



HRSA

Health Resources & Services Administration



Title V MCH Block Grant Program

MASSACHUSETTS

State Snapshot

FY 2016 Application / FY 2014 Annual Report

April 2016

Title V Federal-State Partnership - Massachusetts

The Title V Maternal and Child Health Block Grant Program is a federal-state partnership with 59 states and jurisdictions to improve maternal and child health throughout the nation. This Title V Snapshot presents high-level data and the executive summary contained in the FY 2016 Application / FY 2014 Annual Report. For more information on MCH data, please visit the Title V Federal-State Partnership website (<https://mchb.tvisdata.hrsa.gov>)

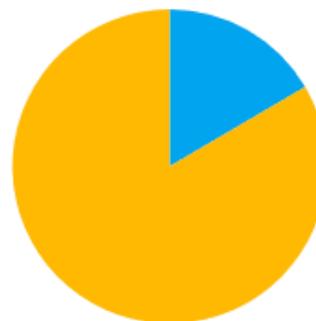
State Contacts

MCH Director	CSHCN Director	State Family or Youth Leader
Ron Benham	Ron Benham	Suzanne Gottlieb
Director, Bureau of Family Health and Nutrition	Director, Bureau of Family Health and Nutrition	Director of Family Initiatives, BFHN
ron.benham@state.ma.us	ron.benham@state.ma.us	suzanne.gottlieb@state.ma.us
(617) 624-5901	(617) 624-5901	(617) 624-5979

Funding by Source

Source	FY 2014 Expenditures
Federal Allocation	\$8,455,446
State MCH Funds	\$42,614,311
Local MCH Funds	\$0
Other Funds	\$0
Program Income	\$0

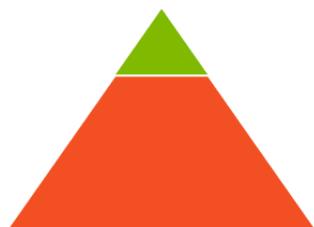
FY 2014 Expenditures



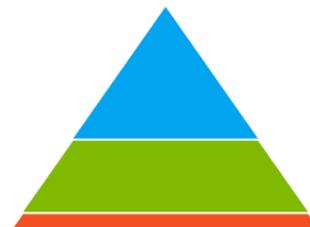
Funding by Service Level

Service Level	Federal	Non-Federal
Direct Services	\$11,681	\$25,410,800
Enabling Services	\$2,498,303	\$13,772,151
Public Health Services and Systems	\$5,945,462	\$3,431,360

FY 2014 Expenditures Federal



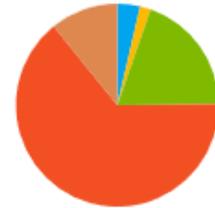
FY 2014 Expenditures Non-Federal



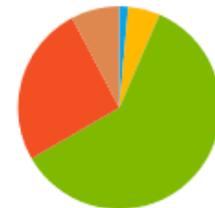
Total Reach of Title V in Serving MCH Populations

Populations Served	Individuals Served	FY 2014 Expenditures	%
Pregnant Women	15,404	\$1,907,041	3.6%
Infants < 1 Year	56,538	\$912,397	1.7%
Children 1-22 Years	663,553	\$10,242,010	19.5%
CSHCN	282,642	\$33,890,556	64.4%
Others *	85,389	\$5,696,842	10.8%
Total	1,103,526	\$52,648,846	100%

FY 2014 Expenditures



FY 2014 Individuals Served



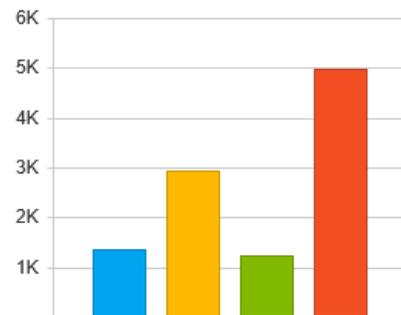
*Others– Women of childbearing age, over age 21, and any others defined by the State who are not otherwise included in any of the other listed classes of individuals.

Selected National Performance Measures

Measure #	Measure Short Name	Population Domain
NPM 1	Well-Woman Visit	Women/Maternal Health
NPM 4	Breastfeeding	Perinatal/Infant Health
NPM 5	Safe Sleep	Perinatal/Infant Health
NPM 7	Injury Hospitalization	Child Health, Adolescent Health
NPM 10	Adolescent Well-Visit	Adolescent Health
NPM 11	Medical Home	Children with Special Health Care Needs
NPM 12	Transition	Children with Special Health Care Needs
NPM 13	Preventive Dental Visit	Cross-Cutting/Life Course

Communication Reach

Communication Method	Amount
State Title V Website Hits:	1,353
State Title V Social Media Hits:	2,939
State MCH Toll-Free Calls:	1,252
Other Toll-Free Calls:	4,988



Executive Summary

I. Introduction

Maternal and child health is a significant priority and investment in Massachusetts (MA), a national leader in MCH programs and policy. The Massachusetts Department of Public Health (MDPH), the state Title V agency, is committed to protecting and improving the health status, functional status, and quality of life of residents across the lifespan, with special focus on at-risk populations, low-income groups, and cultural and linguistic minorities. In FY15, MA received \$10.7 million in federal Title V funds, and matched every \$4 in federal funding with \$16 in state funding. Title V population-based preventive and systems building services benefit all women and children in the state. In FY14 Title V provided direct and enabling services to 977,906 pregnant women, infants, children, and children and youth with special health needs. In addition, MA has achieved almost universal health insurance coverage with less than 4% of adults, and less than 2% of children, uninsured in 2014. There are high quality and diverse health resources in the state, offered along a continuum of care. MDPH provides outcome-driven, evidence-based programs to promote wellness and prevent and control disease. While MA has made progress on the 2010-2015 MCH priorities, health disparities persist and the Title V program is trying to improve its services and outcomes with fewer financial resources. Key accomplishments and challenges relative to the 2010-2015 Title V priorities and the MCH population domains are described below.

II. Accomplishments & Challenges

Women's/Maternal and Perinatal/Infant Health

MDPH's Sexual and Reproductive Health Program (SRHP) saw a 2.7% increase in long-acting reversible contraception (LARC) provision in its clinics from FY13 to FY14. In FY14, SRHP convened a group of OBGYNs to improve access to postpartum LARC insertion in hospitals prior to discharge to reduce the risk of subsequent pregnancies. Medicaid reimbursement structure was identified as the primary challenge to providing this service; the group is working with Medicaid to explore reimbursement options.

MA has a strong newborn screening program. Since 2009, MA has achieved timely follow-up annually for 100% of infants with positive screens for definitive diagnosis and clinical management for all MA mandated conditions. In FY14, 99.3% of MA births were screened for hearing loss.

The breastfeeding initiation rate for MA births in 2013 was a record high 86.0%. In 2014, 53.7% of infants were breastfed at six months of age, exceeding the national prevalence of 49.4%. Currently, 23 of the 48 MA hospitals and one birth center are committed to becoming Baby Friendly.

Challenges exist to improving the health and well-being of women in their childbearing years, such as the increasing number of babies born to mothers using opiates. In 2012, 17.2 infants/1000 live births developed neonatal abstinence syndrome (NAS) in MA, an incidence five times the national average. The increase in maternal use of opiates and subsequent NAS diagnoses is indicative of a larger trend in substance use among MA residents.

Child and Adolescent Health

Access to reproductive and sexual health services and education for adolescents has improved significantly. The teen birth rate in 2014 was 4.9 births per 1,000 women aged 15-17 years, down from 6.0 in 2013. Since 2009, the rates for 15-17 years old have been steadily declining. However, disparities in teen birth rates persist; rates for blacks and Hispanics are three to seven times higher than for whites.

In 2011/2012, 88.7% of children were in excellent/very good health, and 26.2% of children had one or more current chronic conditions. Injuries remain the leading causes of morbidity and mortality among children and adolescents. Between 2003 and 2012, the rate of non-fatal hospital discharges for children aged 0-9 decreased 13%, and rates of unintentional motor vehicle-related deaths for ages 0-14 decreased 54.8%. The percent of child passengers under age 12 observed to be properly restrained increased from 88% in 2009 to 94% in 2014.

There has been an increased focus on bullying and violence. Anti-bullying legislation was passed in 2010, and subsequently screening has increased. Homicides for youth aged 10-24 are down in all high incidence areas by as much as 50%. Comprehensive data collection and analysis are a challenge. The National Violent Death Reporting System does not include many MA towns and the YRBS only surveys in-school youth, which may miss more vulnerable youth.

Children and Youth with Special Health Needs

MDPH is committed to promoting medical home for all children. Initiatives such as the Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant contribute to improving medical home. MDPH Care Coordinators were located in the CHIPRA practices and provided direct care coordination services, technical assistance on medical home transformation, support for family partnerships, and participated in the national medical home learning collaborative. In FY15 MA received a Systems Integration Grant from HRSA/MCHB to enhance the system of services for CYSHCN and their families and plans to increase the proportion of CYSHCN who receive integrated care through a patient-centered medical home.

Transition to adulthood for CYSHCN remains an unmet need. Based on 2009/10 data, only 47% of MA youth with special health care needs aged 12-17 years received the services necessary to make transitions to appropriate adult health care, work, and independence. Parents are often not aware of all of their rights, how to advocate for their child's needs, or the resources they have to

advocate for their child. Providers often lack knowledge and skills to facilitate transition planning and readiness. In FY14, MDPH hired a full-time Youth Transition Coordinator to identify needs, resources, and training and support for families, youth, and providers.

Crosscutting/Lifecourse

MA made progress improving emotional wellness and social connectedness across the lifespan. MDPH played a key role in passing 2010 postpartum depression (PPD) legislation that requires a clinical provider to report data to MDPH annually if they screen a postpartum woman for PPD. MDPH will add a social emotional connectedness question to the MA Pregnancy Risk Assessment Monitoring System (PRAMS) Questionnaire in FY16. Despite these accomplishments, there is still a dearth of mental health services. For example, the increasing number of children with identified behavioral health challenges is outpacing the system's ability to address their needs.

MA is a leader in oral health. An Advisory Committee was established in FY14 to develop the Perinatal Oral Health Practice Guidelines for prenatal, dental and pediatric providers, making MA the seventh state to have specific perinatal and pediatric guidelines. Additionally, MA Health Quality Partners, a coalition of physicians, hospitals, health plans, patients, academics, and government agencies is working to improve the quality of health care, and included oral health screening and treatment for pregnant women in its 2013 Perinatal Care Recommendations.

Racial and ethnic disparities are seen across all Title V priorities and in most MCH outcomes, including maternal health status prior to pregnancy, school readiness, childhood obesity, violence, preventive care visits, medical home, and transitions for CYSHCN. Although MA is seeing measurable progress in its previous five-year priorities, these advances may still mask health inequity.

III. Needs Assessment

Over the past year, MDPH conducted a statewide needs assessment to understand the strengths and gaps in services and identify the most pressing MCH health needs. An expert Steering Group advised and guided the process. A Work Group collected and analyzed data from interviews, focus groups, surveys, and state and national data sources, and developed 10 MCH priorities with corresponding objectives and strategies. Town hall meetings allowed public commentary on the proposed state priorities and strategies. The result is a five-year state action plan for addressing the priorities.

IV. Needs Assessment Findings & Plan for the Coming Year

Emergent needs identified through the Needs Assessment and strategies for addressing the new priorities are highlighted below. The table illustrates the final 10 Title V priorities for 2015-2020 and the corresponding National Performance Measures.

Domain	Priority	National Performance Measure
Women's/Maternal	<u>Preventive care</u> : Promote equitable access to preventive health care including sexual and reproductive health services.	NPM 1: % of women with a past year preventive visit
	<u>Substance use</u> : Address substance use among women of reproductive age to improve individual and family functioning.	State Performance Measure TBD
Perinatal/Infant	<u>Healthy Lifestyle</u> : Improve environments, systems, and policies to promote healthy weight, nutrition, and active living.	NPM 4: A) % of infants who are ever breastfed and B) % of infants breastfed exclusively through 6 months
	<u>Violence & Injury</u> : Promote safe, stable, nurturing environments to reduce violence and the risk of injury.	NPM 5: % of infants placed to sleep on their backs
Child	<u>Violence & Injury</u> : Promote safe, stable, nurturing environments to reduce violence and the risk of injury.	NPM 7: Rate of injury-related hospital admissions per population ages 0 through 9 years
	<u>Environmental Health</u> : Reduce the impact and burden of environmental contaminants on children and their families.	State Performance Measure TBD
Adolescent	<u>Violence & Injury</u> : Promote safe, stable, nurturing environments to reduce violence and the risk of injury.	NPM 7: Rate of injury-related hospital admissions per population ages 10 through 19 years
	<u>Preventive care</u> : Promote equitable access to preventive health care including sexual and reproductive health services.	NPM 10: % of adolescents with a preventive services visit in the last year
CYSHCN	<u>Medical Home</u> : Increase connections to Medical Home for all children, including those with special health needs.	NPM 11: % of children with and without special health care needs having a medical home
	<u>Transitions to Adulthood</u> : Support effective health-related transition to adulthood for adolescents with special health care needs.	NPM 12: % of children with and without special health care needs who received services necessary to make transitions to adult health care
Crosscutting/Life course	<u>Health & Racial Equity</u> : Promote health and racial equity across all MCH domains by addressing racial justice and reducing disparities.	State Performance Measure TBD
	<u>Emotional Wellness & Social Connectedness</u> : Promote emotional wellness and social connectedness across the lifespan.	State Performance Measure TBD
	<u>Oral Health</u> : Promote equitable access to dental care and preventive measures for pregnant women and children.	NPM 13: A) % of women who had a dental visit during pregnancy and B) % of infants and children, ages 1 to 6 years, who had a preventive dental visit in the last year

Women's/Maternal Health

Substance use and preventive care, with a focus on sexual and reproductive health, are priorities for Maternal/Women's Health. The incidence of substance use disorders in pregnant women and subsequent delivery of infants with NAS is increasing. An advisory group of staff and community partners will convene to identify data and programmatic needs and to develop and implement strategies to address maternal substance use.

There is also a need to promote sexual and reproductive health services within a preventive care framework. Women's health must become broader than preconception and interconception health alone, with an increased focus on coordinated and continuous women's health care. A key strategy in FY16 is to work with providers to implement expanded federal family planning services recommendations for preconception health and other preventive health services.

Perinatal/Infant Health

Healthy lifestyle promotion and violence and injury prevention are priorities for Perinatal/Infant Health. A key aspect of healthy lifestyle is breastfeeding. In FY16, MDPH will strengthen collaboration between birth hospitals and WIC. WIC will focus on breastfeeding education during the prenatal period and continue its postpartum education and support for breastfeeding.

Safe sleep practices are associated with a lower rate of Sudden Infant Death Syndrome. MDPH is participating in the National Collaborative Improvement and Innovation Network to reduce infant death through initiatives promoting safe sleep, reducing preterm births, and addressing social determinants of health.

Child Health

Violence and injury prevention and environmental health are priorities for Child Health. Injuries remain the leading cause of morbidity for children; the main causes of non-fatal hospital discharges among children 0-9 are falls and poisonings. In FY16 WIC, Department of Children and Families, Early Intervention and Head Start will collaborate to increase poison prevention program education sessions for vulnerable populations. MDPH will continue to support the MA/RI Regional Poison Control Call Center.

MA ranks second nationwide for old housing stock, a major source of childhood lead poisoning. Asthma rates are among the highest in the country, with about 1 in 10 children having a diagnosis. To address the environmental health priority, a key strategy for FY16 is to work with clinicians and other health care providers to improve screening and provide culturally appropriate education about lead and other environmental hazards to children.

Adolescent Health

Violence and injury prevention and preventive care are priorities for Adolescent Health. Injuries are the leading cause of morbidity for adolescents; the top causes of hospitalization are poisonings, falls and motor vehicle injuries. Self-inflicted injury is of particular concern, and a key strategy for the next year is to assume a coordinating role for all of the suicide prevention related components of the 2014 An Act Relative to the Reduction of Gun Violence.

Preventive care, with a focus on sexual and reproductive health and substance use, is also a need for adolescents. To address this priority, School-Based Health Centers (SBHC) will focus professional development on increasing SBHC clinicians' capacity to address adolescent male concerns and increase behavioral health screening.

Children and Youth with Special Health Needs

Medical home and transition to adulthood are priorities for CYSHCN. A key strategy to increase awareness and connection to medical home is to align work with the CYSHCN Systems Integration Grant. Staff will participate in a cross-state Learning Community to develop common aims related to three systems integration strategies identified by MCHB: cross-systems care coordination, integration (e.g. establishing a reliable feedback loop), and development/enhancement of a shared resource that will provide families, providers and others with needed resources and/or information. To improve transitions to adulthood, a strategy in FY16 is to seek opportunities to present health-related transition information, including information on public benefits for youth and their families.

Crosscutting/Lifecourse

Health and racial equity, oral health, and emotional wellness and social connectedness are priorities for the Crosscutting/Lifecourse domain.

Racial and ethnic disparities are seen in most MCH outcomes, and continue to disproportionately affect non-Hispanic black and/or Hispanic populations compared to whites. In the next year, strategies to address this priority will focus on workforce development and training for Title V staff. Leadership will incorporate the principles of health equity, racial justice, and the social determinants of health into a new staff orientation and provide opportunities to learn from expert speakers and colleagues.

A high percentage of children and pregnant women do not receive recommended dental preventive and treatment services. Disparities in both access to oral health services and oral health status persist among racial/ethnic groups, CYSHCN, low-income, and rural populations. The MA Perinatal Oral Health Practice Guidelines are being finalized; they will be promoted through professional organizations and piloted in three community health centers.

The need to promote social and emotional wellness across the lifespan continues to be a priority in MA. To improve emotional wellness and social connectedness for families in FY16, MDPH will conduct activities to increase social connectedness screening rates, reduce social isolation through support groups and improve access to community resources for pregnant and parenting families.

MA has improved MCH health outcomes over the past five years. Nearly all MA residents have health insurance; maternal and infant mortality rates are among the lowest in the nation; teen birth rates are declining and are among the lowest in the nation; hospitalizations due to injury for children and adolescents continue to decline; and MA is a national leader in family engagement. With these strengths, MA is well positioned to address challenges and emerging issues including health disparities, rising numbers of homeless families, increasing numbers of families affected by substance use, the need for more behavioral health services for families and young children, and increasing the percentage of children receiving primary care in a medical home, including those with special health needs.