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**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH RESOURCES AND SERVICES ADMINISTRATION  
MATERNAL AND CHILD HEALTH BUREAU  
DIVISION OF STATE AND COMMUNITY HEALTH**

**MATERNAL AND CHILD HEALTH  
BEST PRACTICE WORKSHOP\***

**Workshop Draft Report**

**December 16-17, 2002**

**Jacob B. Javits Federal Building  
26 Federal Plaza  
6<sup>th</sup> Floor Conference Room-A  
New York, New York**

**INTRODUCTION**

Purpose

HRSA's Maternal and Child Health Bureau organized a "Best Practice Workshop" for representatives of the nine states with the largest populations to examine and compare selected indicators of maternal and child health. The states were California, Florida, Illinois, Michigan, New Jersey, New York, Ohio, Pennsylvania, and Texas.

The meeting was intended to identify the strategies that have been most successful in promoting maternal and child health as measured by key indicators drawn from the annual reports submitted by states in compliance with the Title V Information System (TVIS) guidelines. A secondary goal of the meeting was to gain insight into the meaning and validity of the reported data through clarifying the significance of variations in outcomes among states.

The key maternal and child health indicators that formed the core of the agenda were: (1) teen birth rate; (2) infant mortality; (3) availability of facilities for high-risk mothers and children; (4) prenatal care during the first trimester of pregnancy; (5) child deaths from motor vehicles; (6)

teen suicides; (7) immunizations; (8) application of dental sealants; (9) breastfeeding at hospital discharge; (10) newborn hearing screening; (11) services for children without health insurance; (12) and provision of Medicaid services for eligible children.

Anticipated benefits to states and HRSA include:

- More focused technical assistance requests
- Increased dialogue among states
- Effective and efficient “peer” technical assistance

### Participants

Federal MCHB participants were Cassie Lauver, Director; Jeff Koshel, Deputy Director; and New York State Field Representative Shirley Smith.

State representatives were: California: Ellen Stein, MD, Epidemiology Evaluation Section and Joan S. Dorfman, MD, MPH, Chief, Sacramento Regional Office, California Children’s Services; Florida Department of Health, Maternal and Child Health: Jody Bryan and Carol A. Graham, Ph.D.; Illinois Department of Human Services, Office of Family Health: Steve Saunders, MD, and Ralph Schubert; Michigan Department of Community Health: Douglas Paterson and Bao-Bing Zhul; New Jersey Department of Health and Senior Services, Lakota Kruse, MD, Medical Director, Family Health Services, Kevin McNally, Kathy Aveni, and Leslie Beres Sochas; New York Division of Family Health: Nancy A. Wade, MD, MPH; Michelle W. Cravetz; Mike Medvesky; and John Talerico; Ohio Department of Health: Davis Shore, MD, MPH, FAAP, Division of Family and Community Health; and Virginia Haller; Pennsylvania Department of Health, Bureau of Family Health; Crystal Fox; and Carolyn Cass; and Texas Department of Health, Margaret Mendez and Fouad Berrahou.

Additional assistance was provided by Victoria Freeman, MCHB consultant from the SHEPS Center, University of North Carolina, and Delora Shedrick and Perry Frank, MCHB consultants from Westover Consultants, Inc.

## **DISCUSSION OF NATIONAL CORE PERFORMANCE MEASURES**

### **NPM #6: Teen Birth Rate**

Data indicate that there are not more teen pregnancies relative to the total population, but there are more unmarried teen pregnancies. Among mothers under 20, 82% of pregnancies are unplanned. While numbers on deliveries are solid, the number of teen pregnancies is more difficult to measure because some state Medicaid programs pay for abortions, while others do not. Large states tend to have lower teen birth rates, perhaps because of their relative affluence. Experience indicates that a comprehensive approach works best—sex education in the schools, abstinence programs, school-based counseling services, clinics geared to teens, and mandatory counseling for unmarried teen welfare mothers after delivery is some strategies that, in combination, apparently reduce teen pregnancy.

## **NPM #8: Child Deaths from Motor Vehicles**

State rankings for this indicator are especially dependent on data collection techniques, because different states use various sources and criteria to determine the number of child deaths from motor vehicles. In some states, the data comes directly from vital statistics records, while others use broader criteria that include pedestrian and bike fatalities. The trend in child motor vehicle fatalities seems to be down, perhaps because of the prevalence of mass transit, strict laws regarding child safety seats and DWIs, and the prevalence of Level III trauma centers. It is important to analyze data in states with wide variations in conditions to assess the impact of factors such as licensing age and average driving speed. NITZA grant money may be available to help fund studies.

## **NPM #16: Teen Suicides**

Rates of teen suicides have fallen, although representatives were uncertain as to how to interpret this trend. States expressed a general dissatisfaction with the reliability of the data, feeling that the number of teen suicides is underreported. Death certificates may list cause of death in suicides as “accidental.” Studies found that many more teens had contemplated suicide than had succeeded, males are more likely to succeed than females, and gay and lesbian teens are more likely to attempt suicide than their heterosexual counterparts. It is important to identify variables that affect rate: reduced teen births and high numbers of Catholics would seem to be logical factors, but investigation seems to rule them out. Other possibilities include the availability of guns, access to level III trauma centers, and teen support and intervention services. Apparently successful programs include risk assessment in the schools; community coalitions and health worker training; and suicide “hot lines.”

## **NPM #5: Immunizations**

States reported progress on increasing immunization rates. Data issues include spotty reporting by providers and multiple sources for numbers. Successful programs have focused on implementation and computerization of statewide immunization registries, co-location of immunization services with the WIC program, and technical assistance to private physicians to increase awareness of both opportunities and counter-indications for immunizations.

## **NPM #7: Dental Sealants**

Access to dental care is difficult, causing a wide discrepancy between coverage and utilization—47% vs. 25%. States speculated that part of the problem stems from lack of transportation to dental providers, and reluctance of dentists to treat Medicaid patients. Raising rates in some states has not increased usage; however, speed in payment may be a factor. Some states have increased access by providing coverage through third-party insurers, thus making it impossible for dentists to identify Medicaid patients. Procedures guaranteeing that slots will be filled even if a child cancels have also helped. Underinsurance is a major problem: Many children are on private insurance plans that don't include dental coverage. School programs providing dental insurance to children who are eligible for free lunch has helped to close this gap. Some states have located dental clinics in their health departments. Other initiatives include recommending

fluoride mouth washes, developing a Web site for dentists who are willing to see Medicaid patients, creating a strategic plan through the state health department, and educating professional associations to encourage pro bono services. Data on dental access comes from most varied sources of all measures States agree about the need for standardized reporting and national surveys.

### **NPM #9: Breastfeeding at Hospital Discharge**

Breast feeding at hospital discharge has increased dramatically in the last 10 years, in some cases more than doubling. As studies have demonstrated the benefits of breast feeding, states have instituted a variety of successful programs to encourage mothers to breast feed in the hospital. Nevertheless, follow-up studies show that only 16% of mothers are still breast feeding after 6 months. Support for breast feeding is mandated under Healthy Start, part of the Medicaid reenactment. Breast feeding initiatives are concentrated in state WIC programs, which include increased nutrition services for breast-feeding mothers, use of WIC money to purchase breast pumps, and publication of lists of breast feeding friendly businesses. State WIC staff, as well as hospital and medical associations, have developed special programs, including speakers, pocket guides, and magnetized reminders. Ethnicity and culture are important factors in promoting and sustaining breast feeding, a factor that helps states customize services. Nevertheless, states with similar ethnic composition showed a large, unexplained discrepancy in breast feeding patterns. States are also promoting breast feeding through graphical displays on Web sites, brochures, and signage. Respondents commented on indications of soft data--one survey found much more consistency in reporting the mandated 72-hour heel stick than in reporting whether the mother was breast feeding at discharge. Numbers come from different sources: some states use the Ross Survey, others use WIC data.

### **NPM #15: VLBW Live Births**

Many unknowns and caveats surround the issue of the cause and prevention of low birth weight babies. Data from a variety of sources suggest that demographics rather than public health initiatives are related to low-weight births. Perinatal profiles based on a compilation of birth and fetal mortality statistics for hospitals and birthing facilities have been useful in identifying types of providers and practices that are associated with higher incidences of low birth weight babies. States reported success with a public education program, including technical assistance to help local health departments analyze their own data and extra training for everyone, including gynecologists. One state used census data to target high-risk areas and provide customized technical assistance and support. States that have less centralized authority in overseeing county programs have not been as successful in attacking the problem. Because of demographic variables, crude rates may not be best indicator of state success in preventing low birth weight babies. Factors that should be investigated are average age of mothers, prevalence of multiple births through assisted reproduction methods, and definition of "live birth," as well as the presence of domestic violence, infections, and stress. Other important considerations are the lack of consistency among states in defining low birth weights, and confusion on the goal of interventions—whether to save lives or prevent pre-term deliveries.

### **NPM #17: VLBW at High-Risk Facilities**

Since 1996, the incidence of low birth rates has increased for all states, but outcomes vary geographically, by state and region. Analysis indicates that gains in infant viability are primarily the result of medical breakthroughs, and not public health efforts. Risk adjustment by ethnic and economic variables has proved political and contentious. Although states are required to monitor and report the care of high-risk mothers in appropriate facilities, this approach is problematic because mergers and closings have led to reclassification of facilities. Additionally, data suggests that adherence to regulations mandating prenatal care of high-risk pregnant women at CCS facilities is probably linked to proximity to facilities and/or the availability of transport services for mothers. Better outcomes are reported under managed care than under Medicaid fee-for-service. Technical assistance to satellite clinics that care for high-risk mothers has proved helpful. Receiving care in the 1<sup>st</sup> trimester of pregnancy is an important factor in outcomes.

### **MPM # 18: Women Served in 1<sup>st</sup> Trimester**

Data show that receiving care in the 1<sup>st</sup> trimester of pregnancy is one of the most important factor in predicting maternal and child health outcomes. One state reported that women who had poor prenatal care had 5 times as many preterm births as those who had good care. Reflecting this fact, states have implemented aggressive programs to support early care. High-level support at the state level has augmented programs, including production of wellness guides distributed through health care facilities, and implementation of a community college program to train prenatal workers. Successful state maternal and child health initiatives include contracts with insurers for provision of services to high-risk women, expanded service eligibility criteria, simplified and expedited enrollment procedures, and various state-funded programs that encourage self-care and empowerment.

### **NPM #12: Children without Health Insurance**

Coverage of uninsured children through the S-Chip program is fraught with difficulties. States reported large groups that are ineligible under current guidelines, including families who have any type of insurance, regardless of how inadequate, and, in some states, undocumented immigrants. S-Chip children have been refused care in some states because of provider prejudice and dislike of the fee structure. The waiting period of six months to a year is burdensome for families. Older children and adolescents are especially underserved. Successful strategies to increase coverage include development of a simplified two-page application; incentives to community-based organizations to help applicants complete the enrollment process; promotion of the program through the schools; and a major media campaign to encourage enrollment. States commented that it is difficult to assess progress since historical data on this issue is missing, and analysis of data from the rolling 3-year CPS masks changes

### **NPM #13: Medicaid Services for Eligible Children**

States reported a problem with the reporting and analysis of data on this issue. The term “Medicaid eligibility” is meaningless, since *everybody* is potentially eligible—therefore, it is only possible to refer accurately to “Medicaid enrollee.” The HIPPA 416 can only generate the

percentage of eligible children receiving preventive care. Eligibility varies among states—in some cases a missing parent is a qualifying factor, other states provide services to families with income less than 200% of poverty level, and some do not serve undocumented immigrants. The participants unanimously supported redefining the performance measure to reflect the information required on the HIPPA 416.

### **NPM #10: Newborn Hearing Screening**

States report outstanding success in implementing newborn hearing screening programs. Some states have now legislated hearing screening for all newborns, and state health departments are providing start-up funds for equipment and training. Tests are electronically administered and reported. One state has linked Medicaid reimbursement for delivery to documentation that the test has been administered. States have integrated the test with eligibility for audiology services. Partnerships with universities and advocacy groups have strengthened programs. Follow-up procedures are in place; however, many patients fail to return for additional tests and intervention. Some states pay for a limited number of hearing aids. One state is considering a study to track epidemiology and risk factors for hearing loss.

### **CONCLUSION**

Several important themes emerged from the meeting. States agreed that some approaches had been useful, regardless of the outcome measure being discussed. Also, participants identified a number of data issues that may affect results.

#### Best Practices

- Measurements and Comparisons as Tools. States found that measuring outcomes and ranking state jurisdictions and programs is a valuable tool in identifying best approaches.
- Reward good results. Positive feedback and public recognition can be powerful motivators.
- Create interdisciplinary teams to examine measures. Looking at data and outcomes from a variety of disciplines and perspectives yields valuable insights and ideas..
- Optimize program organization. Analyze services to eliminate redundancy and co-locate related programs wherever possible.
- Involve the community. Solicit community in-put and recruit members of the community as volunteers and allies.
- Enhance data collection, analysis, and sharing capabilities. Expanding data information systems is key to providing services in the 21<sup>st</sup> century. Improved data collection and analysis target key conditions and interventions—for example, low birth weight babies States should use this information to direct resources and design programs accordingly.
- Expand strategies that have proved successful. Broadening eligibility for programs such as Healthy Start and standardizing screening for domestic violence are examples.
- Revise performance indicators every 10 years. Re-evaluation of indicators every 10 years assures that data captures current issues and the national health objectives.

- Co-locate the MCHB in the state department of health. This organization strengthens programs in myriad ways.
- Seek high-level support of programs for maternal and child health programs. Such support at the level of the governor has been instrumental in creating strong programs.
- Provide technical assistance. TA for community-based organizations, state units, and medical practitioners can make a big difference.
- Expand eligibility criteria and simplify enrollment. The more people getting services, the better the outcomes will be.
- Focus on 1<sup>st</sup> trimester care. Care of pregnant women in the 1<sup>st</sup> trimester of pregnancy is the most important single determinant of maternal and child health.
- Encourage treatment of poor women and children. Reluctance of providers to treat poor patients can be addressed through education of the health profession, improved reimbursement processes, payment through private insurers, and work with patients on compliance issues.
- Link data reporting to Medicaid reimbursement. This is an effective incentive for consistent and accurate input.

#### Data Issues

- Performance as Basis for Funding. Some states are experimenting with use of performance measures as a basis for funding. While this policy clearly has some potential benefits in helping to weed out bad programs and reward good ones, the approach has been questioned based on the quality of performance data and the possibility of designing and recording services for the purpose of “gaming” the system.
- Standardize data collection and reporting procedures. Comparisons and ranking among states are complicated by different definitions and data sources.
- Use statistical methods to conduct analyses of variables. What seems to be an obvious connection may break down under statistical scrutiny. Hire staff who can perform sophisticated analysis to disaggregate variables and determine the true causes of outcomes.
- Create fail safe data reporting procedures. Correct reporting should be built into every procedure.
- Develop strict, comprehensive confidentiality guidelines. Maintaining confidentiality is an important issue that must continue to be addressed and reassessed as technology and collection procedures change.

### ***Project Director Acceptance of Report***

**Task: Maternal and Child Health Best Practice Workshop Draft Report**

**Acceptance:** \_\_\_\_\_ **Date** \_\_\_\_\_

**\*Written and submitted by Perry Frank, December 2002. Not for citation and distribution.**