatal mortality rate per 1,000 live births.
5. The perinatal mortality rate per 1,000 live births plus fetal deaths.
6. The child death rate per 100,000 children aged 1 through 14.

4. Colorado MCH State Measures

In addition to these national performance measures, states can identify their own state-specific measures. State-specific measures reflect local concerns that arise from a state needs assessment, required every 5 years.

Colorado's 10 State Performance Measures (2006)

1. The proportion of children and adolescents attending public schools who have access to basic preventive and primary, physical and behavioral health services through school-based health centers.
2. Percent of Medicaid-eligible children who receive dental services as part of their comprehensive services.
3. The percent of women with inadequate weight gain during pregnancy.
4. The rate of birth (per 1,000) for Latina teenagers age 15-17.
5. The motor vehicle death rate for teens 15-19 years old.

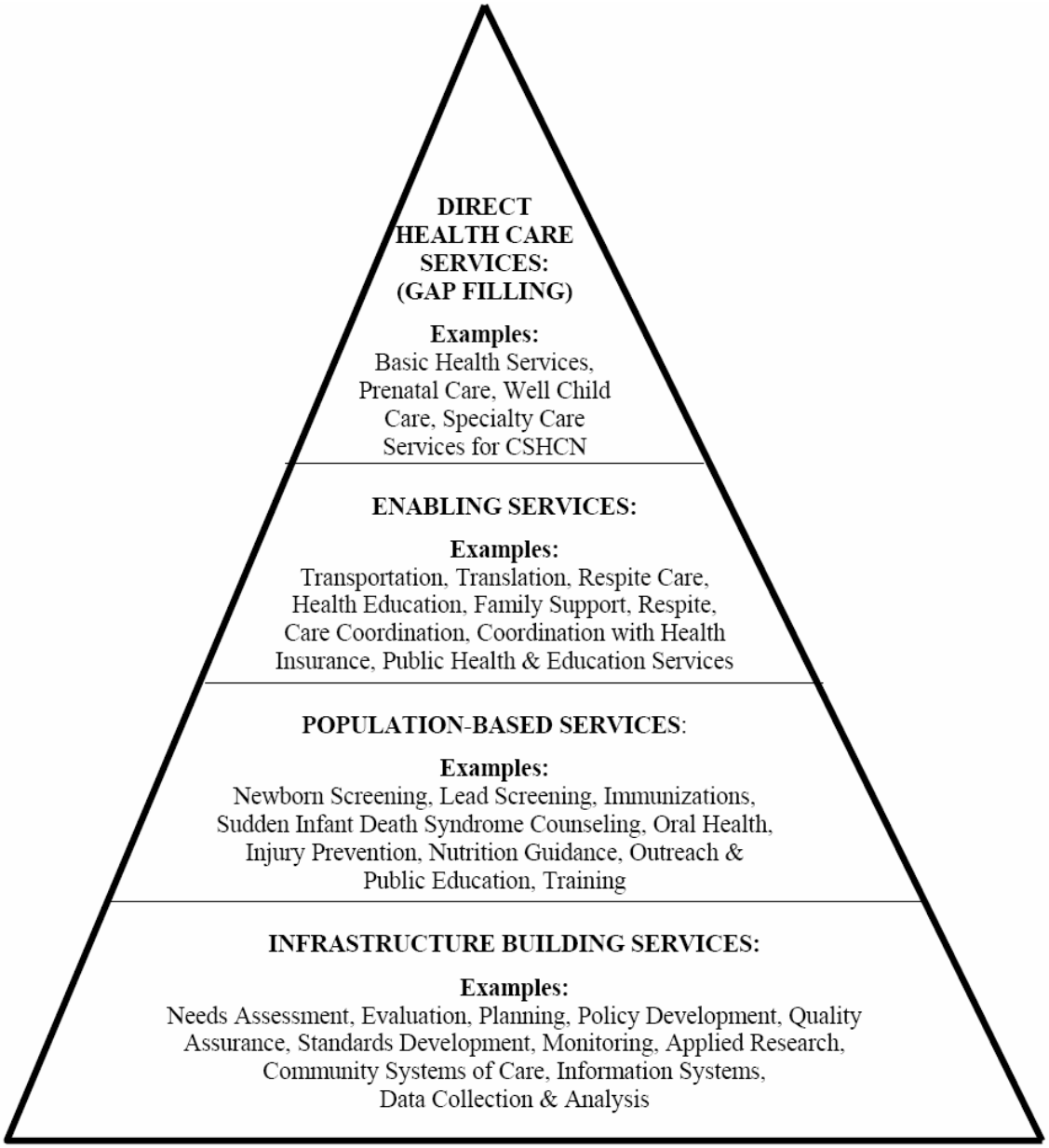
6. The percent of mothers smoking during the three months before pregnancy.
7. The proportion of all children 2-14 whose BMI > 85 percent normal weight for height.
8. Percent of children who have difficulty with emotions, concentration, or behavior.
9. Percent of center-based childcare programs using a childcare nurse consultant.
10. The proportion of high school students reporting binge drinking in the past month.

Colorado's Additional State Outcome Measure

1. The low birth weight rate per 1,000 live births.

C. Core Public Health Services Provided by MCH Agencies

MCH federal, state, and other professionals developed the MCH Pyramid to provide a conceptual framework of the variety of MCH services provided through the MCH Block Grant. The pyramid includes four tiers of services for MCH populations. The model illustrates the uniqueness of the MCH Block Grant, which is the only federal program that provides services at all levels of the pyramid. These services are direct health care services (gap filling), enabling services, population-based services, and infrastructure building services. Public health programs are encouraged to provide more of the community-based services associated with the lower-level of the pyramid and to engage in the direct care services only as a provider of last resort.



Core Public Health Services Provided by MCH Agencies[3]

1. Direct Health Care Services

Direct health care services are generally delivered "one on one" between a health professional and a patient in an office, clinic, or emergency room setting. Basic services include what most consider ordinary medical care: inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs may support services such as prenatal care, child health (including immunizations and treatments or referrals), school health, and family planning, by directly operating programs or by funding local providers. For CSHCN, these services include specialty and subspecialty care.

2. Enabling Services

Enabling services are defined as services that allow or provide for access to and the derivation of benefits from the array of basic health care services. Enabling services include transportation, translation, outreach, respite care, home visiting health education, family support services (e.g., parent support groups, family training workshops, nutrition, and social work), purchase of health insurance, case management, and coordination of care with Medicaid, CHP+, and WIC. These kinds of services are especially necessary for low-income, disadvantaged, and geographically or culturally isolated populations, and for those with special and complicated health needs.

3. Population-Based Services

Population-based services are defined as services that are developed and available for the entire population of the state, rather than in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn and genetic screening, lead screening, immunizations, oral health, injury prevention, outreach, and public health education. Population-based services are generally available for women and children regardless of whether they receive care in the public or private sector or whether or not they have health insurance.

4. Infrastructure Building Services

Infrastructure building services are defined as those services that are directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health service systems, including standards/guidelines, training, data, and planning. Needs assessment, coordination, evaluation, policy development, quality assurance, information systems, applied research, development of health care system standards and systems of care are all contained within the infrastructure umbrella.

[3] As defined by the Maternal And Child Health Bureau

1. Local Core Public Health Services for the Prenatal Population

Direct Services

- Provision of Prenatal Care Services (gap-filling)

Enabling Services

- Medicaid/Child Health Plan Plus (CHP+) Information and Outreach
- Translation and Transportation Services
- Prenatal Care/Resources, Referrals and/or Care Coordination
- Client Health Education regarding Breastfeeding, Seat Belts, Immunization, Prenatal Weight Gain and Smoking Cessation

Population-Based Services

- Public Education/Social Marketing Campaigns related to Prenatal Weight Gain, Smoking Cessation, and other Health Behaviors
- Unintended Pregnancy Prevention Projects
- Breastfeeding Promotion Campaign
- Medicaid/CHP+ Countywide Outreach

Infrastructure Building

- Community Needs Assessment, Planning and Evaluation
- Policy Development
- Monitoring and Quality Assurance
- Coalition Leadership and Collaboration
- Perinatal Periods of Risk Analysis
- Prenatal/Prenatal Plus/PRAMS Data Collection and Analysis
- Training Providers and Professionals

2. Local Core Public Health Services for Children and Adolescent Populations

Direct Services

- Well Child Care for Uninsured Children (gap filling)
- Primary Care in School-Based Health Centers
- Immunization Clinics (gap filling)

Enabling Services

- Health Education regarding Breastfeeding, Seatbelts, Immunization, Smoking Cessation, etc.
- Medicaid/Child Health Plan Plus (CHP+) Information and Eligibility
- Translation Services
- Transportation Health Care Resources, Referrals and/or Care Coordination
- Client Health Education re: Pregnancy Prevention, Fitness, Nutrition, Motor Vehicle Safety, Immunizations, Substance Abuse

Population Based Services

- Breastfeeding Promotion Campaign
- Medicaid/CHP+ County-wide Outreach
- Public Education/Social Marketing related to Child Abuse Prevention, Injury Prevention, Importance of immunizations
- Car Seat Safety Checks
- Working with Schools to improve Nutrition, Fitness and Health Education

Infrastructure Services

- Community Needs Assessment, Planning and Evaluation
- Policy Development
- Quality Assurance (working with private immunization providers and child care providers)
- Coalition Leadership and Collaboration
- Collaborate with School Health Team and Early Childhood Specialists to identify and plan to address unmet community needs
- Monitoring and Quality Assurance
- Training MCH staff, Parents and Community Professionals

3. Local Core Public Health Services for Children with Special Health Care Needs

Direct Services

- Provision of Specialty Care in HCP Specialty Clinics (gap filling)
- Diagnostic Services in Diagnostic and Evaluation (D&E) Clinics (gap filling)

Enabling Services

- Family Advocacy and Support
- Health Consultation for Medical Home, Specialty Care, Transition to Adult Health Care, Early Intervention and School Services.
- Individual and Family Care Coordination Services - Colorado Traumatic Brain Injury Trust Fund Program
- Health Care Resources, Referrals and Care Coordination for CSHCN, Families and Providers
- Medicaid/Child Health Plan Plus (CHP+) Information and Outreach

Population Based Services

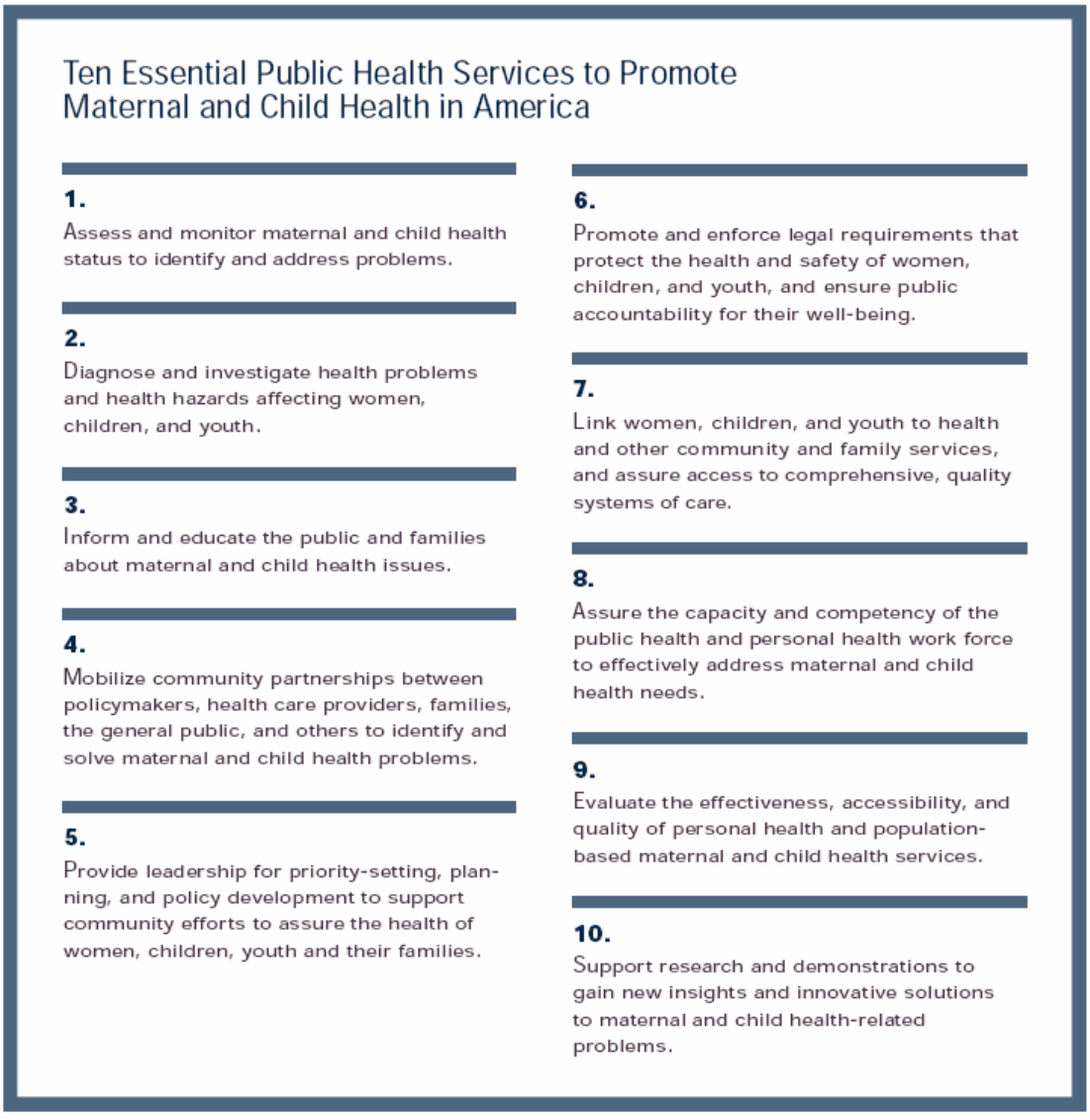
- Follow-up of Newborn Hearing Screening
- Tracking and monitoring for Colorado Responds for Children with Special Needs (CRCSN) Notification program
- Medicaid/CHP+/Supplemental Security Income (SSI) Outreach
- Public and Provider Education – Medical Home, Newborn Hearing Screening, Early Vision Screening, Developmental Screening (including mental and emotional)
- Training Families, Community Partners and Providers

Infrastructure Services

- Community Needs Assessment, Planning & Evaluation
- Interagency Leadership and Collaboration – Medical Home, Community Systems, Early Intervention, Insurance, EPSDT, Respite, D&E Services, Developmental Screening and Transition to Adult Health
- Assist State in Development of Information Systems
- HCP/CHIRP Data Collection and Local Data Analysis
- Monitoring and Quality Assurance

D. MCH Essential Public Health Services[1]

Since 1988, the public health field has built consensus around the core public health functions (assessment, policy development, and assurance) and the corresponding set of ten essential public health services. These now serve as the blueprint for local and state public health agency operations. In the maternal and child health field, a corresponding discipline-specific tool was developed, the Ten Essential Public Health Services to Promote Maternal and Child Health in America.
www.jhsph.edu/wchpc/publications/mchfxstapps.pdf



[1]Grason, H.A., and Guyer, B. *Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America.* Baltimore, MD: Child and Adolescent Health Policy Center, The Johns Hopkins University, December 1995. www.jhsph.edu/wchpc/publications/mchfxstapps.pdf